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The present and future role of community pharmacy in South Africa

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THE PRESENT AND FUTURE ROLE OF COMMUNITY PHARMACY IN SOUTH AFRICA

Leah Gilbert (Steinberg)

A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, in fulfilment of the requirements for the Degree of Doctor of Philosophy. This thesis is presented as a series of manuscripts.

1997

DECLARATION

I declare that this thesis is my own independent and unaided work. All the chapters in this thesis originated out of my own ideas, were executed, analysed and written up by myself. It is being submitted to the University of the Witwatersrand, Johannesburg in fulfilment of the requirements for the Degree of Doctor of Philosophy. It has not been submitted before for any degree or examination in any other University.

Leah Gilbert

BA (Sociology), MA (Public Health)

To my late parents, Sara and Moshe Steinberg, for their unconditional love, and to my family - Dave, Shirli and Tal - who made it all worthwhile.

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PUBLICATIONS AND CONFERENCE PROCEEDINGS

PUBLICATIONS

Gilbert Leah (1995)
Sociology and the "new public health" in SA.
***South African Journal of Sociology*, 26, 4, 1-10.**

Gilbert Leah (1998)
Community pharmacy in South Africa - A changing profession in a society in transition. ***Health & Place* - In Press.**

Gilbert Leah (1995)
The pharmacist's traditional and new roles - A study of community pharmacists in Johannesburg, South Africa.
***Journal of Social and Administrative Pharmacy*, 12, 3, 125-131.**

Gilbert Leah (1998)
Pharmacy's attempts to extend its roles - A case study of amendments to legislation and special permit holders in South Africa.
***Social Science & Medicine* - In Press.**

Gilbert Leah (1997)
Is the pharmacist the 'poor man's doctor'? - A study of utilisation of community pharmacies in Johannesburg, South Africa.
***International Pharmacy Journal, Official Journal of FIP*, 11, 100 - 104.**

Gilbert Leah (1998)
Transforming community pharmacy in South Africa - The position of training.
***Journal of Social and Administrative Pharmacy* 15, 1, 23-32.**

Gilbert Leah (1998)
Pharmacist and nurse: A team approach towards Primary Health Care or a convenient "Therapeutic Alliance" ?
***International Journal of Nursing Studies*, 34, 11, 367-374.**

Gilbert Leah (1998)
Dispensing doctors and prescribing pharmacists: A South African perspective.
***Social Science & Medicine*, 46, 1, 83-95.**

Gilbert Leah (1997)
The pharmacist as a primary health care team member - The role of the community pharmacist as perceived by doctors and nurses.
***International Journal of Pharmacy Practice*, 5, 4, 192-200.**

CONFERENCE PROCEEDINGS

Gilbert Leah (1996)
Community pharmacy in South Africa - A changing profession in a society in transition. *Presented as a poster at* ***The 9th International Social Pharmacy Workshop,*** *University of Wisconsin School of Pharmacy, Madison, Wisconsin, USA, 11-14 August 1996.*

TABLE OF CONTENTS

	Page Number
TITLE	1
DECLARATION	2
DEDICATION	3
ACKNOWLEDGEMENT	4
LIST OF PUBLICATIONS AND CONFERENCE PROCEEDINGS	5
TABLE OF CONTENTS	7
LIST OF ABBREVIATIONS	9
INTRODUCTION	10
METHODOLOGY	17
CHAPTER I	38
Sociology and the "New Public Health" in SA	
CHAPTER II	81
Community pharmacy in South Africa - A changing profession in a society in transition	
CHAPTER III	120
The pharmacist's Traditional and New Roles - A study of community pharmacists in Johannesburg, South Africa	
CHAPTER IV	139
Pharmacy's attempts to extend its roles - A case study of amendments to legislation and special permit holders in South Africa	

CHAPTER V 182

Is the pharmacist the 'poor man's doctor'? - A study of utilisation of community pharmacies in Johannesburg, South Africa

CHAPTER VI 208

Transforming community pharmacy in South Africa - The position of training

CHAPTER VII 249

Pharmacist and nurse: A team approach towards Primary Health Care or a convenient "Therapeutic Alliance" ?

CHAPTER VIII 264

Dispensing doctors and prescribing pharmacists: A South African perspective

CHAPTER IX 312

The pharmacist as a primary health care team member - The Role of the community pharmacist as perceived by doctors and nurses

GENERAL CONCLUSION 349

THE WAY FORWARD 369

BIBLIOGRAPHY 375

APPENDIX I - QUESTIONNAIRES

NOTE: As the manuscripts presented in Chapters I-IX had to comply with the requirements of the different scientific journals to which they were submitted, editorial inconsistencies are evident. The most obvious of these concerns the format of the reference lists at the end of each chapter. In addition, since each of these chapters was submitted for publication as an independent unit, some overlap between the chapters has been unavoidable.

LIST OF ABBREVIATIONS

DHS - District Health System

FIP - International Pharmaceutical Federation (Translation from French)

INCH - Institute for Contemporary History

ISAPC - Interim South African Pharmacy Council

MASA - Medical Association of South Africa

MCH - Maternal and Child Health

NCHE - National Commission on Higher Education

NHI - National Health Insurance

NDP - National Drug Policy

NPH - New Public Health

PHC - Primary Health Care

PPAC - Pharmacy Professional Awareness Campaign

PSSA - Pharmaceutical Society of South Africa

RDP - Reconstruction and Development Programme

SA - South Africa

SAMDC - South African Medical and Dental Council

SAPC - South African Pharmacy Council

WHO - World Health Organisation

INTRODUCTION

The recent political transformation which has taken place in South Africa has set the scene for a metamorphosis of thinking paradigms and structures, in society in general, and in the health arena in particular. One of the main shifts has been the growing emphasis on **Primary Health Care** and its implementation, a move which has necessitated a reevaluation of the roles which the various health professions fulfil within this framework. The need for new types of solutions to respond to peoples' health needs, along with the poor fit between research and the knowledge required to improve the situation, has contributed to the movement now referred to widely as the **"New Public Health".**

The developments which gave rise to the new public health movement coincided with attempts by the **pharmacy profession** to redefine its roles. The limitations of the bio-medical paradigm combined with the need for a broader perspective of analysis and, in particular, the adoption of a sociological perspective, have been identified in both, and have thus emerged as links which could facilitate a better understanding of the processes involved. In addition, one of the defining characteristics of the new public health is the recognition that the knowledge and skills of all health professions are necessary for devising and implementing effective responses to the complex public health challenges facing contemporary societies.

The present study of community pharmacy against the background of a society in transition provides an example of sociology's engagement with the new public health and

its attempts to create a sound, relevant and interdisciplinary knowledge base.

Pharmacy is a profession in transition which is engaged in various forms of **reprofessionalisation** and **role extension** in order to maintain its meaningful contribution to health care. Of all the major health care professions, pharmacy has received the least amount of attention from social researchers. The result has been that pharmacy is a somewhat 'invisible' health care profession, and those outside of it are relatively uninformed about pharmacy and the challenges it faces. In addition, the contribution of the social sciences to pharmacy practice research has been modest and of limited significance.

It is the aim of this thesis to address both gaps by exploring and analysing the position of community pharmacy within a wider framework of public health and the transformation of health services in South Africa. It is my hope that the adoption of a sociological perspective will facilitate a new and more in-depth understanding of the complexities of the profession[1], thus adding to the existing body of knowledge. This will in turn inform future policies and offer more insightful solutions based on a unique interdisciplinary analysis.

The rationale for this study is that since the role of the community pharmacist has been

[1] Although this thesis makes use of theories of professions, it is not its intention to produce a sociological analysis of pharmacy as a profession or to enter the debates in this field.

coming under increased scrutiny and reappraisal, its nature and potential in the health system in South Africa needs to be examined. This is particularly important due to the changes taking place, and due to the fact that no similar studies exist within the South African context.

This thesis is presented as a series of nine manuscripts which have been prepared for publication in scientific journals. Note should be taken that for this reason there is no separate section on the literature review, since each article contains its own relevant literature review. In the same manner, each manuscript contains a section in which the issues raised in that particular manuscript are discussed and critically analysed. Although each manuscript stands as an independent entity, it is my hope that all of them together meet the general aims of the thesis. However, in order to provide a more coherent and incisive framework for the research as a whole, an attempt has been made to critically interpret the data presented and analyse the issues emerging out of the nine manuscripts in the final sections of the **"general conclusion"** and **"the way forward".**

I. SOCIOLOGY AND THE "NEW PUBLIC HEALTH" IN SOUTH AFRICA - The various dimensions of the "New Public Health" in general and in the South African context in particular are explored in this paper. Sociology's role in public health research and training is examined through an historical perspective.

II. COMMUNITY PHARMACY IN SOUTH AFRICA - A CHANGING PROFESSION IN A SOCIETY IN TRANSITION - The analysis of community pharmacy as a profession in transition acquires an additional dimension in South Africa, since it is inextricably linked to its social characteristics as well as to the political transformation taking place. The relevant societal features are presented in this paper and some of the complexities associated with the existing as well as the potential future role of community pharmacy in the context of changing health services in a society in transition are explored.

III. THE PHARMACIST'S TRADITIONAL AND NEW ROLES - The existing activities of community pharmacists, their perceptions of their present and future roles, as well as the appropriateness of their training in preparing them to fulfil the diverse components of their role are the main themes included and examined in this paper.

IV. PHARMACY'S ATTEMPTS TO EXTEND ITS ROLES - A CASE STUDY OF AMENDMENTS TO LEGISLATION AND SPECIAL PERMIT HOLDERS IN SOUTH AFRICA - The role expansion of community pharmacy in South Africa, against the background of phenomena such as professional dominance and boundary encroachments, is scrutinised in this paper.

V. IS THE PHARMACIST THE 'POOR MAN'S DOCTOR' ? - A STUDY OF

UTILISATION OF COMMUNITY PHARMACIES IN JOHANNESBURG, SOUTH AFRICA - The pharmacist was the 'poor man's doctor' and in the days before the labouring classes qualified for a medical aid system, he (she) was for many the first line of defence in the maintenance of personal and family health. In this paper I reflect on the above statement and similar perceptions by examining the changing role of pharmacists and the way they are utilised in the South African context.

VI. THE ROLE OF TRAINING IN TRANSFORMING COMMUNITY PHARMACY - A CASE STUDY OF PHARMACISTS AND STUDENTS IN JOHANNESBURG, SOUTH AFRICA - The new vision of the profession as presented by the South African pharmaceutical societies and the South African Pharmacy Council, is the focus of this paper. The question of how training is perceived by faculty, students and pharmacists as equipping them appropriately to engage in the range of activities required of them in terms of this new professional vision, forms the main thread of this paper.

VII. PHARMACIST AND NURSE: A TEAM APPROACH TOWARDS PRIMARY HEALTH CARE OR A CONVENIENT "THERAPEUTIC ALLIANCE" ? - The nature of the therapeutic alliance between nurses and community pharmacists in the South African context is explored and analysed in this paper.

VIII. DISPENSING DOCTORS AND PRESCRIBING PHARMACISTS - A SOUTH AFRICAN PERSPECTIVE - Adopting an historical and international perspective, the relationship and controversy between pharmacists and dispensing doctors in South Africa are explored in this article.

IX. THE COMMUNITY PHARMACIST AS A MEMBER OF A PRIMARY HEALTH CARE TEAM IN SOUTH AFRICA - PERCEPTIONS OF PHARMACISTS, DOCTORS AND NURSES - The growing emphasis on Primary Health Care all over the world and in South Africa in particular, has drawn increased attention to disease prevention and health promotion from many health professionals, among them pharmacists. For this reason, the role of the community pharmacist as a member of the PHC team in SA, through the perceptions of pharmacists, nurses and doctors is the focus of this paper.

METHODOLOGY

INTRODUCTION

The research methods employed in this study were shaped by the way in which the project was conceptualised. The aim of the study was to explore the position of community pharmacy in South Africa, as well as the factors that mould it. From the very beginning, it was clear that this examination should be done against the background of its social and political context - in particular the deficiencies and lack of resources in the existing health services, and government attempts at restructuring these services with an emphasis on Primary Health Care. This study was therefore conducted with a view to examining the existing as well as the potential role of the community pharmacist within the wider context of public health.

The fact that the study dealt with a complex and current issue, in addition to its broad conceptualisation, meant that a range of data and information were required. This in turn necessitated using a multiplicity of approaches and a variety of research methods (Leedy, 1993:139).

As outlined in "Sociology and the New Public Health in South Africa" (Gilbert, 1995), public health has been strongly associated with medicine, and thus tends to rely on methodologies derived from laboratory-based medical science. Although both medicine and social science have contributed to public health methodologies and knowledge, the divide between medical science and social science remains strong.

According to Baum (1995), the debate is often seen as 'hard' medical science versus 'soft' social science, despite the fact that many social scientists are on the quantitative side of the methodological divide. Unfortunately, as McKinlay has pointed out, the rigid adherents to either quantitative or qualitative methods have tended to see the two sets of methods as "fundamentally incompatible" rather than (as he feels they should be) "mutually enriching partners in a common enterprise" (1993:113).

In sociological research today, it is becoming more and more recognised that the combination of quantitative and qualitative methods, or triangulation, usually enhances the study. It increases the range and richness of the data obtained, since every research method has specific strengths and flaws (Mechanic, 1989; Babbie, 1992:109; Goodwin and Goodwin, 1984; Knafl et al, 1988; Leedy, 1993). This trend, although less overt, can be detected in public health research as well (Yach, 1992; Black, 1994; Baum, 1995).The growing acceptance of the validity of non-quantitative research has not been limited to public health. In an article published in the Journal of Clinical Epidemiology, Holman argues that "true understanding of medicine cannot be achieved without adding qualitative methods to the research arsenal" (1993:35). A similar need for qualitative research has been identified in the area of family medicine (Stange and Zizanski,1988), and oral health (Blinkhorn et al, 1989), mainly due to the increased focus on contexts that influence and affect processes and outcomes (Gift, 1996; Atchison, 1996). A case for qualitative research in pharmacy practice has also been made (Laumso, 1991; Strong, 1992). In his critical review of health services

research in pharmacy, Mays (1994) remarks that insufficient use has been made by researchers of the variety of research methods at their disposal. In particular, he suggests that pharmacy practice research would benefit from greater use of qualitative research techniques, a recommendation which has been since applied in various studies (Britten et al, 1994; Weiss, 1994; Hassel and Hibbert, 1996).

The revival of public health in the 1980s and the 'new' public health movement produced criticism of the biomedical model (Yach, 1992; Gilbert, 1995). Associated with it was a growth in social science advocates for a new way of thinking, and more importantly for the purpose of this chapter, for more creative methods of inquiry. Baum claims that a consideration of public health history over the past century highlights the need for flexible research methods, since the complexities of most public health issues require researchers to draw on a spectrum of qualitative and quantitative methods (1995:459), a view supported by others (Yach, 1992). Public health is invariably linked to political and professional agendas, therefore interpretative methods, generally based on qualitative techniques, are well suited to studying such intricate matters, and can only add to our understanding of the range of factors involved. As put so aptly by Baum, "given the complexities of most contemporary public health problems researchers need all the methodological variety they can muster to be effective" (Baum, 1995:464).

The approach adopted in this study relies heavily on the above ideas, and follows

McKinlay's assertion that "a paradigm of choices rejects methodological orthodoxy in favour of methodological appropriateness as the primary criterion for judging methodological quality" (1993:39). Thus, it complies with the notion that "methodologies for health research should be diverse and selected to suit the problem being investigated" (Baum, 1995:466), and aims to integrate the various methods employed.

The different quantitative and qualitative research methods used in this study, review of primary and secondary material, interviews with key informants, surveys of relevant role players and limited observation, are each discussed in turn below.

THE RESEARCH METHODS EMPLOYED

Review of primary and secondary material

The examination of relevant primary and secondary material was essential for providing the historical as well as the socio-political context. As such it fed into most of the articles written as part of this study.

Some of the data were collected by means of a **documentary search** which included reports and publications produced by the Government as well as Pharmaceutical Societies. The establishment of a good working relationship with the management of

the SA Pharmacy Council provided the necessary access to minutes of meetings dealing with topics relevant to the study, as well as to a range of records, statistical data and other related publications (details available in the list of references). Once analysed, these sources proved to be of great value since they provided an insight into policies, planning processes as well as professional agendas.

Since the focus of the study was on a profession in transition against the background of a society in transition, material was also collected from current newspapers as well as other publications, reflecting the changes as they occur. All main newspaper articles dealing with topics relevant to this study between 1992 and 1996 were reviewed and analysed. For this purpose the clipping service INCH developed by the Institute for Contemporary History at the University of Orange Free State, available in the reference library of the Rand Afrikaans University (RAU), was used (this service allows access to the articles via the use of relevant key words). In addition, a collection of press cuttings with the latest newspaper articles was provided by the Directorate of Health Promotion and Communications in the Department of Health. Since the articles were collected and classified in a systematic manner by both sources, it would be reasonable to assume that they represent the coverage of the topic in the written media during the period studied. As such they depicted the issues as presented to the public, and provided an additional dimension to the interpretation of events and debates. This study confirms Morris's claim that newspaper clippings can be an "invaluable source, especially for ... contemporary history" (1996: 53). One of the

many examples of the use of newspapers as a source of analysis is provided by Babbie while describing a study carried out by Funkhouser (1992:322-333).

A video presentation in which most of the key role players in community pharmacy in South Africa had an opportunity to present their views was also used. This video documents a significant event in the history of pharmacy in South Africa. As announced by the organisers: "It was the day that approximately 1 580 pharmacists throughout the country gathered to witness 'access to Act 101' - a live M-Net business broadcast arranged by the Pharmacy Professional Awareness Campaign (PPAC) in collaboration with the South African Pharmacy Council". Panellists who went live on the air were Gary Kuhn, president of the Pharmaceutical Society of SA; Gert van der Vyver, president of the SA Association of Community Pharmacists; Neville Lyne, chairman of PPAC and Johan van der Walt, president of the SA Pharmacy Council (PPAC, 1993).

Interviews with key informants

As stated by Babbie (1992), the use of informants is of particular value in the early stages of the research. Although one needs to be aware that members of a particular group (in this case, the various professional groups) are unlikely to give the researcher completely unbiased information (Babbie, 1992:290), they are a good source of material. The intensive interviews conducted with a range of people provided the

necessary facts and details and allowed me to familiarise myself with the issues as well as to understand the general context. These were mostly unstructured, nondirective, in depth interviews which differed from formal survey research interviews. Corresponding with the nature of these kind of interviews (Neuman, 1994:358), good rapport was established with some of these informants following the initial interviews, thus facilitating the continuous existence of 'resource people'. These were used throughout the study to gain additional information and clarify issues.

The following acted as key informants:

Mr C. M. Van Niekerk - Registrar, The South African Pharmacy Council (at the time the study was carried out).

Lorraine Osman - Lecturer in "Pharmacy Practice" - University of the Witwatersrand, Johannesburg (at the time the study was carried out), currently responsible for continuing education at the Pharmaceutical Society of South Africa.

Mr O.M.B. Pharasi - researcher at the Centre for the Study of Health Policy, Department of Community health, University of the Witwatersrand, Johannesburg (at the time the study was carried out), currently Chief Director Registration, Regulation and Procurement. Department of Health.

Mr G.M. Kuhn - President of the Pharmaceutical Society of South Africa (this interview was conducted by students).

Faculty members engaged in teaching pharmacy practice in all training institutions in South Africa provided an additional group of relevant informants. With the assistance of Lorraine Osman, a self administered questionnaire, including closed and open ended questions was completed by seven members from the various institutions.

Limited participant observation

The method of participant observation is often used as a supplementary research strategy to the interview. In this case the interviewer "identifies him or herself as a researcher and interacts with the participants in the social process but makes no pretences of actually being a participant", or "is observing a social process without becoming involved in any way" (Babbie, 1992:289). Both roles were adopted in this study while visits were made to the various pharmacies. The observation concentrated on the area where the pharmacy is situated, so as to be able to locate it in its social context; the layout of the pharmacies, and the interactions between staff members and clientele were specific areas of investigation. The observations provided me with snippets of the 'social reality' of a community pharmacy, and as such provided useful information and insight towards the analysis of the issues dealt with.

Surveys

Survey research is probably the best method available to the social scientist interested in collecting original data for describing and analysing a population too large to observe directly (Babbie, 1992:262). For this reason, surveys of the relevant groups of role players were conducted as part of this study.

The surveys were conceptualised around the following main themes: (I) the nature of activities undertaken by the community pharmacist; (ii) the appropriateness of training; (iii) contact with other health professionals; (iv) changes in the profession; and (v) vision for the future. An additional focus was the nature of the 'user population'. The questionnaires were structured around these themes, and an attempt was made to keep the unique structure of the questionnaires, whether as a basis for an interview or as self administered, in order to be able to make comparisons where appropriate (see appendix I). The questionnaires included closed- and open- ended questions. This was done on purpose, after an examination of the advantages and disadvantages of open versus closed questions (Neuman, 1994:232), in order to facilitate the collection of quantitative as well as qualitative data, thus combining the benefits of both. The rationale was that it facilitates the exploration of the issues from different angles and thus has the potential to produce more comprehensive results (Tudiver et al, 1991). An analysis of both kinds of data provided answers to questions such as "how often" as well as "what" and "why", which are the distinguishing features of quantitative versus

qualitative research (Black, 1994).

The advantage of using open-ended questions, and learning from the respondents became apparent in the early stages of the study, when the issue of dispensing doctors surfaced as a main problem which warranted further research, and altered the course of the original study design. This confirms Bryman's claim that "qualitative research is deemed to be much more fluid and flexible than quantitative research in that it emphasises discovering novel or unanticipated findings and the possibility of altering research plans in response to such serendipitous occurrences" (1984:77-78).

Face-to-face interviews, which have the highest response rate and permit the longest questionnaires (Neuman, 1994:245) were used to gather the data in all surveys (excluding the survey of the special permit holders). An additional advantage of this kind of interviews is that the interviewer can observe the surroundings as well as non-verbal communication. The interviews were conducted by me with the assistance of well-trained interviewers. The detailed questionnaires can be found in Appendix I and although they contain a high number of questions, the interview did not last longer than one hour in most cases. For this reason, interviewer or interviewee fatigue has not presented a problem in this study.

For practical reasons, a decision was made to limit the surveys to the Johannesburg area. At the time in which the study was conducted, the municipal boundaries of

Johannesburg were about to be changed (and changed as the study progressed). To simplify the study framework, the 'old' boundaries of Johannesburg were used for the surveys of community pharmacists, nurses and doctors.

A more detailed account of the various surveys is provided in the following section.

I. Survey of community pharmacies in Johannesburg

A full register of pharmacies in Johannesburg was supplied by the South African Pharmacy Council, and provided the sampling frame of this survey. A representative sample of 55 community pharmacies was selected by means of random numbers allocation out of a total of 275 community pharmacies in Johannesburg. All except two of the pharmacists approached agreed to participate in the study. The final number of participating pharmacies was therefore 53. Around the time of conducting the interviews with the pharmacists and the 'users', an **observation** based on guidelines was carried out at each pharmacy in order to examine the activities performed by the pharmacist and establish the nature of the encounter with users and other staff members.

II. Survey of community pharmacists

In addition to this observation, a structured interview, based on a questionnaire with closed as well as open ended questions, was conducted with the pharmacist. The guidelines to the observation and the questions for the interview were developed out of an analysis of hundreds of previous projects carried out by pharmacy students as part of their requirements in my course[1]. Staff members teaching pharmacy practice were consulted and 'piloted' with the interview. The observations as well as the interviews were done by me and two trained research assistants. The quantitative data was analysed using SPSS PC , while the qualitative data based on the observation and open questions from the interviews was analysed by means of grouping and classifying according to the various topics covered, which is the accepted technique for this kind of analysis (Babbie, 1992;Neuman, 1994).

III. Survey of 'users' in community pharmacies in Johannesburg

One of the aims of the study was to establish who used the services provided by the pharmacists, and for what reason. For this purpose a short, structured interview was conducted with at least five users (customers, clients, or patients) in each of the pharmacies visited. A total of 283 interviews were completed.

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[1] As part of the course: "Pharmacy, Society, Health and Disease - A sociological perspective", students conducted observations of community pharmacies as well as interviews with pharmacists.

IV. Survey of dispensing doctors in Johannesburg

The phenomenon of **dispensing doctors** emerged as a central issue in the analysis of community pharmacy in South Africa. Due to the magnitude of the problem, although not previously intended, structured interviews with a random sample of 45 dispensing doctors in Johannesburg, taken by a random numbers selection from the complete list of dispensing doctors provided by the South African Medical and Dental Council in Johannesburg, were conducted by me and a trained interviewer. The interviews were based on a questionnaire which included open as well as closed questions.

V. Survey of nurses working in community pharmacies in Johannesburg

Interviews with all nurses (15) operating out of pharmacies in Johannesburg were conducted by me and a trained interviewer. All pharmacies in Johannesburg were contacted telephonically to establish whether a nurse was employed there. The finding of this telephonic survey was that twenty two pharmacies in the Johannesburg area employed nurses on their premises at the time the study was conducted. Since some nurses work in more than one pharmacy, on different days, the 15 nurses interviewed represent all the nurses, except one who refused the interview.

These interviews were based on a structured questionnaire which included closed as well as open questions, and which dealt with the role of the community pharmacists

as well as the anticipated partnership with the nurse. At the same time observations were carried out in the pharmacy before, during and after the interview in order to ascertain the nature of activities taking place. There was no problem in gaining access to the pharmacies since both the pharmacists and the nurses were fully cooperative.

VI. Survey of pharmacists in possession of section 22A (12) permits.

An additional issue to come to the fore from the documentary analysis was the special permit given to 66 pharmacists in SA in terms of 'section 22A(12)' to prescribe medicines in higher schedules. Since this facilitates a different kind of practice, their experiences were thought to have been of utmost importance in the context of this study.

Most of them operate in out-of-reach places all over the country, and this dictated the research method used to obtain the necessary information. Despite the advantages of a face-to-face interview (Neuman, 1994:245), it was not feasible within the scope of this study to interview them all personally. A telephonic survey was considered, but the idea was dropped since the SAPC was in possession of a list of names and addresses but no telephone numbers. The assumption was that due to their special status, the pharmacists in possession of this permit would be willing to complete and return the questionnaire. It was thus decided to do a mail survey of all of them. Questionnaires, which included a set of closed as well as open questions, were mailed

to all pharmacists on the list. The package included an explanatory letter and an addressed, stamped envelope. Thirty two replies were received after 2 months and only one reminder. Huysamen related that "Bassa & Schlebusch (1984) and Bluen & Goodman (1984) report response rates of 37.19% and 36% in local postal surveys conducted on registered clinical psychologists and personnel practitioners, respectively"(Huysamen 1994:149). A study published by Adamcik et al (1986), in which the legitimacy of expanding the role of the pharmacist was studied through a survey of nurses, pharmacists and physicians in California, had similar response rates as described by Birenbaum: "In none of the samples was the return rate for the mailed questionnaire above 45 percent, and the response rate for a sample of 200 randomly selected Los Angeles physicians was a mere 31 percent" (Birenbaum, 1990:148). In light of these examples, since the response rate in this study represents 49% of the total population, it was considered to be an adequate response in a mail survey of this kind, particularly for the purpose of this study, which aimed only to explore their views and nature of practice in general terms. For this reason the findings of this mail survey are used only to highlight the differences between the activities undertaken by the pharmacists in possession of the special permit who participated in the survey and the pharmacists in Johannesburg[2].

The returned questionnaires were well completed. In some cases additional material

[2] Note should be taken that this is not an epidemiological survey, however, I was aware of the limitations posed by a low level response rate. For this reason, I used the survey for a specific purpose It should also be noted that for this kind of sociological survey the response rate in this study is relatively high.

was added in the open section, and telephone numbers were provided in case a follow-up was necessary. Based on this, and a comparable survey carried out by the SAPC, I was satisfied that there was sufficient data to produce the necessary analysis.

VII. Survey of final year pharmacy students at the University of the Witwatersrand, Johannesburg

Since the study was concerned with changes in the profession, it was important to gain data from students on the verge of becoming new members of the profession. For this purpose, interviews with 38 final year pharmacy students were completed, which represents 76 percent of all students in this year. (Although the intention was to interview all of them, it became impossible to locate all). The interviews were based on structured questionnaires which included open as well as closed questions.

CONCLUSION

The various methodologies employed allowed me to achieve the objectives of the research. They allowed for the collection of data which equipped me to examine the position of community pharmacy in the South African context as set out in the proposal. They were thus the appropriate methodologies for the study at hand. The strength of triangulation is that it allows the respective methodologies to reinforce each other. In particular, it facilitated the integration of the methods used in the analysis of

the various issues, as is evidenced in the publications that follow.

The research did not generate any ethical issues since anonymity was kept, and access did not present a problem due to a high degree of cooperation.

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CHAPTER I

Sociology and the "New Public Health" in South Africa

INTRODUCTION

"Health is a crossroads: It is where biological and social factors, the individual and the community, and social and economic policy all meet. In addition to having its own intrinsic value, health is a means toward personal and collective realization; it is therefore also an index of the success achieved by a society and its government institutions in the search for well-being, which, after all, is the ultimate goal of development" (Frenk, 1994:68).

Against this background, this paper aims to explore the dimensions of the **New Public Health** and to examine **Sociology's** role in general and in the South African context in particular.

Societies differ in their definitions of health problems, as well as in their ways of seeking explanations and organizing them, and these differences are shaped by social factors as well as historical development. The evolution of Public Health has been associated with these factors. It is for this reason that an historical perspective of the relevant developments has been applied throughout this paper.

Firstly, the changes that have occurred in society, health and medicine linked to the need for a sociological understanding for health professionals, will be examined. Within this framework, the **socio-environmental model** of health and disease, which

is the outcome of the new understanding, is presented. This is followed by a discussion of the development of public health and primary health care with its links to sociology. Finally the **New Public Health in South Africa** and the potential role **Sociology** can play in its research, practice and education are dealt with.

SHIFTS IN SOCIETY IN RELATION TO HEALTH & DISEASE

"Sociology is a relatively recent addition to the syllabuses of health care professionals: yet the interrelationship between sociology and health is not new. Indeed the very early social surveys by Rowntree (1901) and Booth (1892, 1894) showed that ill health was related to poverty and one of the early classic works in sociology took suicide as its subject (Durkeim, 1897)" (Bond & Bond, 1986:1).

Thirty or even twenty years ago, it was uncommon for students preparing themselves for a career in health to study topics drawn from the social and behavioural sciences. Today, however, the curriculum for the training of all health professionals includes a considerable amount of sociological input. At the same time, there is a growing amount of social research in the health field.

It is clear that those in charge of the planning of training programmes for health professionals have realized that the knowledge and skills required for their successful practice need to be extended to include the Social and Behavioural Sciences. It is

important, therefore, to examine the developments that have created the need for an additional, different perspective in "health practice".

The following section explores the major shifts that have occurred in society in relation to health and disease, which are responsible for the changes in the curriculum and increased focus on social aspects in health research.

***Changing patterns of disease:**

The 20th century has seen what has been termed **"the conquest of epidemic disease"** in the western world. Although this term was coined before the outbreak of the AIDS pandemic, its implications for the issues discussed here remain valid. In most of the developed world, the pattern of causes of death has shifted dramatically from the predominance of infectious diseases in the nineteenth century to that of chronic diseases today. What it means to the practice of health professionals is that since most of the conditions people suffer from today are long term, chronic, degenerative ones, there is a need for a continuous encounter with different health professionals. In addition, most of these conditions are incurable, and health professionals merely play a role in assisting the person in the "management of the disease" so they continue to live as normal a life as possible for as long as is medically possible. They do not **cure** the disease but take **care** of the patient. This brings with it a range of psychological and sociological issues that health professionals need to have some understanding of

in order to be able to help patients react to and cope with their conditions.

***Causation of disease**:

The shift in patterns of disease discussed earlier is linked to a change in the concept of causation of disease. The **"doctrine of specific aetiology"** or monocausal model of disease which was associated with the germ theory, has been replaced by a **multi-causal model** or **multi-factorial** approach. According to the new approach, the great majority of diseases today are caused by a multiplicity of factors and complex interrelationships between them. Therefore the way to examine disease and disability is to take into consideration all the variables and contributing factors as well as the interdependence between them. This approach is the cornerstone in current epidemiology and is well illustrated in the models presented by Kark (1974). It suggests that the physical and biological causes of disease often work in relationship with a variety of other causes, including psychological, social and environmental factors, rather than a specific disease being the product of a single risk factor. This approach brings the social and behavioural sciences into the picture and creates the need for its contribution.

***Comprehensive care - multi-disciplinary approach - team work:**

The understanding of the complexity of factors involved in the disease process, calls

for **comprehensive care** integrating the patient's physical, psychological as well as social well-being. Since this kind of care could not be provided by a single health profession, it has brought with it the need for a **multi-disciplinary** approach based on **team** work. In the ideal situation, the different disciplines contribute additional dimensions towards the well being of the patient or to the health system as a whole. Working with other members of the team and interacting with various disciplines requires insight into and understanding of social behaviour.

***Sociological factors in the aetiology, development and treatment of disease**:

In light of the developments discussed above, it is clear that there is a greater awareness of the importance of psychological and sociological factors and the role they play in the different stages of the disease process, from its aetiology, development and treatment to its outcome.

The recognition of the pervasive effects of social and psychological factors on health and disease has resulted in attempts to explain the differential distribution of disease in the population, or why certain groups are more susceptible to disease. This development shifted the emphasis to an examination of related lifestyles and behaviours and has in turn given rise to a wide range of conditions that contribute to the inequalities in health and disease of various social groups.

***Demographic change**:

Infant Mortality Rates (IMR), which are generally regarded as sensitive indicators of a country's level of health, have been declining in all Western countries, though disadvantaged groups always have the highest IMR. This, coupled with the development of public health measures, has led to an increase in **life expectancy**. The result is a general increase in the population of the elderly, and due to lower **birth rates**, their relative proportion in the total population. This phenomenon has been termed the **"Ageing of the population"**. Big groups of older people in the population bring with them a host of psychological and sociological problems and needs. Quite often these are the people in need of health care, suffering mostly from degenerative conditions.

***Health promotion and disease prevention**:

The realization that some of the major diseases of our times are incurable, coupled with the increasing cost of medical care, has shifted the emphasis towards the **prevention** of disease. The latter part of the twentieth century is characterised by the growing **health promotion** movement and the emphasis on **"health and maintenance rather than disease and treatment"**. Numerous health professionals spend a substantial proportion of their time focusing on the preventive and promotive side of their practice. Health promotion and disease prevention rely on peoples' attitudes and

behaviours, and as such are mainly in the domain of expertise unique to the social and behavioural sciences.

***The emergence of health care organizations**:

The provision of health care has developed into complicated organizational structures. Most health professionals operate within the structures of big and growing medical organizations, such as clinics and hospitals. Their activities are greatly influenced by overall governmental policies with regard to health care and its means of financing it in particular. This necessitates a basic understanding of the workings of bureaucracies and organisational structures, which form one of the areas of concern of sociology.

THE BIO-MEDICAL and PSYCHO-SOCIO-ENVIRONMENTAL MODELS of HEALTH AND DISEASE

Some of the 'shifts' or 'changes' discussed in this context represent components of a more general shift in the dominant framework or 'paradigm' of thinking in medicine, namely, the shift from the sole emphasis on the so called **"bio-medical model"** to the inclusion of a more comprehensive **"psycho-socio-environmental model"** of health and disease.

Bio-medical model - this term was given to the scientific paradigm in medicine. The

basic assumptions underlying this way of thinking are:

* The nature and causes of health and disease - all diseases can be traced to a specific aetiology (or origin) such as virus, parasite or bacterium.
* The patient - the treatment focuses on the patient's body, and the assumption that it can be treated like a machine in that it is passive during treatment.
* The nature of the intervention - focuses on treatment and the belief that medical knowledge and skills ('engineering') is sufficient to 'make the patient's body better'.
* The role of medicine - medical care with its technology and chemical intervention is perceived to have played a major role in the eradication of infectious and parasitic diseases as well as in lowering IMR.

These assumptions created the link between health and the medical care system, and maintained the powerful image of the role of medicine in improving health. However, the real result is an emphasis on treatment of disease (rather than health), based on technological/ chemical means, organised around medical specialities. This emphasis is reflected in the education of health care professionals as well.

In essence, the bio-medical model views health and disease through the 'microscope' and offers technical solutions to what are to a large extent social problems (Harding, Nettleton and Taylor, 1990).

Psycho-socio-environmental model - this represents a shift in the thinking mode about health, disease and the role of medicine in improving and maintaining health. While the bio-medical model focuses on the impact of medicine in the elimination of disease, the psycho-socio-environmental model focuses on the **promotion and maintenance of health through socio-environmental and behavioural changes**. It emphasises the role of peoples' behaviour, what work they do and how and where they live their lives, in determining their health status. There is recognition of the fact that the above factors are not less significant than the biological ones considered by the bio-medical model. Prevention, management of illness and comprehensive rehabilitation are, therefore, more appropriate than intervention.

According to this, people are no longer seen as passive victims of disease, but can themselves participate in their recovery as well as in the production of good health. More than that, changes in society and the environment are perceived to greatly contribute to disease management, prevention as well as health promotion. Thus social solutions are being sought to the problems of health and disease in society.

The bio-medical model keeps health in the biological context, while the **psycho-socio-environmental model** puts it in the social context, and as such offers a broader perspective, or a **'macroscope'** view.

The two models represent different 'paradigms' of thinking, and emphasise different

aspects of health and disease. Although the adoption of the **"psycho-socio-environmental model"** by all health professions who adhere to the **"bio-medical model"** is encouraged, it needs to be said that the two models provide complementary explanations rather than alternative or competing ones. As such, they broaden our understanding of health and disease in society and the role of health professionals in it.

THE DEVELOPMENT OF "PUBLIC HEALTH"

Societies differ in their definitions of health problems, ways of seeking explanations and organizing them, and these differences are shaped by social factors as well as historical development. In a similar manner, the public health field, which has been developing since the Industrial Revolution, has been subjected to these influences and has undergone reconstitutions that have reflected new relationships between society and state "particularly in their ways of reacting to health problems of individuals and populations." (Paim, 1992:136)

The public health movement of nineteenth-century England and America was stimulated by unhealthy social conditions in both industrialised urban and rural areas (Feinberg et al, 1994). It emerged as "social action" to combat the spread of infectious diseases (Afifi & Breslow, 1994).

In tandem with the developments discussed earlier, various interventions were initiated by the medical profession. These varied initiatives have been alternatively named as, public health, community health, social, community or public medicine.

It is significant to note that the common denominator is a 'group' - community or public - and the distinguishing feature is the use of the word 'health' or 'medicine': it is not just a semantic difference, but illustrates the confusion and inconsistencies within the different approaches.

The impetus to all these interventions and more recently the 'new public health' movement was the inadequacy of the 'bio-medical model' to explain disease patterns and the realisation that health of an individual includes the family, work environment, community and society at large (Tarlov, 1992).

The term "public health" is charged with ambiguous meanings. One particular problematic connotation equates the adjective "public" with government or "non-personal" health services. This has been addressed in the more recent comprehensive conception of public health.

A search for a definition of 'public health' produces a variety of interpretations, of which only a small sample will be introduced here: "Public health is one of the efforts organised by society to protect, promote, and restore the people's health. It is the

combination of science, skills and beliefs that are directed to the maintenance and improvement of the health of all the people through collective or social actions. The programmes, services, and institutions involved emphasise the prevention of disease and the health needs of the populations as a whole. Public health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, premature death, and disease produced discomfort and disability in the population. Public health is thus a social institution, a discipline and a practice" (Last, 1988:107); "Public health is conceived of as the effort (organised or unorganised) of a society stemming from its commitment to meet and attain its health ideals." (PAHO, 1992:4)

In an attempt to come to grips with public health and what it is, Menendez (1992:93) states that "[p]ublic health may be defined or regarded as a science, as a set of disciplines, as a series of techniques, as a political/technical sector of the state, as a social phenomenon that is managed by part of civilian society and so forth."

According to the Pan American Health Organisation (PAHO,1992), the most important elements in public health are:

* strategy of population based intervention
* health promotion
* multisectoral activities
* the role of the family and

* the mobilising capacity of values inherent in such concepts as quality of life, social participation, citizenship and social control.

A comprehensive outline of the public health approach is presented by Feinberg et al (1994) and includes the following elements:

* Understanding of health problems in the context of defined populations.
* Recognition that many problems of public health are deeply rooted in the behaviour of individuals and their social context.
* The public health problems of the late twentieth century are rooted in the technologies of economic development: industrialisation, super-urbanisation, agricultural mechanisation, rapid and mass transportation, communication and information management and massive exploitation of natural resources.
* Public health problems continue to require the engagement of the body politic, in the form of government participation, for their solution.

Considering the various presentations, it is vital to remember that the "[e]volution of the health-related knowledge, attitudes, traditions and practices of each individual society is causally related to specifics of that society's economic, political and social context." (PAHO, 1992:4)

This is particularly relevant to the South African context, where the history of public

health is linked to the social and political structure, as will be demonstrated later.

THE PRIMARY HEALTH CARE APPROACH

At the International Conference of Alma-Ata in September 1978, the countries of the world unanimously declared that primary health care was the key strategy for attaining the societal goal of **"health for all by the year 2000"** (WHO-UNICEF,1978). It is important to note that this goal was established as a collective decision to direct health-related efforts in a common direction. The countries were well aware that this is a social and political response to a social and political problem - a problem of global proportions but one that was clearly most severe in the developing countries (De Rivero, 1992). The social and political problem refers to the inequities among different population groups as far as their health status is concerned, as well as to the distribution of resources allocated to health.

The conference in Alma Ata and the declaration that followed (WHO, 1978) are seen as milestones in consolidating thinking and practice in public health (WHO-UNICEF, 1978).

That public health sees itself as a multidisciplinary entity became evident in the 1970s in the forging of the concepts and strategies of primary care, which seek to globalise the approach to health problems from a new 'medicine'-community relationship and

multisectoral action to change living conditions in which disease is generated (Orellana, 1992).

The most significant contribution to the development of the Primary Health Care Approach (PHCA) are the main principles it is based on, which distinguish it from the dominant paradigm in the traditional curative medical care services. These principles consist of equitable distribution, community involvement, focus on prevention, appropriate technology and a multi-sectoral approach. Primary health care starts with people and recognizes the major role they play in solving multi-faceted health problems.

Some of the sources of the ideas that led to the development of the Primary Health Care Approach which are significant in the context of this paper, were:

* Changing theories of development, which helped to link health to other sectors and emphasised the need for an integrated, intersectoral approach that stresses equity.
* Disenchantment with a technological approach to diseases and medical services which did not sufficiently consider social, economic and political aspects of life. It was argued that health care had to be more appropriate to the situation in developing countries (Walt & Vaughan, 1981).

These ideas put sociology in the forefront as a discipline that has contributed to the

developments so far, as well as a major potential discipline required in the realisation of some of the above principles.

Although nearly 20 years have passed since the Alma-Ata meeting, and although attempts to implement the PHCA all over the world have not met with great success (De Rivero, 1992), it remains the most significant approach that has been guiding health developments all over the world. In fact, sociological theories and concepts have been used and need to be further applied in order to analyse some of the failures in implementing the PHCA.

THE HISTORY OF "PUBLIC HEALTH" IN SOUTH AFRICA

There is no comprehensive document that gives a thorough account of the history of 'public health' in South Africa, and it is not the intention of this paper to produce one. However, mention will be made of the most significant developments in South Africa, which ironically influenced the development of public health elsewhere, but not in South Africa.

Although the principles of Primary Health Care and its associated outcomes were officially embraced by the World Health Organization only in 1978, there were significant innovations in this area in South Africa in the 1940s, which were later adapted to address relevant problems in highly developed nations in several instances

in the 1960s (Geiger, 1993).

In 1940, two young South African Physicians, Drs. Sidney and Emily Kark, opened a health Centre in Pholela, Zululand, Natal. Without going into a detailed account of their activities it is meaningful to refer, in this context, to the main principles that guided their operation as well as some of the outcomes.

Some of the main components of the activities in Pholela included a **"community diagnosis"** in order to define the population and its broad characteristics. This involved epidemiological and environmental surveys to assess health status and other relevant problems. The work was carried out in **multi-disciplinary teams** which included physicians, nurses, midwives and laboratory personnel. More importantly, **health workers** from the community were recruited and trained to act as health educators. Their main focus was the community rather than the individual, and Primary Care was regarded as the basis for targeting additional medical interventions. Incorporated in the activities was a process of ongoing surveillance and evaluation, which included quantitative as well as qualitative research methods, to measure impact and identify new problems as they arose.

The Pholela model was so successful that it became a model for a network of some 40 health centres, established by 1948, predominantly in black communities (Geiger, 1993), and by 1954 it had its educational counterpart: the Department of Social,

Family and Preventive Medicine at the University of Natal Medical School, the first black medical school in South Africa. Although the work at Pholela and other centres was published in the South African Medical Journal (Kark & Cassel, 1952) and international health journals, "it remained virtually unknown - or, at best ignored as irrelevant - in the United States" (Geiger, 1993:101).

Yach & Tollman (1993) present a detailed account of "Public Health Initiatives in South Africa". Although it is not the intention of this paper to go into the details, it is important to mention John Casel's name as Kark's collaborator in Pholela, as well as the work done by Mervyn Susser and Zena Stein in Alexandra Health Centre and University Clinic in the mid-1950 during a period when apartheid policies were being intensified. Harry Phillips and Eva Slaber were a third husband-and-wife team, who contributed in this area by focusing on social aspects of child health problems in Cape Town (Yach & Tollman, 1993).

The Gluckman Commission with Kark as its technical advisor and the report (1945) that followed served as a blueprint for the development of the health centres with the support of the ministry of health with Gluckman as health minister, and can therefore be considered as one of the major landmarks in the evolution of public health in South Africa.

According to Geiger (1993) and Tollman (1991), the work carried out in South Africa

laid the foundations for the formation of the core elements that came to be defined later as Community Oriented Primary Care (COPC). Directly and indirectly, this influenced the development of Primary Health Care and Public Health in the USA and Israel (Tollman, 1991; Geiger, 1993; Yach & Tollman, 1993).

From the historical/sociological point of view, the key to the development of these health centres in South Africa "was the early realization of the need to focus on broad aspects of health" (Yach and Tollman, 1993:1046). They adopted the 'Psych-socio-environmental model' in their approach before the 'model' had been constructed as such. Factors such as family structure, culture, urbanisation and the migrant labour system were identified and considered in their association with disease patterns.

The irony of this early example is that the very same forces these pioneers took into account in their understanding of health and disease, namely wider societal influence, were responsible for their collapse, as put by Yach & Tollman (1993:1047): "the disjunction between the social philosophy and community development objectives of community-oriented primary care, together with the White supremacist ideology of the governing National Party, led to the movement's demise and the departure of its leading proponents."[1]

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[1]Cassel was recruited as professor and chair of epidemiology at the University of North Carolina at Chapel Hill in 1960. Kark left to found the Department of Social Medicine and Health Centre at the Hebrew University in Jerusalem

During this period the contribution of sociology to 'public health' was mainly as a source of knowledge with regard to the social aspects of health and disease and the implication thereof in the planning of comprehensive health programmes as well as in training of health professionals.

In the years that followed there was very little or no formal consideration given to the development of 'public health' as was understood by most of the world. The results were and still are apparent in the existing health services, with their fragmentation, emphasis on curative services, characterised by gross maldistribution of resources between the private/public sector, different racial groups, urban and rural areas and the corresponding disparities in the health levels of the people (ANC, 1994).

Presently, there are no schools of Public Health in South Africa. The training in "community health" is available to doctors and nurses in a limited intraprofessional capacity only (Ijsselmuiden,1993). Some of the existing departments of community health, however, offer training towards a "Diploma in Public Health". Additional training in the form of short courses is offered on an ad-hoc basis by the new "public health" initiatives.

Since the dominant ideology during the apartheid era did not encourage the study of the links between society and health, most of the 'sociological' contribution was in the way of sporadic research that critiqued the features of existing structures (Westcott &

Wilson, 1980; De Beer, 1984) and the nature of training health professionals (Rudolph et al, 1985).

In the early eighties, some collaborative efforts were made in departments of Community Health and Dentistry where research and teaching included some sociological elements and students became familiar with the terminology and philosophy of the Primary Health Care Approach (Hammond, 1984; Gilbert, 1985).[2]

Against the background of the government's unwillingness to address the health problems of the majority of the people, voluntary organisations and resource groups have responded to the health needs of communities in many different ways, resulting in some "community based health projects" that came into being on this basis (Zwi, 1986).

The publication of "Critical Health" by an editorial collective on a voluntary basis and the articles published in it, can be seen, to a large extent, as reflecting the efforts of people in South Africa who were concerned with the outcomes of an unjust social system on the health of its people (Buch, 1987).

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[2]This paper does not attempt to give a full review of the above activities, and therefore these are just a few examples of outcomes; there are probably many more which have not been mentioned.

The creation of the National Medical and Dental Association (NAMDA) and the conferences that followed produced additional material that can be classified under the umbrella of public health (Owen, 1987).

In light of the wide definition of public health, as discussed earlier in the paper, all the developments mentioned above can be seen as contributing to 'public health' in this country and to the understanding of the links between society and the health of its people. In a review of De Beer's book, Jacklyn Cock states: "This book makes a valuable contribution toward exposing the relationship between social injustice and ill health in South Africa" (Cock, 1984:69).

The establishment of the Progressive Primary Health Care Network and other progressive organisations as well as their later amalgamation were signs of a growing movement pushing for the transformation of existing health structures. Even the 'old' government in 1991 began talking about Primary Health Care and familiarised itself with the appropriate terminology; however, there were no substantial outcomes.

With the political transformation which took place after the election in 1994, the scene has been set for the metamorphosis of thinking paradigms and structures in health as well.

The ANC National Health Plan (1994) in combination with the Reconstruction and

Development Programme, which can be considered as the guiding documents for the new government, places great importance on Primary Health Care. It seems that despite the difficulties, the new government is committed to the principles of the Primary Health Care Approach and their practical implementation, and the new National Health System presented by the Minister confirms this.

In line with the above it strongly supports the current initiatives to establish schools of Public Health: Transvaal School of Public Health, Western Cape Public Health Programme and the Natal Institute For Community Health Education (Ijsselmuiden, 1993).

What emerges is that there is a great need for the establishment of a strong public health movement based on the Primary Health Care Approach, integrating training, research and service.

THE 'NEW' PUBLIC HEALTH - CONCEPTS AND CRITIQUE

The reason why the term 'new' public health has been introduced in this paper is that it is a term that has surfaced in the literature during the past few years. Although based on the analysis so far, it should be obvious what is meant by 'public health', it seems necessary to redefine it in terms of 'new' as opposed to something different or something in a process of change.

According to some (Editorial,1991:1381-1382), "public health has been enjoying a renaissance". The definition adopted by the Acheson Inquiry refers to public health as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (Department of Health, 1988).

Based on the above the British experience of this 'new' public health has two elements:

a. development of the multisectoral and multidisciplinary new public health movement and

b. shaping of the new public health doctor and the newly styled speciality of "public health medicine".

According to Frenk (1992:70), "the essence of public health is that it adopts a perspective based on groups of people or populations. This populational perspective inspires its two applications, as a field of knowledge and as a sphere of action."

As a multidisciplinary field of research, the 'new' public health can be defined according to Frenk (1992:70) "as the application of the biological, social and behavioural sciences to the study of health phenomena in human populations."

The reality that health problems emerge mainly in response to conditions of life, requires that public health remain highly adaptive, especially when living conditions are changing rapidly (Afifi & Breslow, 1994). Therefore one of the main features of

public health in the past and today in particular is its dynamic nature. Its core disciplines must always remain "on the ready" (Afifi & Breslow, 1994:224).

Sociology as a discipline in the centre of the study of society and change is therefore well situated to contribute to this necessary feature of constant adjustability and adaptability to changing circumstances. This is particularly relevant to South Africa as a society in transition. The HSRC's national research programme on "Global Change & Social Transformation", or on a smaller scale, the research programme in the Sociology department, University of the Witwatersrand, Johannesburg, with "Southern Africa in Transition" as its main theme can be seen as examples of such a response.

It is of significance to note that although the understanding is that the 'new' public health has developed to meet a whole new set of diseases (as discussed earlier) - those associated with increasing longevity and overpopulation, with industrialisation, with inequalities in health, environmental damage and ecological imbalance during a re-evaluation of the effectiveness of therapeutic medicine - it is perceived as a specialisation of "medicine" and remains in that realm, dominated by the medical profession.

Menendez (1992:94) maintains that "public health, both as knowledge and as a political and technical sector, was and continues to be in the hands of either physicians or technicians from other disciplines who have adopted the medical perspective".

According to Menendez (1992), this is the key to understanding not only the orientations that have been imposed on public health but also the errors of interpretation that have been made.

It seems that the relative power of medicine in relation to other disciplines is a central "bone of contention" within the public health movement. The continuing struggle over the relationship of public health to medicine explains why so many terms have been used in the field, either to define public health or to indicate the specific contributions of the medical profession.

An additional point of critique relates to the rendition of the **population model**, which is a major component of public health. One interpretation of this model is that "the 'patient' is a population, that is, a group of people ... with certain characteristics in common" (Ijsselmuiden, 1995). Without underplaying the importance of the population model as a component in public health, this kind of interpretation merely demonstrates the emulation of the medical model by public health experts, in their use of terminology, reasoning and understanding of health and disease.

The new public health movement seeks the active **participation** of individuals and communities in decisions that affect their health and in taking the action required to

make them healthier [3]. If one adopts this premise, public health action will be based on the population model and its active participation in the intervention. However, often, even the language used defies the declaration. One talks about 'population-based **control** strategies'. An example given by Ijsselmuiden (1995:98-99) is typical of this misconception: "A good example of the relevance of these last two factors (democracy and population model) is the continuing tuberculosis epidemic in South Africa. More than sufficient knowledge on tuberculosis exists, and adequate treatment has also been available for over 40 years. The tuberculosis epidemic in South Africa, however, is out of control, with at least 75,000 new cases annually - and the numbers are still rising. Only through adequate application of **population-based control strategies** and the equitable distribution of expertise and resources, may we hope to start making an impact on this epidemic."

Here lies the explanation to the failure to 'control' the epidemic. TB is a disease firmly rooted in the cultural and social structure, in addition to poor nutrition and living conditions which contribute to its rapid spread, the beliefs associated with the understanding of the disease and the way to treat it are embedded in the culture of the people and peoples' responses to attempts by 'public health officials' to **control** the epidemic are shaped by these beliefs[4]. A complicating factor is the fact that in the

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[3]Alma-Ata and subsequent direction provided by the WHO "Health for All by The Year 2000" strategy (European Office of the World Health Organisation, 1985, Targets in Support of health for all by the year 2000 in the European region. Copenhagen:WHOEURO)

[4] This was acknowledged by Kark and his team in their work in Pholela in the 1940s.

South African setting, the 'controlling' body was/is mainly white and most of the 'population' in whom TB was/is to be controlled is black - so the issue acquires a racial angle as well. All this means is that in reality, people affected by TB in South Africa had little or no say in the way TB should be controlled, and were definitely not reached on the level of social understanding of the meaning of the disease; solutions therefore were, and continue to be, unsuccessful. Early attempts by the government to control the spread of HIV were fraught with similar problems. Cases like these present an example and offer opportunities where sociology could make a real contribution to public health.

As referred to earlier, although public health challenges the bio-medical model, it is in a strange way trying to emulate it in reasoning and structure in order to gain acceptance among the very people or propagators of the philosophies it criticises.

Najera (1992:113-114) talks about "[t]he difficult and lopsided marriage spoken of by Fee (1987) between the rich and powerful medicine and the weaker public health ... public health has been relegated to the less dominant role in an unequal marriage within a macho society". Fee (1987) states more accurately that "public health is struggling for autonomy and independence, while at the same time wishing to have status of her stronger companion, as well as his[5] protection."

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[5] The notion of differential power structure is carried further with the use of gender allocation.

Najera (1992) takes the argument further by suggesting that some of the schools and practices of public health have assumed the role of the "submissive wife" without expressing the crisis openly. He further proposes some crucial questions for public health to think of:

"* Might it not be thought necessary to begin a conceptual search for new ways of thinking about health?

* Could we come to believe that, although it has been in many senses ultimately an abortive process, the gestation of public health over the past 80 years is finally making us - however recently and timidly - begin to think about health?

* Could we promote a process of change and a true rebuilding of our thinking about health, totally liberating health from medicine if medicine continues to be totally dependent on, and revolve around, disease?

* Shall we work to generate a new theory?" (Najera, 1992:114)

Interdisciplinary thinking and intersectoral collaboration is forging the path towards a theory of health.

Feinberg et al (1994:255) maintain that " the field of public health has never attained the status of a recognised, single independent profession and thus endures an ongoing crisis of identity."

TRAINING FOR PUBLIC HEALTH

The debate about what constitutes public health is reflected in the various approaches to training in public health. In the USA (Fee & Acheson, 1991:161), "[o]ne option was to regard public health as a unique amalgam of the biomedical, engineering, and social sciences, requiring specialised training in each of these fields. Some suggested that public health be treated as a combination of sanitary engineering and bacteriology, so that the contribution of engineers and physicians could both be honoured. Others regarded public health as mainly a problem of social reform and social organisation, in which social and political scientists should take a leading role. Yet others thought that public health should be a specialised branch of medicine, drawing on physicians' knowledge of disease processes, diagnosis and therapy."

As can be seen from the analysis thus far, the major tensions are between public health and clinical medicine and between the social and biological approaches to health, and these feature widely in the debates about the nature of training in public health.

Basic questions about the form of education for public health centre around "who should be trained?"; "what should be taught in what proportions and who should do the teaching?"; "what is the appropriate mix of disciplines and the balance between theory and practice?"; "what is the proper role of physicians, nurses, engineers, statisticians, sociologists, economists etc. and how should these different professional

groups relate to each other within the larger endeavour of public health?" (Fee & Acheson, 1991).

The answers to these questions are as varied and complex as the definitions and interpretations of 'public health' in different and changing social contexts. They are shaped by the same forces and accompany the historical changes. This is linked to the dynamic nature of public health.

In addition to constant changes in the training, the multidisciplinarity of public health ensures that the material is presented from different perspectives and this changes according to the nature of the problem under consideration.

In an attack on public health, Vandenbroucke (1994:994) states: "There is a discipline in medicine that over the past 200 years has been known by various names: sanitary medicine, public hygiene, public health, social medicine and community medicine. Its newest incarnation proudly calls itself 'the new public health' ... In each new generation of doctors, however, this branch of medicine attracts not only analytical minds but also people who feel a strong personal vocation to improve health in society by attacking plain injustice." (1994:225)

A similar sentiment is echoed by Fee & Rosenkrantz , where they present the declining numbers of physicians in schools of public as a problem and state that "[t]hose

attracted to the field will continue to share with their non-medical colleagues a social commitment that often conflicts with the dominant priorities of the medical system and that transcends the care of the individual patient to focus on the health of populations". (1991:271)

SOCIOLOGY AND PUBLIC HEALTH

The purpose of this paper has been to examine the links between sociology and public health in general, focusing on the South African context in particular. It is conspicuous that sociology can and has been making a contribution to public health. It is also important, however, to point out some of the many ways in which sociology can benefit substantively, theoretically and methodologically from collaboration with the field of public health.

Riley (1994) mentions two of the ways in which social science efforts to understand and to improve health have benefited from interchanges with the field of public health:

1. in demonstrating how people's lives are influenced by changes in social structures and environments.
2. in defining goals for structural interventions that could enhance people's lives in the future.

It has further been argued that "[t]he large number of congruent or complementary

theoretical and methodological approaches shared by the two fields has made the development of working relationships in research, teaching and service areas mutually profitable." (Suchman, 1963:9)

Sociologists working in public health need to be problem-orientated, not discipline-orientated. This applies to all disciplines involved; however, it should not be confused with forfeiting the unique contribution a discipline like sociology can make to solving health problems through multi-disciplinary efforts.

Health, illness and health care constitute significant areas of sociological concern. The development of the 'sociology of health' is confirmation of the above. In addition to advancing sociological knowledge, research in the field of public health offers a number of opportunities for methodological progress. The growing concern of public health with international health programmes offers fertile ground for the development of comparative or cross-cultural research. In fact, the methodology adopted for public health research is, to a large extent, the methodology of social research.

The close affinity between sociology and public health is in terms of unit of study, theory and method. They share a common concern with populations of individuals, a theoretical orientation toward abstract generalizations and a similar methodological approach. They also share a 'problem' focus. To a large extent public health problems are social problems. The social forces that determine whether a health condition will

be viewed as a public health problem are similar to those that define a social problem in general.

Suchman (1963) goes so far as to say that it is not incorrect to attribute much of the origin of public health movement to early attempts of social reformers to meet social problems created by the industrial revolution and the rise of urban slum. As Dubos states, "out of the reform efforts of the nineteenth century, there emerged our modern concepts of sanitation and public health." (Dubos, 1960:168)

There is no doubt as to the necessity of sociology's participation in public health. However, there is a need to point out some of the potential dangers, one of which is the danger of sociology being 'taken over' by health professionals as another one of their contributing disciplines. Notwithstanding the fact that the inclusion of sociology in public health is of utmost importance, one needs to maintain the independent perspective of the discipline in order to be able to study health in the social context and public health as a social phenomenon.

One should not confuse the contribution of the discipline of sociology to public health with the adoption of public health as a sociological approach to health. Sociological contribution to public health is beyond its influence on the performance of medical practitioners in clinical work or health service administration (Jefferys,1991).

Additional tensions of collaboration can be attributed to:

* ordinary problems related to the interdisciplinary nature of the collaboration between people with different 'scientific' paradigms of thinking and operating
* strain associated with practitioner - researcher relationship
* different cultural backgrounds
* low status within a rigid status-conscious institutional setting
* differing conceptions of self and expectations of others.

In summary, the areas where sociology can contribute include:

* social factors as determinants of the distribution of disease
* social factors in the aetiology of disease
* definition of a public health problem in sociological terms
* social factors as responsible for society's responses to illness influencing reactions to public health programmes
* basic social research.

This can be used in training public health workers in order to equip them with the necessary background knowledge. On a more instrumental level sociology can contribute by providing useful knowledge with regard to the social factors that need to be taken into consideration in planning, development and operation of public health programmes, in particular with regard to community participation, support and action. As such sociologists can contribute to teaching, research and practice in public health.

The very definition of public health research involves an effort to achieve interdisciplinary integration. As stated by Frenk (1992:72), "[c]learly all human populations are organised into societies. Therefore, the social sciences are indispensable for fully understanding health in populations - that is public health." Public health as an institution provides sociology with an opportunity to explore its structure, key role players and the associated tensions, goals and objectives, and interrelations with other 'agencies' in the community.

Since the current development of public health in SA is only beginning, it is vital to identify the areas where mutual contributions can be made. It seems that there are six major questions that need to be answered.

Although the full answers to these questions as set out by Suchman (1963) are beyond the scope of this paper, it is hoped that the paper provides the background to start thinking about the following questions:

1. What are the current needs in public health that sociology is attempting to meet, and how did these develop?
2. What is the nature of the relationship of sociology to public health? What forces lead to convergence or divergence of the two fields?
3. What contribution does sociology have to make to public health in the understanding of health problems?
4. What contribution does sociology have to make to public health in the

study and organisation of public health structures and personnel?

5.What activities do sociologists in public health engage in; where, how and with what results?

6.What problems of collaboration exist between sociologists and public health workers and how are these being met?

Any social science programme in public health must accept the responsibility of working on problems that are meaningful and useful to public health. A social science programme to be meaningful must be free to develop an inherently social science approach to public health problems.

CONCLUSION

Although there is great variety in the understanding and implementation of public health, there is wide agreement that the challenges to public health today are as serious, if not more so, than those at the end of the nineteenth century (Jefferys & Lashof, 1991). This is probably more poignant in the South African context.

In the latest South African interpretation of public health, Carel Ijsselmuiden, as chairman of the "Transvaal School of Public Health" initiative, made the following statement: "Public Health is a social movement which was started in the middle of the 19th century around issues of hygiene, sanitation and occupational health, and which

focuses now on equity in health and in access to health care, and on the balance between development, health and wellbeing. By definition, therefore, Public Health is not the property of a specific profession, nor of professionals in general, but both as a practice and a social movement it belongs to all. As a discipline, Public Health is the academic or scientific expression of the people's right to optimal health and to a fair distribution of disease interventions and health care." (Ijsselmuiden,1993:67)

Since Sociology in South Africa has the potential to make a valuable contribution in the training, research and practice of Public Health, it should seize this opportunity and work towards the development of a force in Public Health, where its guiding philosophy and principles do not remain meaningless declarations of intent, but are mirrored in its reality. By doing so, it will support the following plea made by Yach & Tollman (1993:1049):

"The work in public and community health in South Africa during the 1940s and 1950s represent extraordinary coherent and comprehensive integration of teaching, service and research dimensions of public health practice ... Having made this original contribution, it is time for South Africans to reclaim this experience and apply its profoundly contemporary lessons to the current reality" .

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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CHAPTER II

COMMUNITY PHARMACY IN SOUTH AFRICA - A CHANGING PROFESSION IN A SOCIETY IN TRANSITION

ABSTRACT

The analysis of community pharmacy as a profession in transition acquires an additional dimension in South Africa, since it is inextricably linked to its social characteristics as well as to the political transformation taking place. Using data collected by means of a documentary search, interviews with key informants and a survey of community pharmacists, this paper presents the relevant societal features and explores some of the complexities associated with the existing as well as the potential future role of community pharmacy in the context of changing health services in a society in transition. It concludes that the changes in community pharmacy and the role it can play in the provision of Primary Health Care to all the people of South Africa are linked to the greater transition in society and its future health care services.

INTRODUCTION

Pharmacy is among the oldest of the health professions. Since its inception it has been closely linked with medicine in providing services of fundamental value to society. At present, however, it is a profession in transition, and is characterised by considerable ambiguity and uncertainty concerning its status as a health-care profession. Over the last decade pharmacists all over the world have been debating the direction their profession should take (Nuffield Foundation Committee of Inquiry, 1986; Edwards, 1987; Bush, 1983, Pharmaceutical Services Negotiating Committee, 1987), tending to stress the need for 're-professionalisation' (Birenbaum, 1982) and role expansion (Gilbert, 1995b). In the case of community pharmacy, the latest development in this direction is the preparation of the pharmacist as a Primary Health Care provider (Trinca, 1996).

According to the literature, the most significant characteristic of community pharmacists is their accessibility. They are available to the public throughout the working day, with no appointments, no receptionists and no direct charges - there are thus no barriers for help-seekers. They are readily available to provide advice on health care, and there is clear evidence that despite some problems, they offer a service that many general practitioners and consumers both value and use (Guy, 1986; HSRC, 1986; Reekie, 1988; Barron, 1989).

The ease of access to a community pharmaceutical outlet means that it is often the first point of contact for people in need of advice or information about medical care (Mukerjee and Blane, 1990), and as such they stand in the front line of service provision (Turner, 1986; Cunningham-Burley, 1988).The pharmaceutical literature claims that with appropriate incentives and training, the community pharmacist is appropriately situated to provide limited Primary Health Care (Dunphy, Batalden and Davis, 1983; Harding and Taylor, 1990). This, however, requires a paradigm shift from an emphasis on product, sales and individual practice to an emphasis on meeting the needs of the patient and the community as part of a health team[1].

In South Africa, the analysis of community pharmacy[2] as a profession in transition acquires an additional dimension, since it is inextricably linked to its social characteristics as well as to the political transformation taking place. The aim of this paper is, therefore, to present the relevant societal features and to explore some of the complexities associated with the existing as well as the potential future role of community pharmacy in the context of changing health services in a society in transition.

In order to fully appreciate the complexities involved in this debate, it is necessary to

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[1]For more about this, see Gilbert L., The community pharmacist as a member of a Primary Health care Team in South Africa. *International Journal of Pharmacy Practice*. 5:192-200.

[2]This term for retail pharmacy was suggested by the Commission of Inquiry into Health Services. The Browne Report. 1986.

present the characteristics of South African society with regard to political, demographic, economic and social factors as well as access to resources. Understanding the distribution of health care services as well as pharmacies and pharmacists in South Africa highlights the role of community pharmacy and the nature of the current debate.

METHODS

The data were collected by means of a documentary search which included reports and publications produced by the Government as well as Pharmaceutical Societies and the South African Pharmacy Council (SAPC). Qualitative as well as quantitative methods were employed. Since we are dealing here with a profession in transition against the background of a society in transition, material for this paper was also collected from current newspaper articles as well as other publications, reflecting the changes as they occur. Interviews with key informants and a survey of community pharmacists[3] provided additional sources of information[4].

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[3] Note should be taken that this paper is based on one section of a more comprehensive study, and deals only with the issues examined here. For more details about the wider study see Gilbert (1995a).

[4] For more details about the methods employed see chapter on "Methodology".

CHARACTERISTICS OF THE SOUTH AFRICAN SOCIETY

It is widely recognised that the health status of the community is profoundly affected by environmental and socio-economic factors. Social inequalities in society will therefore be reflected in both the health of the people as well as the health services available to them. Years of apartheid rule and racial segregation in South Africa have resulted in a society characterised by gross disparities among the different racial groups. For this reason it is vital to explore in more depth some of the characteristics of South African society relevant to the current discussion (Gilbert, 1996).

The inequalities which characterise South African society manifest themselves primarily along racial lines. Due to the Population Registration Act of 1950, all South Africans were classified into a 'population group' at birth, and assigned a status as White, Indian, Coloured or Black (African)[5]. Although this act was repealed in 1991, its social effects will remain present for a long time to come and for this reason, statistics in this paper will be presented according to population groups or race where appropriate [6].

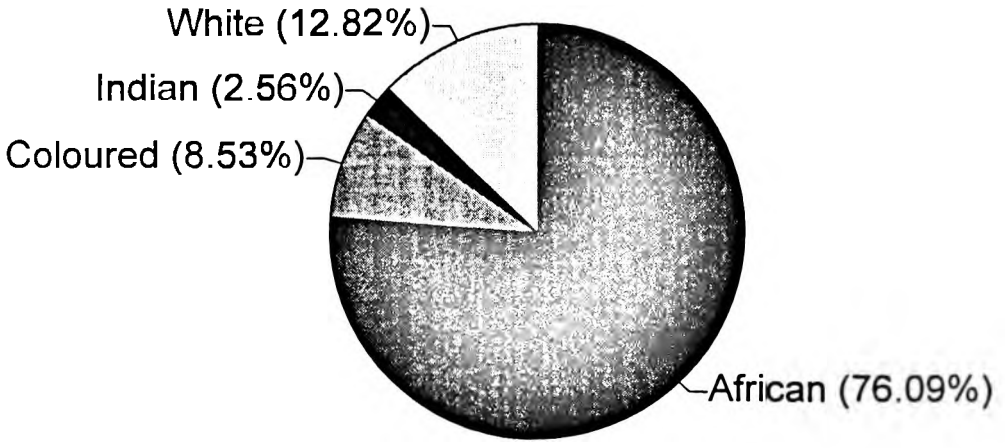
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[5]For this reason reference to the different 'population groups' is made in Capital letters.

[6]A fuller discussion on this issue can be found in Chikte U.M.E., Gilbert L., Brand A.A.and Lewis H. Racial Classification in Dental literature - Is it Always Necessary? *Journal of the Dental Association of South Africa* 44, 337-463, 1989.

The current demographic profile has been shaped by racial conflicts over many decades. The data presented in Fig I provide a general picture of the different 'population groups' in South Africa.

Figure I: Population Groups



Source: Central Statistical Services, 1995.

Additional points with regard to the relevant characteristics in the context of this paper according to South African Health Review 1995 (SA Health Review, 1995) are:

Age structure - The African population is young and expanding, with over 25% of the population below the age of 15 years. In contrast, the White population is ageing and shrinking, with as much as 9.4% of the population aged 65 years or older.

Life expectancy - The national average is 62 for men and 68 for women. It ranges, however, from 59 for Coloured males to 76 for White females.

The economy - South Africa is classified as a middle-income country by the World Bank, but the economy has declined severely over the last decade, with negative growth rates in 1991 and 1992. The economic growth rate in 1994 increased to 2.5%, still far from the 3.5% estimated by the International Monetary Fund necessary to reduce unemployment.

Income and Poverty - Although all population groups experienced a moderate increase in real income over the past fifty years, the gap between rich and poor is great compared to many other developing countries of similar status. In 1991, White per capita incomes were more than 12 times those of Black people. In 1991, it was estimated that 17.3 million people and about half of all households lived below the minimum subsistence level. Two thirds of African households were estimated to live in poverty, compared to 6.7% of White households.

Employment and unemployment - Unemployment in the formal sector now stands at about 40% of the economically active population. Owing to high levels of unemployment and temporary contracts, many South Africans have been unable to

make adequate provision for illness, injury or retirement. Government-provided Old Age Pensions and Disability Grants have become important sources of income for people living in poverty.

Access to land - Apartheid policies, together with agricultural policies which favoured large-scale agriculture, pushed millions of Africans off their land into impoverished reserves, homelands and townships. At present the White agricultural sector owns 88% of arable land in South Africa.

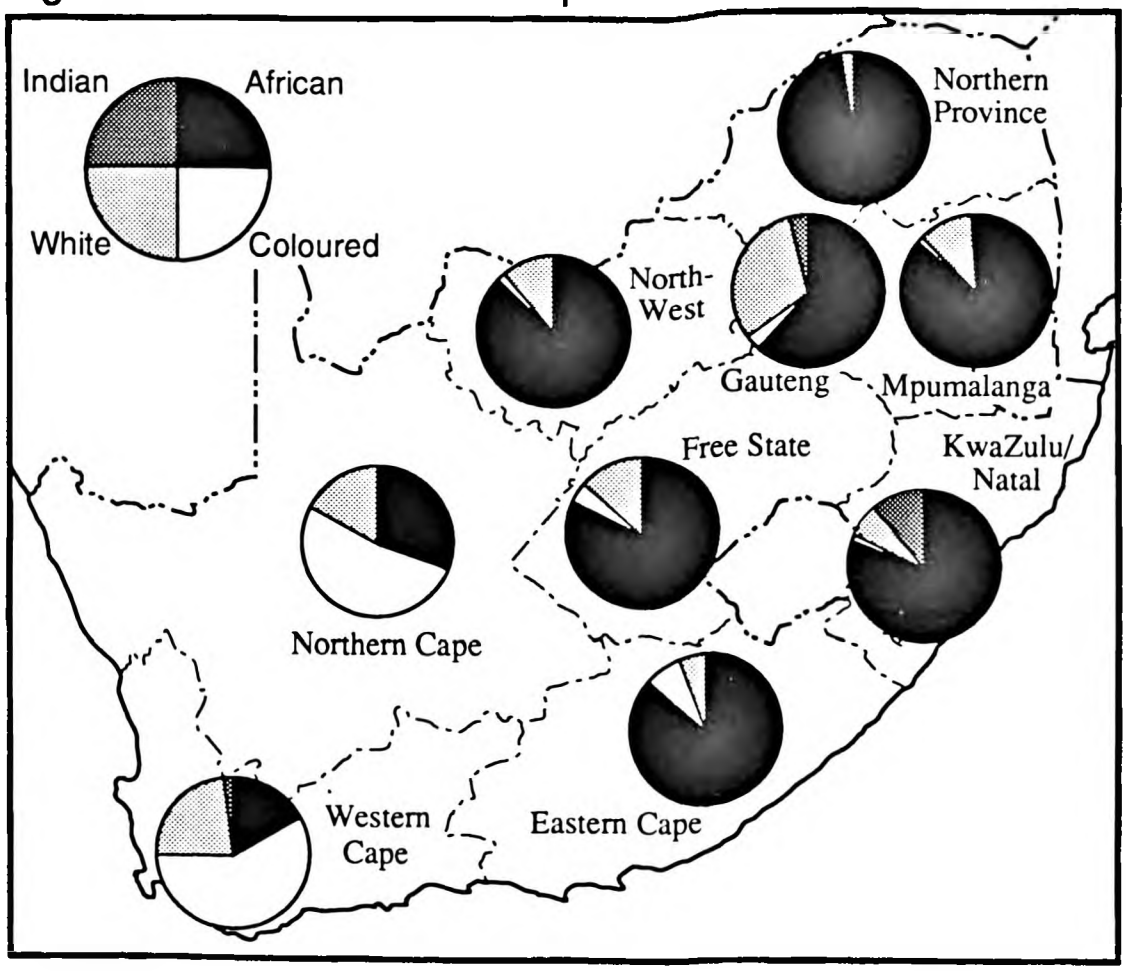
Education - Racial imbalances exist in education on every level, with African people most severely affected. In 1993 teacher pupil ratios were 44.4:1 in African schools, 22.2:1 in Coloured, 21.9:1 in Indian and 18:1 in White schools. Almost 90% of children less than six years of age do not have access to educare facilities. It was estimated in 1993 that 30% of the South African adult population had not reached the formal educational level of standard 9.

Housing - Urbanisation has been an important factor in determining the health of the population as well as the levels of urban violence. By 1985, about 57% of South Africa's population was urbanised, mainly in the major metropolitan areas. The population of the cities is predicted to double by the year 2010, creating an enormous challenge for planners of health, housing and other social services. The 1991 census showed that 9% of the population were living in shack settlements in urban areas, with inadequate provisions of basic facilities like safe water, sanitation, electricity and health services.

Inequalities according to the different regions - According to the apartheid policies

of separate development, the so-called independent homelands were created in largely rural and underserved areas. Although they have now been incorporated into South Africa, their existence has influenced the distribution of people and services within the provinces. In an attempt to restructure governing powers and responsibilities, the new government has divided the country into nine provinces for administrative purposes. This process took place in 1993, and the current provinces came into being after the elections in 1994. Parts of the past homelands were incorporated in different provinces, but due to geographic constraints it was impossible to mask the past maldistribution of resources. This new division, therefore, does not eliminate the existing inequalities along racial lines; rather, these are now reflected in the different regions, as illustrated in the following maps . Figure II presents the racial distribution in the provinces and explicitly indicates the differences between the regions and their racial mix. It is clear that this carries with it the legacy of the past and its disadvantages for provinces with high percentages of Black people from the previous homelands.

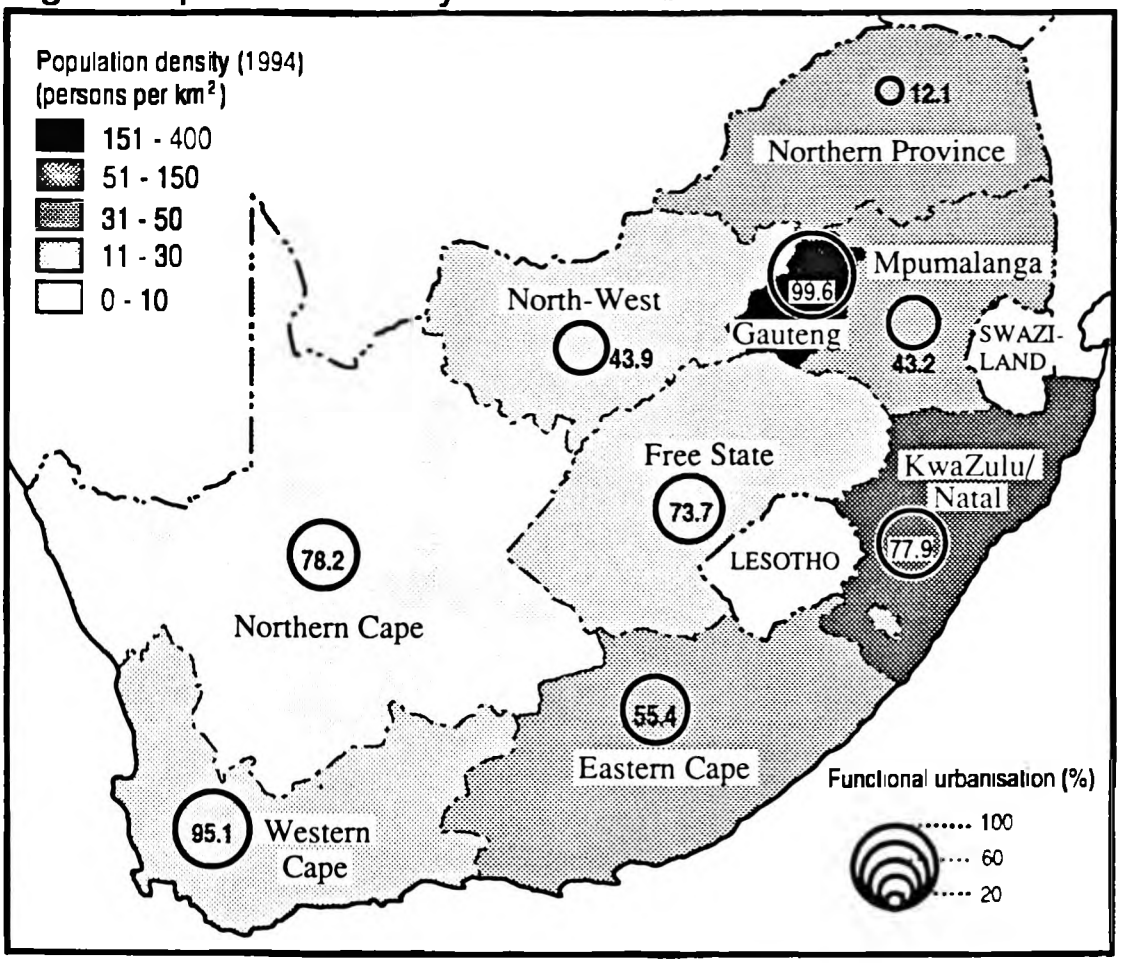
Fig. II Racial distibution of the provincial population, 1994



Source: Martins JH. et al. Social Profile of the Nine Provinces of South Africa. 1994

Population density and **level of urbanisation** are additional factors depicting the differences between the provinces and are of significance to the focus of this paper, as illustrated in Figure III.

Fig. III Population density[1] and functional urbanisation.[2]



Source: 1 Chimere-Dan in Demographic patterns in South Africa, 1995
2 Development Bank of South Africa. South Africa's nine provinces:
A human development profile, Halfway House. 1994

The recent political changes and their consequences in South Africa distinguish it as a society in transition. One of the many challenges of the new regime is to redress the imbalances of the past. Thus, the transitional period has been characterised by policy developments and programmes aimed at changing the situation. The implications of this are that everything is in a state of flux and continual transformation.

The points highlighted here portray the current social context in South Africa and provide the setting for the analysis to follow, which focuses on health services in general and then on pharmacy in particular.

HEALTH CARE SERVICES

The inequalities identified in the society are mirrored in the health sector. As Price argues, "South Africa possesses a large private health sector composed of politically powerful health care providers and a clientele constituting over 20% of the population. Despite providing for only a fifth of the population, the private health sector contains over half of the doctors, nearly all the dentists, and spends more than half the total public and private financial resources spent on health care" (Price, 1994, p.55). The result is fewer health care resources for poorer people. Coupled with the poor living conditions alluded to earlier, it also means less available health care for people with higher levels of IMR and general morbidity levels. The most socio-economically disadvantaged sub-groups of the population are the African people who live in rural areas. Death and disease from preventable causes continue disproportionately to affect the African and Coloured populations (Rispel and Behr, 1992). This is further illustrated in table 1, which presents the Infant Mortality Rates (IMR) in the different provinces by race.

Table 1. Infant mortality rates for province and racial group

Province	Racial group				
	African	Coloured	Indian	White	ALL
Western Cape	42.8	25.9	21.3	6.8	24.4
Eastern Cape	49.3	33.4	17.9	9.0	44.7
Northern Cape	45.3	21.0	52.0	6.0	42.9
Free State	51.1	44.9	13.0	10.7	45.8
Kwazulu-Natal	52.0	9.1	14.4	6.5	44.9
North West	45.3	31.3	17.0	7.0	40.1
Gauteng	42.6	15.9	7.6	7.2	32.3
Mpumalanga	51.9	22.2	12.5	7.1	45.1
Northern Province	54.3	23.0	18.0	6.2	52.9
SOUTH AFRICA	48.3	28.6	15.9	7.4	40.2

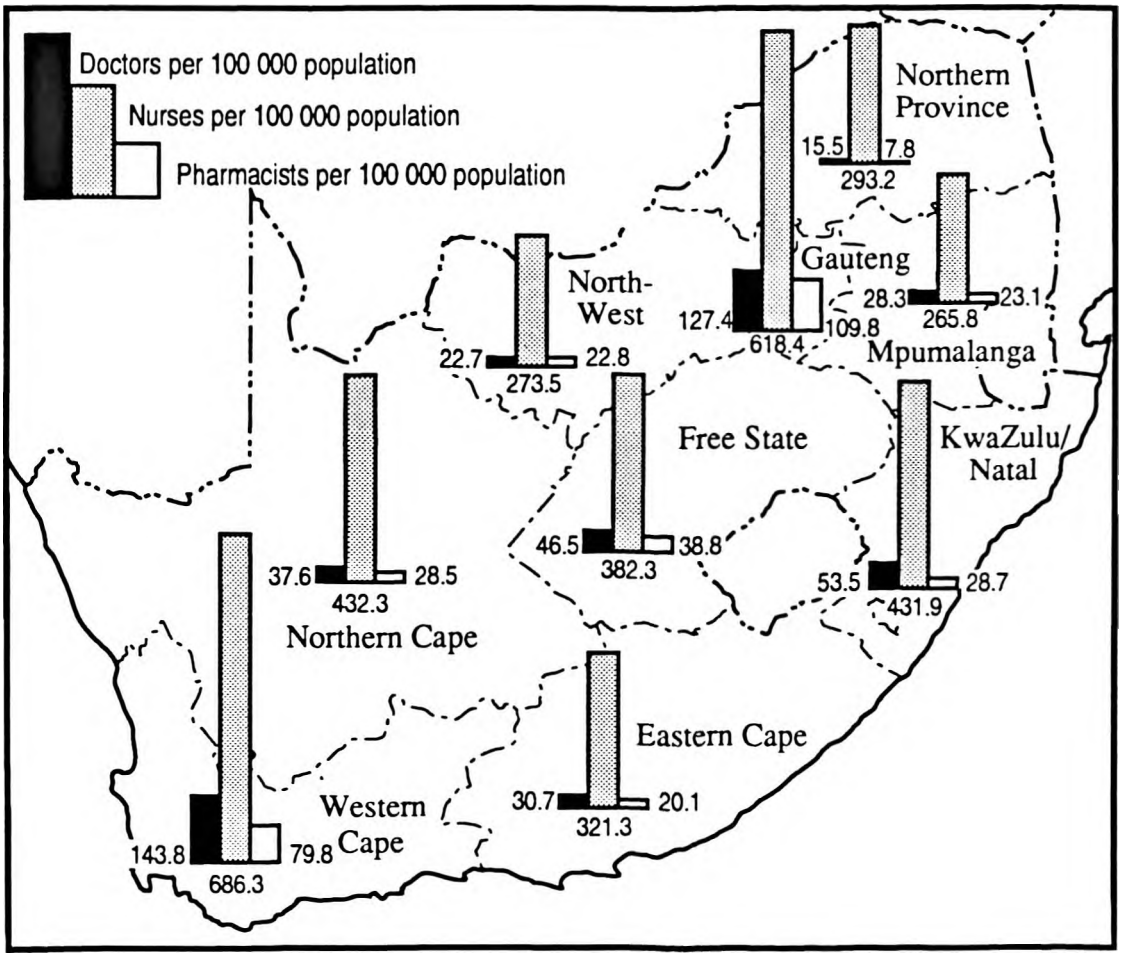
Note: Small numbers of coloureds in Kwazulu-Natal, and Indians in the Northern Cape result in anomalous figures.

Source: DBSA for SALDRU. University of Cape Town. 1993.

Regardless of the provinces, Blacks have the highest IMR's and Whites the lowest. However, a closer look reveals differences between the provinces, in particular where the Black population is concerned. The lowest IMR's of Blacks are in Gauteng and the Western Cape, which are the richest, most urbanised and best resourced provinces. The above is made more explicit in Figure IV, which maps the distribution of

nurses/doctors and pharmacists in the nine provinces, and clearly depicts that a smaller number of health personnel is available in the provinces with higher IMR's.

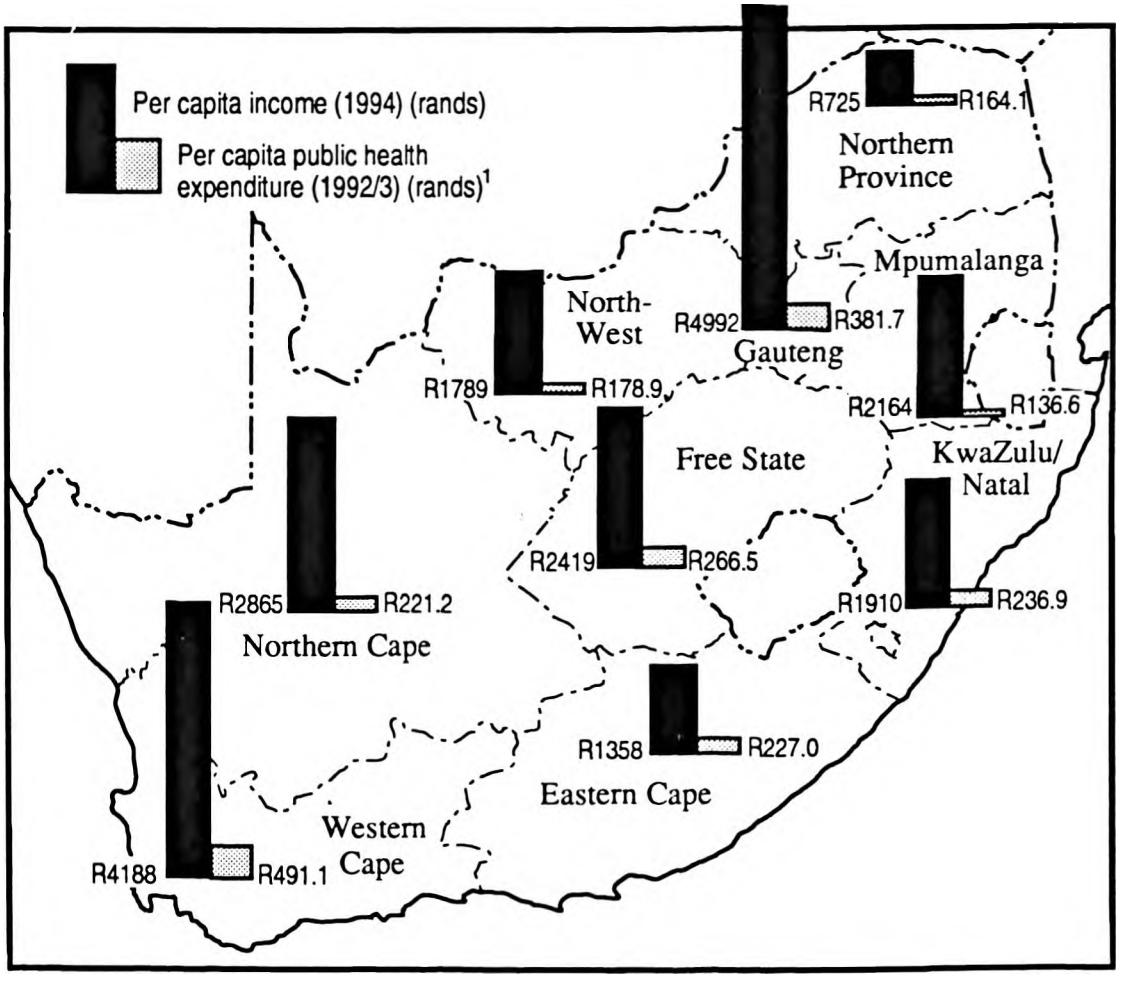
Fig. IV Distribution of health personnel (public and private) between provinces (1992/93)



Source: Chetty (1994) and Development Bank of Southern Africa (1994)

An additional dimension of the inequalities outlined is presented in Figure V, where the per capita expenditure on health is juxtaposed with per capita income in the various provinces. A consistent picture emerges where the poorest provinces are allocated the least health resources.

Fig. V Public health expenditure/ per capita income



Source: ReHMIS Survey in Health Expenditure Review. Durban. 1995

The systematic maldistribution of resources (money, facilities and personnel) between rural and urban areas, between government-defined population groups and between the public and private sectors, has led to a situation where the health services do not meet the needs of those communities suffering from the greatest burden of disease, and good quality primary health care is not available to them in the public sector. Private health facilities are expensive and affordable mainly to an affluent minority. Most facilities are, in any case, concentrated in those communities that can afford to pay for the services (Pharasi, 1993). Some of the above is reiterated and further illustrated in Table 2, which presents the number of health workers per 100 00 population in the magisterial districts sorted by per capita income.

Table 2. Health workers per 100 000 population in the magisterial districts sorted by per capita income (1992/93).

Quintiles of magisterial districts sorted by income per capita	General doctors	Specialist doctors	Registered nurses	Other nurses	Health inspectors	Pharmacists
Q1 (lowest)	5.1	0.4	78.7	109.4	1.1	0.5
Q2	9.4	1.8	90.9	119.2	2.2	1.1
Q3	15.8	3.2	128.4	137.1	4.3	2.5
Q4	13.5	1.8	128.2	131.5	7.6	4.0
Q5 (highest)	23.3	12.3	189.9	185.4	6.7	5.4
TOTAL	14.1	5.4	129.5	143.1	4.1	2.8

Source: ReHMIS survey, 1992/3.

It is distressingly noticeable that the poorer the district's population, the less health workers are available for them. The situation is particularly serious in the poorest

category, where the number of health workers is completely inadequate. Once again the existence of the 'inverse care law' in the provision of health care in South Africa is demonstrated (Gilbert et al, 1996). The people in the poorer regions are more likely to suffer higher rates of mortality and morbidity as illustrated, but the services available to them are insufficient.

The general scenario is best presented in the foreword of the ANC National Health Plan for South Africa: "The South African government, through its apartheid policies, developed a health-care system which was sustained through the years by the promulgation of racist legislation ... with the specific aim of sustaining racial segregation and discrimination in health care ... The net result has been a system which is highly fragmented, biased towards curative care and the private sector, inefficient and inequitable ... there has been little or no emphasis on health and its achievement and maintenance, but there has been great emphasis on medical care" (ANC Health Plan, 1994, p.7).

The policies developed since the inception of the new government are an attempt to transform health care into a more equitable, accessible service with an emphasis on Primary Health Care (Department of Health, 1995&1996).

PHARMACISTS AND PHARMACIES IN SA

Since the pharmacy profession does not operate in a vacuum, it is essential to make links to the context presented heretofore, as well as to introduce a global perspective. Table 3 presents the ratio of pharmacists to population in selected countries.

Table 3. Pharmacists per Population in Selected Countries

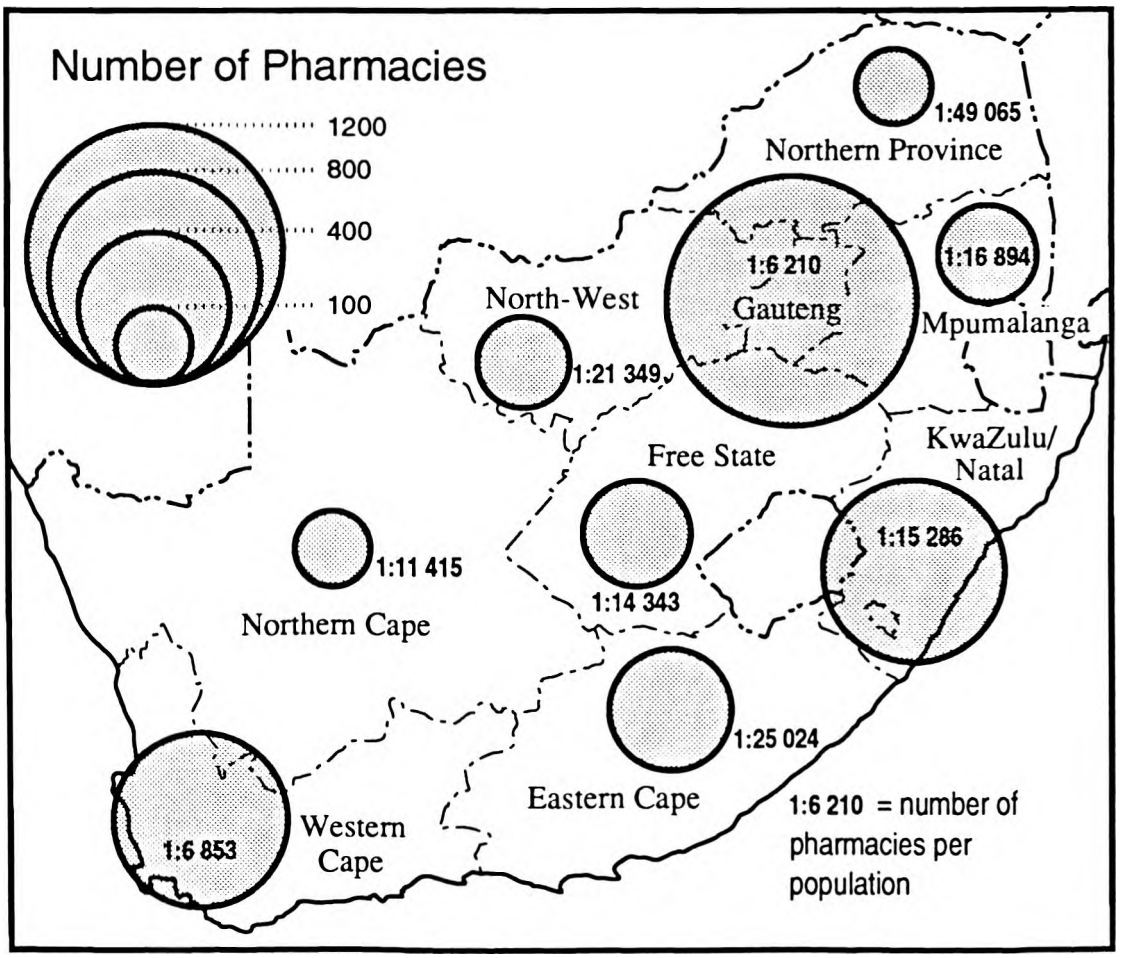
Country	Pharmacists per population
Cameroon (1989)	1:50 000
Canada (1991)	1:1 639
Egypt (1991)	1:14 285
France (1989)	1:1 101
Korea (1991)	1:1 126
South Africa (1995)	**1:3 702**
Sweden (1992)	1:2 380
UK (1990)	1:1 515
US (1993)	1:1 500
West Germany (1992)	1:2 227
Zimbabwe (1990)	1:33 333

Source: WHO Statistics of Member States, 1994 and Overseas Report, 1993

The table unequivocally shows that this ratio is more favourable in developed countries. In all these countries there is the utilisation of the majority of pharmacists to provide services to the state. An examination of the general ratio of pharmacists per population in SA puts it relatively close to the developed countries and in a much more

preferable position than Egypt, Cameroon and Zimbabwe. However, this conceals the disparities so peculiar to the South African reality as discussed earlier in this paper. The following map (Figure VI) is an attempt to unpack the general scenario by looking at the number of pharmaceutical establishments per province.

Fig. VI Number of pharmaceutical establishments, 1995



Source: Pharmaciae, 3: 22, 1995

It is apparent that there is a maldistribution of pharmaceutical establishments (Fig VI) and pharmacists (Fig IV) between the provinces. While Gauteng and Western Cape are well off, the Northern Province, Eastern Transvaal and Northern Cape fare the worst. It should be noted that these provinces are largely disadvantaged in other resources as well, as illustrated in this paper. Thus, the general distribution of pharmaceutical establishments and pharmacists in SA reflects the inequalities referred to earlier (Gauteng is the richest province). A similar maldistribution is evident where community pharmacies are concerned (Table 4).

Table 4. Distribution of Community Pharmacies per Province

Province	No. of community pharmacies	Population per community pharmacy
Western Cape	444	8 472
Northern Cape	46	17 100
Eastern Cape	267	9 466
Free State	167	17 416
KwaZulu Natal	453	19 766
Gauteng	1 005	7 049
Mpumalanga	149	19 999
Northern Province	76	63 427
North Western Province	153	10 638
TOTAL	2 760	12 845 (average)

Source: Adapted from Report of SA Pharmacy Council Task Group 4, 1994.

What this means is that on the one hand, there are very few community pharmacies in the provinces that are mainly rural and where most of the population is African, and even there, they are mostly situated in the urban centres. On the other hand, most of

the community pharmacies are concentrated in the more developed provinces in White urban areas. Once again, this mirrors the general South African context.

The legacy of the past and social inequalities are reflected through a different dimension when analysing the distribution of pharmacists by race, as shown in Table 5.

Table 5. Distribution of Pharmacists by Race: SA, October 1992

Race	% of Population	% of Pharmacists
White	13	90
Asian	3	6
Coloured	9	2
Black	75	2

Source: Summers, Van den Berg and Summers, 1994

While the Black population constitutes 75% of the total population, it comprises only 2% of the pharmacists. These figures speak for themselves. In addition, this inverse distribution is not unique to pharmacists, and is found in other professions as well. It is due to the social inequalities outlined earlier, as well as to the poor level of education associated with it that Africans were, in fact, denied access to training as health professionals, although the official avenues were open for them to do so.

COMMUNITY PHARMACY

Community pharmacies are the main source of medicines for consumers in the private sector[7]. As was shown earlier, they are not accessible to the greater section of the population as they are concentrated in the mainly White centres of the metropolitan areas. The current provision of the Medicines and Related Substances Control Act of 1965, also known as Act 101, limits the ownership of retail pharmacies to registered pharmacists, close corporations (if all members are pharmacists) and bodies corporate (if all shareholders are pharmacists). Legislative changes are being discussed, with the objective to relax the prohibition on the ownership of retail pharmacies as laid down by the SA Pharmacy Council (SAPC, 1994). Employment patterns of pharmacists as presented in Table 6 show that most are employed in community pharmacies.

Table 6. Employment of Pharmacists: 1992

Community	**64%**
Wholesale	2%
Transmed, Administration, Education	5%
Manufacturing	5%
Hospital	11%
Other	12%

Source: Summers, Van den Berg and Summers, 1994

[7] For further details see Simpson D., Pharmacy in South Africa. The Pharmaceutical Journal. 1994, 253:685-692 and Van der Merwe P.R., Pharmacy in South Africa, International Pharmacy Journal. 1994, 8:79-81.

The global debate[8] regarding the role of the community pharmacist did not bypass pharmacists in South Africa, and several reports have suggested that the future of the profession will be determined by its ability to become 're-professionalised' and shift its emphasis to a professional health-care service function, based on its specific expertise (PSSA, 1980). A document of the Department of National Health and Population Development (1990) states: "The community pharmacist (private sector) plays an important role in the provision of health services to the essentially first-world component of the population. This role must naturally be entrenched and even extended where indicated. The way in which this role is interpreted must however be continually adapted to meet the changing needs of the population. The community pharmacist's professional activities cannot therefore be limited to the confines of his pharmacy, but must be extended in particular to the community in which he practices. If this principle is acceptable, then the pharmacist's involvement in Primary Health Care, with the focus on third-world component or socio sub-economic groups of the population, can become a reality". This was in line with the recommendations made earlier by the Commission of Inquiry into Health Services, which dealt with "extending the functions of the pharmacist and his role in Primary Health Care". The committee reiterated that it "does not see the role of the pharmacist as that of a second rate doctor, but as a screen which could result in better utilisation of the doctor's time" (The report of the Commission of Inquiry into Health Services, 1986, p.125). These

[8]For further details about the nature of this debate see Gilbert L. The Pharmacist's Traditional and New Roles - A Study of Community Pharmacists in Johannesburg, South Africa. Journal of Social and Administrative Pharmacy, 12: 125 - 131.

recommendations, however, had little effect on changing the community pharmacist's role.

Since one of the main functions of the pharmacist is to dispense drugs and receive payments in return, the question of what the major motivator is - the patient's need, or the need for profits - has featured widely in the debate around the role ambiguity (Gilbert, 1976; Shuval and Gilbert, 1978) and remains a major source of conflict. Manasse's response to the question of defining the role of the pharmacist in patient care is that "pharmacy practice will have to make up its mind to what its social purpose is: is it contributing to the care of the patient in direct consultation with the prescribing physician, or is it conveying a material good across a counter and deriving a mark-up fee for the marketing distribution activity?"(1989, p.1142). Bass (1975) states that "the hybrid 'professional-merchant' role causes a dilemma for many pharmacists. As Apple points out, the most valuable service a pharmacist might render is to dissuade the person from self-medication, yet this would be in conflict with his financial interest in selling drugs. It seems that the method of payment to the pharmacist (salary versus profit!) determines the nature of the advice given. It is only when the pharmacist ignores the merchant role that impartial advice can be given" (1970, p.60).

In South Africa, although giving advice has always been part of a pharmacist's professional function, the committee was perturbed that the pharmacist was generally seen as no more than a salesman, since he was not remunerated for his advisory

function (The report of the Commission of Inquiry into Health Services, 1986).

THE NATURE OF THE DEBATE

As mentioned in the introduction, the 'extended' role of the pharmacist is at the centre of the debate as far as community pharmacy is concerned. Although it is a discussion in which the pharmacy profession worldwide is engaged, it takes on a distinctive meaning in the South African context. This is mainly due to the general background of inadequate health services and the transition associated with the officially declared emphasis on Primary Health Care, the pending changes in legislation (Act 101 of 1965) which are meant to increase the pharmacist's discretionary powers[9], combined with the urgent need to provide basic promotive, preventive and curative services to all people.

It appears that the key players in the profession, in various ways, are united in their views and believe that "the pharmacist can make a meaningful contribution towards making health care in this country more accessible and affordable"(Dreyer, 1994); or, as Cecil Abramson, president of the Pharmaceutical Society of SA, puts it: "The government has a bias toward primary health care, and I believe it is aware of the contribution that pharmacists can make in that area" (Abramson, 1994, p.10).

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[9]For more details see Gilbert L. Pharmacy's Attempts to Extend its Roles - A Case Study of Amendments to Legislation and Special Permit Holders in South Africa *International Journal of Pharmacy Practice*. 5:192-200.

The discussions centre around a necessary paradigm shift, as discussed in the introduction, required from the profession to achieve its goals within a restructured health system. However, the full nature of the expected change is not clear to all, confusing for some and threatening to others, as expressed by Herson (1995) in a letter to the SA Pharmaceutical Journal: "Pharmacy is changing at a very rapid pace. Community pharmacists in particular, are realising fast that this 'paradigm shift' has shifted far out of their reach. Pharmacists out there are very confused as to what exactly is expected of them". According to Osman (1993), "there are pharmacists who believe that the new role of the pharmacist will detract from the traditional skills and art that we have so carefully cultivated. I've heard it said that we are being lured away from our areas of expertise into areas we should avoid, and that we are rushing off to become second-rate doctors. Nothing can be further from the truth. We are actually striving to be first-rate pharmacists." Similar views of lack of clarity and apprehension with regard to the uncertainty, were expressed by the pharmacists interviewed in the study.

This is at the core of the conflict the community pharmacists find themselves in. The SAPC and the Pharmaceutical Society of SA vigorously encourage pharmacists to gear up for this change. Most of the pharmacists interviewed, saw themselves primarily as "health-care professionals" and "health educators" and therefore supported the move toward role expansion.[10] However, their "occupational reality" is incongruent with the

[10]More on this topic to be found in Gilbert L, The Pharmacist's Traditional and New Roles - A Study of Community Pharmacists in Johannesburg, South Africa. Journal of Social and

envisaged changes. They continue to do what they have always done, mainly dispensing medication prescribed by a doctor or dealing with over the counter (OTC) medications for minor ailments, for a "fee for product", and at the same time trying to make a living in a climate of economic hardships and competition from dispensing doctors and supermarkets (Gilbert, 1995b). It is conspicuous that the existing reimbursement mechanism, which is based on the sale or dispensing of a drug, is providing little incentive for the pharmacist to engage in patient-orientated services, as expected of him according to the new paradigm. Only when pharmacists are rewarded for providing professional pharmaceutical services[11], whether or not a drug is sold or dispensed, would they be in a position to pay greater attention to patient-orientated services as proposed in the paradigm shift towards the extended role of the pharmacist.

The training of pharmacists poses additional problems. Many feel that their training has not been adequate to equip them to fulfil the new activities that would be required of them. This has been confirmed in another survey (Survey, 1994), where it was reported that respondents felt that "pharmacists needed to become more knowledgeable because they were not adequately trained for their more demanding future role as part of an integrated health team".[12]

Administrative Pharmacy, 1995, 3, 125 - 131

[11]This issue is currently being addressed by proposed changes in the fee structure

[12]More on this topic can be found in Gilbert L., The role of training in transforming community pharmacy in SA. In Press: Journal of Social and Administrative pharmacy

In principle, the pharmacists were willing to undergo further training, and some have already done so. This has been strongly advocated and encouraged by the SAPC. However, appropriate training poses serious challenges to all pharmacists as it is extremely difficult to establish a training programme that will meet everyone's needs. The undergraduate curriculum lends itself to easier adaptation than does the training of registered pharmacists. Practising pharmacists not only have different experience, but there are severe limitations on the amount of time they have to devote to acquisition of new skills. It also raises questions with regard to the feasibility of changing a complete mind-set of practitioners in community pharmacies.

The latest statement on this topic is a position paper on 'The role of the pharmacist', task group 2, Interim Pharmacy Council of South Africa, in which it is stated that "pharmacy is a profession which should fulfil a socially responsible function and keep abreast of modern developments, and be able to adapt to the changing needs of communities for health care" (1995, p.6).

Positioning this discussion against the background of an unequal society and the maldistribution of health and pharmaceutical resources as presented earlier, raises serious doubts with regard to its relevance in the SA context, and the ability of community pharmacy to transform itself to be able to play the role envisaged by the SAPC.

GENERAL DISCUSSION AND CONCLUSION

This aim of this paper is to explore the existing role of community pharmacy in SA in the context of health services in general against a background of a society in transition. As a legacy from the past, the health system in SA is characterised by gross disparities between the different population groups, between rural and urban populations, and the private and public sectors. These differences reflect inequities in the wider society, and as such, are mirrored in the distribution of pharmacists and community pharmacies as demonstrated in this paper.

The maldistribution of community pharmacies in SA presents a paradox. On one hand, although being the main source of medicines for consumers in the private sector, they are not accessible to the greater section of the population in need. On the other hand, they seem to provide a source of cheap and accessible medical advice to the same people deprived of adequate access to organised health care, mainly in the Central Business Districts, and at the same time they also have the potential to extend their contribution by providing primary health care services (Gilbert, 1995a).

The health policy of the new government is an attempt to address some of the problematic issues outlined earlier. It is therefore imperative to take into consideration the underlying philosophy steering the process of restructuring the health system. The guiding principles of the new health minister and health policy are that all legislation,

organisations and institutions have to be reviewed with a view to attaining the following:

* ensuring that the emphasis is on health and not only on medical care;
* redressing the harmful effects of apartheid health care services;
* encouraging and developing comprehensive health care practices;
* emphasising that all health workers have an equally important role to play in the health system; and
* reducing the burden of risk of disease affecting the health of all South Africans (ANC Health Plan, 1994).

The examination of the role of community pharmacy was, therefore, done against this background with a view to exploring how it can fit into this changing scenario.

Theoretically, the move towards the 'extended role' sounds positive, in that it will allow the pharmacist to provide a more comprehensive professional health service to the masses. It falls into the essential and long overdue theme of Primary Health Care and gives legitimacy to statements that community pharmacy delivers a good health-care service to the public. In reality, however, there are serious barriers to the implementation of the changes, such as the existing restrictive legislation, current mode of reimbursement (Pharasi and Price, 1993), public perceptions, economic demands and attitudes of other health professionals[13].

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[13]For more details see: Gilbert L., The community pharmacist as a member of a Primary Health Care team in SA. *International Journal of Pharmacy Practice*, 15:192-200.

The most serious encumbrance is the fact that most community pharmacies are not easily accessible for the majority of the population due to their concentration in urban areas. This reality makes it difficult to consider them as sources of adequate primary health care delivery for the population at large. At the same time, a legitimate question in the South African context is whether the pharmacist is the most appropriate health-care worker[14] to be trained in the future to deliver this kind of care (Pharasi et al, 1993).

In an attempt to deal with some of the problems raised, the SAPC has embarked on seven projects relating to pharmacy education and practice. Of interest in particular to this paper are the goals of Project 1 in Pharmacy Practice, which aims to:

"a. bring about a paradigm shift for pharmacy in SA towards patient care;

b. address total health-care needs of all communities in SA;

c. establish and emphasise the actual unique role of pharmacists in health care; and

d. change perceptions of the role of the pharmacist among the public and other role players" (Education, 1995).

Officially, the pharmacy profession has committed itself to playing a useful role in the provision of health services in SA. As stated by the SAPC in its submission to the Commission of Inquiry into a National Health Insurance, "the demand for health care for all population groups in SA currently exceeds the state's ability to meet this

[14]This question, although important, is beyond the scope of this paper

demand and it is likely that the extent of this inability will continue to increase. It is imperative for the state and private sector to co-operate to the fullest extent to bring about the most cost-effective use of scarce resources available to meet the demand for health care. To this end, the pharmacy profession's infrastructure and manpower in the private sector has reiterated its willingness to contribute to this process and to effectively engage private health care infrastructure and manpower to assist the Reconstruction and Development Programme (RDP)[13] health initiatives and programmes" (SAPC, 1995).

It is vital to note here that the discourse around the expanded role of the pharmacist in SA should not confine itself to the discussions around the changes in legislation that will allow the pharmacists to extend their clinical boundaries. The debate goes beyond that; it is about a greater congruence between training and meaningful professional roles. In the South African context it should be linked to the question of how the pharmacist can be integrated into a truly comprehensive service offered to the patient. This does not imply further clinical powers, but more involvement with other health professionals with greater emphasis on team work, counselling and education.

It is necessary to regard the pharmacist not in isolation, but as a member of the primary health care team, and with due regard to the needs of the communities and the goals of the national health-care strategy (Pharasi et al, 1995). This has been recognised by

[13]The RDP is a programme devised by the government to address the social inequalities in South Africa

the SAPC in its discussion document, which states: "A firm national commitment by pharmacists to especially primary health care is essential if pharmacists want to be seen as role-players in rendering health care services ... pharmacy cannot create its own kind of 'health care services' to suit its present facilities, geographical distribution and training" (Work group 3, 1995).

As discussed, the reality presented in this paper is in the process of being reconstructed with a general bias towards Primary Health Care and emphasis on prevention, equity and community involvement in particular. Community Pharmacy is making an attempt to fit in with the proposed changes in health care philosophies and structures by extending both its range of activities as well as the population it reaches. However, this transition is fraught with attitudinal barriers of health professionals as well as structural and legal ones.

As already alluded to, the changes in the role of community pharmacists can only be achieved in conjunction with major changes in the structure of the health system and training of health personnel as a whole. The intentions are there, but it is a long-term process, determined by a broad spectrum of factors, and related to the general transition within South African society and its health services. Further evidence for the above is found in the statement that "community pharmacy has been changing and developing in response to changing circumstances, and will continue to do so. Any strategy to optimise the role of the pharmacy profession should, however, be part and

parcel of the solution for health care problems in South Africa" (Work group 3, 1995).

The pharmacists represent an untapped - and highly qualified - resource that can be utilised more efficiently and appropriately to the benefit of the health-care system and the public. Selya (1988) claims that through proper legislation, public education and changes in future pharmacy curricula, the pharmacy may represent a relatively inexpensive and readily accessible institution to put in the range of places from which a person may seek medical help. In South Africa it can be achieved only with a change in the distribution of pharmacies in an equal manner so they can become accessible to all, and with the recognition that the profession should aim to fulfill a socially responsible function and be able to adapt to the changing philosophy and structure of health care. This should also include a much wider responsibility for the patient's therapy and a "shift from the professional trader to the trading professional" (Work group 3, 1995).

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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CHAPTER III

THE PHARMACIST'S TRADITIONAL AND NEW ROLES - A STUDY OF COMMUNITY PHARMACISTS IN JOHANNESBURG, SOUTH AFRICA

ABSTRACT

The aim of this paper is to examine the existing activities of community pharmacists, their perceptions of their present and future role, as well as the appropriateness of their training to fulfil the diverse components of their role.

The data were collected by means of an observation of and interviews in 53 randomly selected community pharmacies in Johannesburg, South Africa. It is clear from the results that most of the pharmacists interviewed perceive themselves primarily as "health care professionals" (93%) or "health educators" (72%), while a smaller percentage sees itself mainly as "businessman" (36%) or "manager" (21%). An examination of the different activities grouped into **"Traditional Role"** and **"New Role",** reveals that 82% engage mostly in "traditional" activities while the "new" activities are performed by 28% of the pharmacists only. Among the reasons given for not engaging in those activities are mainly lack of demand, legal restrictions as well as insufficient training. Over 75% of the pharmacists identified shortcomings and inappropriateness in their training. 77% felt that they have been adequately trained to carry out the "traditional" activities. However, only 37% felt that they have been adequately trained to engage in activities that form part of the "new role". On the whole the pharmacists expressed their desire to extend their activities in order to be able to play a major role in Primary Health Care.

INTRODUCTION

Pharmacy in South Africa[1], as in the rest of the world, is a profession in transition and is characterized by considerable ambiguity and uncertainty concerning its status as a health care profession. This poses dilemmas of role definition for both its practitioners and other individuals with whom the pharmacist interacts.

According to Adamcik et al [3], many forces, both internal and external, are working to change the profession of pharmacy. The direction the profession is taking is towards a more patient-orientated, clinical role for its practitioners. Summers [4] strongly recommends that the profession in South Africa adopt a similar approach.

The development of industrialization, large-scale manufacturing of medical products, medical specialization and increased medical technology have resulted in a substantial loss of functions to the pharmaceutical profession and have created a void in the *professional roles of pharmacists, who have found themselves **overtrained** for what they do and **underutilised** in terms of what they know. Over the last decade* pharmacists generally have been debating the direction their profession should take [5,6,7].

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[1] For a general overview of pharmacy in South Africa see Van der Merwe [1] and Simpson [2]

The profession's response to the loss of function and the resultant stress and role ambiguity has been a movement toward **'re-professionalisation'** [8]. This debate did not bypass the pharmacists in South Africa and several reports suggested that the future of the profession would be determined by its ability to become "re-professionalised" and shift its emphasis to a professional health care service function, based on its specific expertise [9]. A major feature of the process of "re-professionalisation" is the discourse around the so called "extended" role of the community pharmacist, which constitutes the main concern of this paper.

The International Pharmacy Federation's (FIP) guidelines [10] call upon the pharmacist to promote and develop the concept of pharmaceutical care, including advice to the public. The World Health Organisation (WHO) recently endorsed the role of the pharmacist by the adoption of a resolution by the World Health Assembly (WHA) in Geneva, where member states were urged to make full use of the expertise of the pharmacist at all levels of the health care system [11].

In some countries it is well-recognised that pharmacists act as health advisors to the general public [12,13,14,15,16,17,18,19,20,21]. An extension of the primary health care advisory role of community pharmacists in Britain was recommended by an independent enquiry into pharmacy [5] and is currently being pursued by the pharmacy profession [19].

A more cautious stand has been taken on this subject in South Africa, but nevertheless several recommendations have been made that can be interpreted as supporting this move. A document of the Department of National Health and Population Development [22:5-6], states the following: "The community pharmacist[2] (private sector) plays an important role in the provision of health services to the essentially first-world component of the population. This role must naturally be entrenched and even extended where indicated. The way in which this role is interpreted must however be continually adapted to meet the changing needs of the population. The community pharmacist's professional activities cannot therefore be limited to the confines of his pharmacy, but must be extended in particular to the community in which he practices. If this principle is acceptable, then the pharmacists involvement in primary health care, with the focus on third-world component or socio sub-economic groups of the population, can become a reality". This is in keeping with the recommendations made earlier by the Commission of Inquiry into Health Services [23:120], which dealt with "extending the functions of the pharmacist and his role in Primary Health Care". Evidence before the committee showed that the pharmacists themselves are of the opinion that they could render, and would like to render, extended professional services. The latest initiative in this direction is the call of The Pharmaceutical Society of South Africa for new functions for pharmacists to be identified, developed and legalised [24]. This includes training pharmacists to carry out functions currently

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[2] Currently, community pharmacies in South Africa can be owned by pharmacists only and shareholders of bodies owning pharmacies must all be pharmacists. This is about to change with new legislation which has been put forward in 1997.

performed by nurses at clinics which will involve the pharmacist administering injections, providing preventive care services and caring for the chronically ill. The suggestions are that these functions will be performed by pharmacists in addition to the nurses in the clinic. This is to fully utilise existing health personnel to alleviate the crisis in health care. Since 1993 over 2500 pharmacists have undergone special training in family planning and can supply oral contraceptives[3] without a medical prescription, on condition that the recipient sees a medical doctor within six months. The extension of the Pharmacist's role was to have been given legal status by the Pharmacy Amendment Act (Act 101)[4] which, according to its propagators, for the community pharmacist, has the potential to "enhance your role by granting you access to higher scheduled medicines[5], access to greater discretionary powers, and access to reach your true potential" [25: 503].

The most significant characteristic of community pharmacists is their accessibility. They are available to the public throughout the working day with no appointments, no receptionists and no direct charges - in other words, no barriers for help seekers

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[3]Not all the pharmacists who have undergone the training course are actually engaged in family planning. This is mainly due to the fact that the remuneration for this function comes from the state, involves complicated administration and is generally very poor.

[4]Due to pressure from the medical profession and the political uncertainty in South Africa, a decision was taken to suspend the changes in legislation. In fact, all health-related legislation was put on hold in 1993-94 until the commencement of the new government and legislative bodies.

[5]All prescription medicines in South Africa are classified into schedules by the Medicines Control Council. The pharmacist can administer only Schedule 1-2 drugs, while for the "higher schedules" they require a doctor's prescription. The proposed regulations are to change some of these restrictions.

[26,27,28,29]. The ease of access to a retail pharmaceutical outlet means that it is often the first point of contact for people in need of advice or information about medical care [30,31]. The pharmacist can suggest appropriate medication for a range of self-limiting complaints, recommend consultation with a general medical practitioner [32] and feed back to prescriber important clinical information about patients, such as adverse drug reactions and inappropriate prescribing [33]. A considerable strength of the community pharmacists' role is that they form a convenient part of existing professional health resources for the lay public. For many they are accessible, informal, helpful and responsive, and as such, they are in a unique position to provide an important link between lay and professional responses to illness [34]. It is important to note that pharmacists may be a useful source of advice about health matters or about pharmaceutical products, but there is still a good deal of ambiguity about the extent to which they should be treating illness.

Considerable support has been given to the idea of expanding the role of the pharmacist; however, the appropriateness of the pharmacist's training to provide an "extended" service has been questioned in this regard. The Committee [23:122] suggested that for the pharmacist to fulfil a role in primary health care he "has to be correctly trained". Appropriate changes in training have also been suggested by Summers [4].

The aim of this paper is to examine the existing activities of community pharmacists[6], their perceptions of their present and future role, as well as the appropriateness of their training to fulfil the diverse components of their role.

METHODS

The data presented in this paper form part of a larger, more comprehensive study entitled "The present and future role of community pharmacy in South Africa".

Qualitative as well as quantitative research methods were used to collect the data presented in this paper, the rationale being that the combination of the two methods facilitates the exploration of the issues from different angles and thus has the potential to produce more comprehensive results [35]. A representative sample of 55 community pharmacies was selected by means of random numbers allocation out of a total of 275 community pharmacies in Johannesburg, South Africa. All except 2 of the pharmacists approached agreed to participate in the study. The final number of participating pharmacies was therefore 53. An observation based on guidelines was carried out at each pharmacy in order to examine the activities performed by the pharmacist and to establish the nature of the encounter with users and other staff members. In addition,

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[6]According to statistics supplied by The South African Pharmacy Council (1993), the total number of pharmacists in South Africa is 9277, with 6435 practising as retail pharmacists in community pharmacy (representing 69% of the total).

a structured interview, based on a questionnaire with closed as well as open ended questions, was conducted with the pharmacist[7]. The guidelines to the observation and the questions for the interview were developed out of an analysis of hundreds of previous projects carried out by pharmacy students as part of their requirements in the course taught by the author. Staff members teaching pharmacy practice were consulted and "piloted" with the interview. The observations as well as the interviews were done by the author and two trained research assistants. The quantitative data was analysed using SPSS [36], while the qualitative data based on the observation and open questions from the interviews was analysed by means of grouping and classifying according to the various topics covered [8].

RESULTS

The pharmacists' perception of their role

The pharmacists were asked to indicate, by ranking in order of importance (from 1 to 7), **"what is a pharmacist?"** Table 1 gives a summary of their responses. It is clear from the results that most of the pharmacists interviewed perceive themselves

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[7]In most cases there was only one pharmacist in each pharmacy. In case of there being more than one the choice was to interview the senior one.

[8]Note should be taken that this paper is based on one section of the study dealing only with the issues examined here.

primarily[9] as **"health care professionals"** (93%) or **"health educators"** (72%), while a smaller percentage sees itself mainly as "businessman" (36%) or "manager" (21%). It might be of interest to note that most of the respondents do not consider the components of "scientist" (84%) and "technician" (74%) as important to the role of the pharmacist.

Table 1. What is a pharmacist? Percentage (%) distribution of rankings

	1	2	3	4	5	6	7
Health care professional	**74**	19	4	2	2	0	0
Health educator	25	**47**	15	9	2	2	0
Clinician	6	13	**30**	13	15	6	17
Manager	13	8	21	**26**	23	8	1
Businessman/woman	25	11	11	17	**23**	4	9
Scientist	**0**	**0**	4	8	4	**38**	46
Technician	0	4	2	9	11	21	**53**

Current activities of the pharmacist

The interview included a list of activities likely to be performed by the pharmacist, and they were asked to indicate to what extent they engage in these activities. In order to present a summarised and simplified version of the responses, the different activities were grouped into **"Traditional Role"**[1] and **"New Role"**[2]. An examination of the results reveals that 82 percent of the pharmacists interviewed engage in **"traditional"**

[9]For this purpose ranking 1 and 2 have been combined

activities "most of the time" or "very often", while the **"new"** activities are performed in that manner by 28 percent of the pharmacists only. Among the reasons given for not engaging in those activities are mainly lack of demand, legal restrictions as well as insufficient training.

A separate examination of the structural barriers hindering the extension of the pharmacist's role to the **"new"** activities is based on Table 2. It is quite clear that the pharmacists perceive the current **"health structure"** as well as the associated **"legal"** status of their profession as the main barriers to the extension of their role. These barriers were further emphasised in the interview and were reflected in some of the comments made by the pharmacists such as "to do more work we need to be paid more " ... "doctors are resentful" ..."pharmacies should become clinics"..."there are too many legal restrictions".

Table 2. Structural barriers to the performance of extended activities

	YES %	NO %
Is the way your pharmacy built/structured convenient to perform most of the activities?	55	45
Does the current "health structure" encourage you to perform the various activities?	25	75
Is the legal position such that you can perform most of the activities?	19	81

Appropriateness of training

An identical list of activities was presented in order to elicit responses with regard to the perceived appropriateness of training, and the same grouping of activities was performed in order to present a summarised and simplified version of the responses. Seventy seven percent of the respondents felt that they have been adequately trained to carry out the activities that form part of the **"traditional role"** of the pharmacist. However, only 37 percent felt that they have been adequately trained to engage in activities that form part of the **"new role".**

In general terms over 75 percent of the pharmacists identified shortcomings and inappropriateness in their training. The lack of training to engage in certain activities was raised by the pharmacists numerous times and was accompanied by requests to make training courses cheaper and more accessible/available.

The future role of community pharmacy in South Africa

The pharmacists were asked about their opinions with regard to the future role of community pharmacy in South Africa. On the whole most of the pharmacists expressed their desire to extend their activities in order to be able to play a major role in Primary Health Care. This was expressed in various ways by direct reference to their desire "to

play an increased role in community education and diagnosis and treatment of minor ailments", or in an indirect manner through their emphasis that "quite often the pharmacist is the first person the patient sees" and as such "should be more patient-orientated". The "need for more cooperation with the doctors" was mentioned as a necessary element in the future functioning of community pharmacy within the framework of Primary Health Care and the move towards more extensive service to the public. The inappropriateness of training received by practising pharmacists and the necessity for retraining as well as required changes in future training were issues raised by the pharmacists while discussing the future role of the community pharmacist in South Africa. It is of importance to note that 81 percent of the pharmacists interviewed expressed their readiness to participate in further training in order to extend their current activities. This is an additional indication that there is a willingness on the part of the pharmacists to extend the boundaries of their professional role.

DISCUSSION and CONCLUSION

This paper demonstrates the complexity of the issue by highlighting the current incongruity between the pharmacists' willingness to expand their professional role and their lack of appropriate training[10] to do so, as well as pointing to some of the barriers to the practical implementation of the expanded "**new role**". It also confirms the in-

[10]The lack of training refers mainly to the fact that the pharmacists did not receive training that provides them with the necessary skills to perform the "new role".

built tensions in the profession as reported in the literature. On one hand we have the **community pharmacists** who perceive themselves mainly as **health care professionals**, who would like to see their role expansion followed by more professional freedom and autonomy, and who are willing to undergo further training in order to achieve this goal. On the other hand their **occupational reality** in South Africa is such that most of their daily activities are within the boundaries of the **"traditional role"** for which, consistent with the literature, they are **overtrained** and **underutilised**, resulting in despondency, frustration and general dissatisfaction with "being a community pharmacist" [11]. The proposed expansion to the pharmacist's role or **re-professionalisation** is the profession's solution to the problems pharmacists in South Africa are facing. However, barriers in the form of the current fee structure (fee for product), legal restrictions, resistance from medical practitioners[12] as well as their own admission of inadequate training to fulfil the **"new role"** obstruct the process and prevent them from reaching this goal. Nevertheless, the process continues and the shift towards re-professionalisation is taking the form of making the changes in legislation a reality; adjusting pharmacy curricula in training future pharmacists to fit in with the new vision, as well as retraining existing pharmacists to be able to expand their role.

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[11]These were the sentiments expressed in the interviews and during the observations.

[12]The Medical Association of South Africa has organised representations to the Parliamentary Joint Committee on Health against the campaign to "legalise the rendering of medical care by pharmacists" (amendments to Act 101 [25]). The MASA presented expert legal and medical opinions in support of its arguments that the proposed amendments would have been legally intolerable and of public disservice.

In conclusion, note should be taken that the examination of community pharmacy in South Africa can only be fully understood when done against the background of a **society in transition** - rapid urbanization, the deficiencies and lack of resources in the existing health services and the attempts of the previous government at restructuring of the services with an emphasis on Primary Health Care and the health policy of the new government[13].

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

[13]The wider study attempts to tackle some of the issues mentioned.

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1. The list of activities that were combined under **"Traditional Role":**

* dispense drugs according to a doctor's prescription
* counsel patients about prescribed drug
* discuss the prescription with the doctor
* manage pharmacy
* counsel patients about OTC drugs
* sell OTC drugs
* advise patients with regard to their personal health
* assess the patient's problem and refer to other health professionals
* provide drug information to other health professionals
* educate consumers (STD, diet etc.)
* attend to emergencies/casualties

2.The list of activities that were combined under the **"New Role":**

* blood pressure monitoring
* cholesterol testing/monitoring
* glucose testing/monitoring
* train home care patients (eg. stoma care or peritoneal dialysis)
* monitor drug therapy of chronic patients
* prescribe in case of acute illness (eg. antibiotics)
* order laboratory tests
* immunisation
* developmental screening (for babies)
* administer injection
* prescribe/administer contraceptives
* participate in health promotion programmes in the community

CHAPTER IV

PHARMACY'S ATTEMPTS TO EXTEND ITS ROLES - A CASE STUDY OF AMENDMENTS TO LEGISLATION AND SPECIAL PERMIT HOLDERS IN SOUTH AFRICA

ABSTRACT

This paper examines the role expansion of community pharmacy in South Africa against the background of phenomena such as professional dominance and boundary encroachments. The study demonstrates pharmacy's thrust towards an extended and more meaningful role, making a clear distinction between the role extension concerning the granting of additional powers to prescribe medications, and that of a wider range of activities. It confirms previous claims that the opposition from the medical profession is particularly fierce when it comes to the pharmacist's ability to prescribe. The successful granting of special permits to a selected group of pharmacists to practice an extended role can be explained by the fact that it has been restricted to rural, under-served areas. The developments to date signify a partial success by the pharmacy profession towards its role extension. However, this is likely to remain limited due to the forces operating against it. Considering this context, the development of "health centres" might prove to be an alternative venue for the integration of pharmacists into the health care team.

INTRODUCTION

Since its inception, pharmacy has been closely connected with medicine in providing services of fundamental value to society (Angorn and Thomison, 1989). Pharmacists have a long history as health advisors to the public (Smith, 1994), and as custodians of medicines (McGhan, 1989). However, the development of industrialisation, the large-scale manufacturing of medical products, medical specialisation and increased medical technology have resulted in a substantial loss of functions for the pharmaceutical profession (Roberts, 1988). "In the span of about 50 years, the profession lost no less than three of the four functions that had been the mainstay of the work of pharmacists since at least the 8th century! The old mysteries of the art of apothecary, drug procurement, storage, and compounding, had vanished" (Mrtek and Catizone, 1989:30). Mrtek and Catizone maintain that "the loss of such deeply rooted functions endangered the identity of the entire profession ... the changes in practice had left a limited role for community pharmacists, the simple dispensing of drugs on order of the prescriber, with its associated monetary transaction. Everything else had been swept aside by 'progress'" (Mrtek and Catizone, 1989:31).

The pharmacists found themselves overtrained for what they did and under-utilised in relation to what they knew. The profession's response to the loss of function and the resultant stress and role ambiguity has been a movement toward 're-professionalisation' (Birenbaum, 1982). A major feature of the process of re-

professionalisation is the discourse around the so-called 'extended' role of the community pharmacist, which is the main concern of this paper.

The process of re-professionalisation took on different forms, manifesting itself primarily in a gradual shift away from the technical paradigm - with the emphasis on drug products and their preparations - toward a more disease and patient orientated approach to pharmaceutical decisions. The development of "Clinical Pharmacy" in the hospital setting was one of the major strides in this direction (Gilbert, 1976; Hepler, 1985; Sogol and Manasse,1989; Mesler, 1991; Ivey, 1993; Cotter, Barber and Mckee, 1994). Where successful, "the clinician pharmacist became truly a contributing partner in the decision process - a colleague whose participation is viewed as essential, by right of independent expertise, for planning rational and optimal drug usage for each patient" (Mrtek and Catizone, 1989:34).

This shift in favour of a more active involvement with patient care was less successful in community pharmacy settings, the main reason being the pharmacist's lack of access to the patient's health status record, as argued by Mrtek and Catizone: "isolated as they are from an accurate and complete patient health status record, there is little that most community pharmacists can do to render clinical judgements that are central to drug therapy decisions" (Mrtek and Catizone, 1989:36). In community pharmacies, the recommendations made by pharmacists in the use of non-prescription drugs "embodies the closest approximation that the community pharmacist enjoys to exercising any

clinical judgement". The advisory role of the pharmacists in cases of minor ailments might be useful for the patients seeking help, "but it hardly qualifies the pharmacist to claim the experience as a significant therapeutic encounter" (Mrtek and Catizone, 1989:37). Mrtek and Catizone insist that the development of the clinical paradigm for pharmacy has a real chance to operate only in those settings where access to health status information is provided to the pharmacist and where other health professionals are at hand with whom the pharmacist may interact as a respected peer.

Various attempts have been made to extend the role of the community pharmacist all over the world. In the UK, the components of the pharmacist's extended role range from advising patients on minor ailments to diagnostic testing (Harding, Nettleton and Taylor, 1994), health education and promotion (Cunningham-Burley, 1988; Todd, 1993), primary care (Smith,1990; Sheppard et al, 1995, Cunningham-Burley, 1994), and record keeping (Britten, 1994). According to Britten, record keeping is an essential part of the new role, and one on which several of the other components depend, such as providing advice on the use of medicines and the monitoring of adverse reactions.

"Pharmaceutical care" is defined as a relationship between a patient and a pharmacist in which the pharmacist accepts responsibility for drug use control function, and provides those services governed by awareness of, and commitment to, the patient's interests. (Hepler, 1989). In the USA, the development of the concept and practice of "Pharmaceutical Care" (Hepler, 1990; Hepler and Strand, 1990; Strand, 1996)

represents an attempt to provide the community pharmacist with a more meaningful role, emphasising the concept of "caring" (Lowes, 1995) and commitment to patient care (Odedina, Segal and Hepler, 1995).

Williams claims that "if we really intend to re-professionalise the practice and implement the principles of pharmaceutical care, then we must give a high priority to obtaining enabling legislation or rules that will permit every pharmacist to best utilise his/her extensive pharmaceutical knowledge and prescribe drugs for patients" (Williams, 1995:9). However, the reality is that some sort of prescribing by pharmacists is only taking place in seven states in the USA. There are several models of pharmacists prescribing available in those states, from independent prescribing authority for a limited numbers of drugs in Florida, to more restricted set-ups in California, New Mexico, Oregon, Mississippi, South Dakota and Washington (Meyer, 1994).

The various attempts at 'role expansion' for pharmacy depict a universal trend among other health professions (McGhan, 1989). According to McGhan, at least since the 1960s, each health profession seems to argue that it is expanding its functions to better meet the needs of society. All professions manifest aspirations for greater responsibilities, larger incomes and enhanced status for their members (Selden, 1989). However, as argued by Freidson (1970), since medicine has maintained its dominance over all 'medical functions', it always claims intrusion. Mumford maintains that

"boundary disputes between professions take place over authority - who has the right to diagnose the problem, who has the right to decide which treatment, and who has the right to charge for services" (Mumford, 1983:264).

At the heart of this issue is the question of professional autonomy, or the legitimated control that an occupation has over the content of its own work. According to Nettleton (1995), related to the notion of autonomy is professional dominance, which refers to the way in which certain professions not only control the content of their own work but can also define the limits of the work of other occupational groups (Freidson, 1970). This point is confirmed by Kronus, in the historical analysis of task boundaries between physicians and pharmacists, where she clearly portrays "the relative ability of the occupation to protect its task domain from encroachment, and/or [to] encroach on others, as the central measure of power" (Kronus, 1976:5).

Pascall and Robinson (1993) argue that boundary disputes between occupations and competition over work roles are an inevitable component of a complex health care system with an elaborate division of labour and a changing social and technological environment. Work roles are not comprehensibly defined in legal terms, and overlapping responsibilities are common (Hardy, 1978). For this reason, para-medical occupations have had to negotiate boundaries with each other as well as with doctors when establishing spheres of competence and responsibility (Larkin, 1983).

Eaton and Webb (1979) referred to the extended role of community pharmacy as "boundary encroachment", claiming that it is an attempt to extend the boundaries of pharmacy practice into the territory of the medical profession (the boundary in this case being that between prescribing and dispensing). According to Halperin (1989), although pharmacists speak about emerging new roles and responsibilities in various areas - prescribing being among them - these roles have yet to be achieved, primarily due to strong opposition from physicians who resist the encroachment on their professional and economic turf (Lambert et al, 1977; Lambert, 1995).

The opposition from the medical profession is extremely fierce, particularly when it comes to the 'ability to prescribe' component of the pharmacist's extended role. A prerequisite for prescribing medication for a patient is the ability to determine what is wrong, or to diagnose the condition. It seems that the right to diagnose is at the centre of the struggle, since it is a deciding factor in the social control and reimbursement for services. Fitting evidence is provided by Mumford regarding the "struggle of nurses to establish the fact that they diagnose patients" (Mumford, 1983:264), and optometrists' fight "to diagnose eye disease ... which was energetically attacked by physicians" (Mumford, 1983:265).

It is the aim of this paper to examine the role expansion of community pharmacy in South Africa against the above background.

METHODOLOGY

To gain an in-depth insight into this complex issue a combination of qualitative and quantitative research methods were employed. This paper is based on data collected through[1]:

I. Interviews with key informers.

II. Documentary analysis of published reports, minutes of committee meetings as well as official publications of The South African Pharmacy Council (SAPC), professional associations and news paper articles.

III. A survey conducted among a random sample of community pharmacists in the Johannesburg area[2].

IV. A survey conducted among pharmacists in possession of section 22A (12) permits.

THE SOUTH AFRICAN SCENARIO

The deliberations with regard to the future role of pharmacy did not bypass pharmacists in SA, and several reports have suggested that the future of the profession will be determined by its ability to become 're-professionalised', and to shift its emphasis to a professional health-care service function, based on its specific expertise

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[1]The data used for this paper are part of a larger study dealing with the role of community pharmacy in South Africa.

[2]As part of the larger study a random survey of community pharmacies in Johannesburg was conducted. For more details see Gilbert (1995a).

(Pharmaceutical Society of South Africa, 1980). A document of the Department of National Health and Population Development states that "the community pharmacist (private sector) plays an important role in the provision of health services ... this role must naturally be entrenched and even extended where indicated"(1990: 5-6).

This is in keeping with the recommendations made earlier by the Commission of Inquiry into Health Services (The Browne Report, 1986:120), which dealt with "extending the functions of the pharmacist and his role in Primary Health Care". Evidence before the committee (The Browne Report, 1986) showed that the pharmacist was of the opinion that he or she could render, and would like to render, extended professional services.

In South Africa, although giving advice has always been part of a pharmacist's professional function, the committee (The Browne Report, 1986) was perturbed that the pharmacist was generally seen as no more than a salesperson, since he was not remunerated for his advisory function.

The potential role expansion of pharmacists in South Africa is synonymous with what has been termed Primary Care Drug Therapy (PCDT) or Pharmacotherapy by the South African Pharmacy Council (SAPC) and academic institutions. It is therefore important to trace its historic development (The South African Pharmacy Council, 1994). Before 1965, the pharmacist had the authority to compound and sell medicines

with virtually no restriction (Ryan, 1986). In 1965, the Medicines and Related Substances Control Act, or Act 101, was introduced. This Act limited the pharmacist's discretion to medicines that fell into schedules 1 and 2. All other medicines in the higher schedules could only be dispensed by the pharmacist following a doctor's prescription.

In 1986 the Commission of Inquiry into the provision of Health Services in SA stated and recommended the following to the government: "The Medicines Control Council should consider in terms of past experience and taking cognisance of circumstances the desirability of rescheduling medicines presently available for prescription use only, in order to strengthen the armamentarium of the pharmacist so as to promote responsible self-medication and to acknowledge his/her professional role as health educator and promoter in the front line of primary health care. This can only be achieved if the pharmacist personally provides his/her patient with such medicines." It further reiterated that "the pharmacist has always fulfilled a diagnostic function but in this he was, however, curbed in what therapy he was allowed to give. Such curbing of the pharmacists' diagnostic abilities lies in the scheduling of medicines." The committee also suggested that greater freedom in the handling of scheduled medicines should be seriously considered in the light of changes in the curriculum. As a result of this recommendation, the curriculum of pharmacy was further adjusted to be more patient and clinically orientated.

The recommendations were accepted by the Government, pending legislative changes. In 1991, Parliament passed Act 94 with the objective of introducing the Browne Report's recommendations that the pharmacist's list of medications be expanded. The South African Pharmacy Council (SAPC) supported the recommendations, due to the shift to primary health care, the professional accountability of pharmacists, their underutilisation, as well as their willingness to provide the services (Van Niekerk, 1995).

The extension of the Pharmacist's role was to have been given legal status by the Pharmacy Amendment Act (Act 101) which, according to its propagators, has the potential to "enhance [the community pharmacist's] role by granting [him/ her] access to higher scheduled medicines, access to greater discretionary powers, and access to reach [his/ her] true potential" (PPAC, 1993:503). The proposed changes would allow the pharmacist to prescribe certain medicines in schedules 3, 4 and 5 which at present may only be legally prescribed by doctors. However, access to these medicines would allow pharmacists to diagnose and treat certain illnesses; this has raised some concerns with regard to its appropriateness (Pharasi, Price and Goldstein, 1993), as well as fierce and organised resistance on behalf of the medical profession (Van Wyk, 1993; Weiss, 1993; Gordon, 1993; PSSA National Committee, 1994). This resistance emerged primarily on the grounds that "the legislation would have entitled pharmacists to diagnose and treat patients", and that the training would be offered by the SAPC, but that "only the South African Medical and Dental Council (SAMDC) may approve

the training of persons to 'diagnose, treat or prevent any physical or mental defect'" (Van Wyk, 1993:821). The chairman of the federal council of the Medical Association of South Africa (MASA) said that [the proposed change to the law] "is likely to compromise quality health care because pharmacists are not trained to make proper diagnoses, which are essential prior to prescribing appropriate treatment" (Gordon, 1993). The pharmacists' diagnostic skills were questioned by The Dispensing Family Practioners' Association as well, when it declared that it had "grave reservations about granting diagnostic powers to pharmacists" (Weiss, 1993).

According to the SAPC, various presentations were made between 1991 and 1993 to the Medicines Control Council (MCC) with regard to the proposed changes in legislation. In anticipation of legislative changes, the SAPC supported and facilitated, in 1992, an application by rural pharmacists to extend the boundaries of their authority. In this period, certain pharmacists, after careful evaluation by the Council, were issued a Section 22A (12) permit which granted them legal authority to provide certain medicines in schedules 3 and 4 under specific circumstances, based on their own discretion. These permits were issued by the Director General of Health after consultation with the SAPC.

The proposed changes to the Medicines and Related Substances Control Act (101 of 1965), were gazetted on June 1993. However, due to pressure from the medical profession and the political uncertainty in South Africa, a decision was taken to

suspend the changes in legislation. Indeed, all health-related legislation was put on hold in 1993-94 until the commencement of the new government and legislative bodies. In 1994, the SAPC again addressed the MCC, which subsequently approved a final list of medicines for pharmacists. The council also recommended that certain regulations be published with regard to supplementary training. These regulations would make it obligatory for pharmacists to register their successful completion of a course in Primary Care Drug Therapy with the SA Pharmacy Council before exercising their rights in terms of Act 101 of 1965.

The general perception is clearly that changes in regulations will be translated into significant changes in the pharmacist's role (Kohn, 1993). In the meantime, community pharmacists have been preparing themselves, as shown by the call of the president of the Pharmaceutical Society of SA, Gary Kohn, in his presidential address: "Although we await the final regulations of Act 101, the Pharmaceutical Society of SA encourages members to undergo appropriate training to be ready when the new regulations are announced" (Kohn, 1994:189). The Professional Pharmacy Awareness Campaign (PPAC, 1995:256) has suggested changing the layout of pharmacies "by simply converting a semi-private counselling area to a private area", an idea which has been implemented in some pharmacies. By doing this, the pharmacists are altering the physical structure of the practice to facilitate an interaction with their patients which is similar to that of doctors and their patients. This is also likely to change the nature of the pharmacy by transforming pharmacies "from shops into community health

centres" (Strachan, 1993).

In anticipation of the changes to the law, the Link chain of pharmacies has launched various plans to convert its pharmacies into "community orientated primary health care centres and to upgrade the pharmacists to pharmaco-therapists, qualified to diagnose and prescribe medications for a wide range of ailments", introducing "Pharmacy Initiated Therapy (PIT)" (The Citizen 1993). At the same time a campaign launched by Family Circle[3] pharmacies emphasised the benefits of PIP (Pharmacist Initiated Prescriptions) (The Herald Times, 1993).

It seems that the pharmacy council, pharmaceutical societies and academics are united in their views that "the pharmacist can make a meaningful contribution toward making health care in this country more accessible and affordable" (Dreyer, 1994). Most key players propagating the proposed changes stress that "the principle where a pharmacist can assess a patient's medicinal needs and provide or recommend medicines is universally accepted and has existed for years: all that changes is that the list of medicines expands and will now include more effective medicine" (SAPC, 1994:15).

The proposed amendments to the Pharmacy Act and the new Regulations to the Medicines and Related Substances Control Act (101 of 1965) were to be processed in 1995, but this has yet to materialise.

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[3] These two companies represent the big chains of pharmacies in SA.

An additional initiative in this direction is the call of The Pharmaceutical Society of South Africa for new functions for pharmacists to be identified, developed and legalised (Pharasi, 1993). This includes training pharmacists to carry out functions currently performed by nurses at clinics, which will involve the pharmacist administering injections, providing preventive care services and caring for the chronically ill. The suggestions are that these functions will be performed by pharmacists in addition to the nurses in the clinics. This is so as to fully utilise existing health personnel in order to alleviate the crisis in health care[4]. Since 1993, over 2500 pharmacists have undergone special training in family planning and can supply oral contraceptives without a medical prescription, on condition that the recipient sees a medical doctor within six months.

In 1996 the Department of Health announced the National Drug Policy , which was to be implemented in 1996. Although it speaks about the role of the pharmacists and the fact that "they also have a critical role to play in primary health care and preventive health services" (Department of Health, 1996:18), it does not refer to the pending changes in legislation.

[4]For more details on the crisis in the South African health care services see Gilbert et al (1996) and the SA Health Review 1995.

SURVEY OF SECTION 22A (12) PERMIT HOLDERS

Background

The fact that 66 pharmacists have been issued with this special permit, creates the opportunity to examine the nature of their practice and to analyse the issues involved based on their experiences. Most of them operate in out-of-reach places all over the country, and this has dictated the research method used to obtain the necessary information. Despite the advantages of a face-to-face interview (Neuman, 1994:245), it was not feasible within the scope of this study to interview them all personally. A telephonic survey was considered, but the idea was dropped since the SAPC was in possession of a list of names and addresses but no telephone numbers. The assumption was that due to their special status, the pharmacists in possession of this permit would be willing to complete and return questionnaire. It was thus decided to do a mail survey of all of them. Questionnaires, which included a set of closed as well as open questions, were mailed to all pharmacists on the list. The package included an explanatory letter and an addressed, stamped return envelope. Thirty two replies were received after 2 months and only one reminder. Since this represents 49% of the total population, it was considered to be an adequate response in a mail survey of this kind, particularly for the purpose of this study, which aimed only to explore their views and nature of practice in general terms. Huysamen related that "Bassa & Schlebusch (1984) and Bluen & Goodman (1984) report response rates of 37.19% and 36% in local postal

surveys conducted on registered clinical psychologists and personnel practitioners, respectively"(Huysamen, 1994:149). A study published by Adamcik et al (1986), in which the legitimacy of expanding the role of the pharmacist was studied through a survey of nurses, pharmacists and physicians in California, had similar response rates as described by Birenbaum: "In none of the samples was the return rate for the mailed questionnaire above 45 percent, and the response rate for a sample of 200 randomly selected Los Angeles physicians was a mere 31 percent" (Birenbaum, 1990:148).

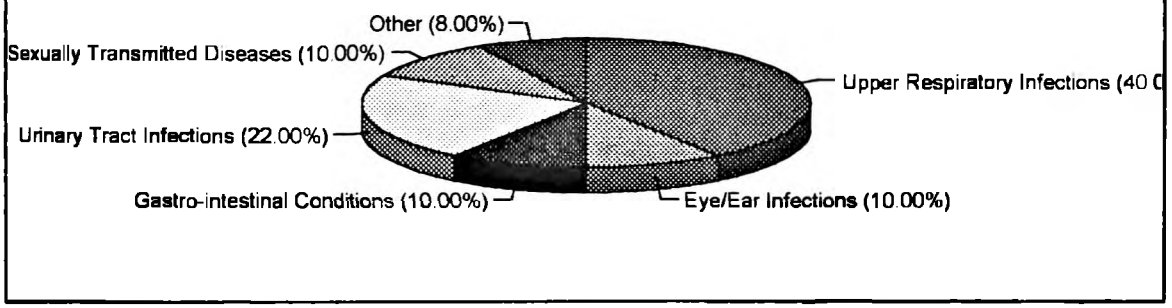
The returned questionnaires were well completed. In some cases additional material was added in the open section, and telephone numbers were provided in case a follow-up was necessary. Based on this, and a comparable survey carried out by the SAPC, a decision was made that there was sufficient data to produce the necessary analysis[5].

Sixty two percent of pharmacies with permits are situated in rural areas, which are generally under-served (Gilbert, 1996). Granting of permits to these pharmacies was thus intended to provide accessible primary care services to the people living in rural areas. All of the pharmacies involved have a private consultation area, making it possible for them to consult and/or examine their patients in a similar manner to other health professionals. Seventy percent of the pharmacies are visited by more than 100 clients a day, which confirms their high level of utilisation. Most of these clients come directly to the pharmacy, without visiting the doctor first. Sixty two percent of the

[5] For a fuller discussion about the limitations of the response rate see chapter on "Methodology".

Figure I

Health Problems Dealt With



Source: Van Niekerk C.M. and Botes M.S., 1995, Primary Care Drug Therapy: The developing role of the prescribing and diagnosing pharmacist in South Africa. Pretoria: The South African Pharmacy Council.

pharmacists reported that more than 40% of their patients did not have a doctor's prescription. Of significance in the SA context is the fact that many (54%) of these pharmacists reported having a high percentage (between 30% - 70%) of Black patients. This is a much higher percentage than that reported by community pharmacists in Johannesburg (Gilbert, 1997a), and might suggest that the permit holders are indeed serving the population in need.

Figure I gives an indication of the range of health problems dealt with by the permit holders. It is clearly evident that they deal primarily with infectious diseases. In 40%, people were treated for upper respiratory infection and 22% for urinary tract infection. The rest were treated for various other, mostly contagious conditions. The 8% of 'other' conditions included tick-bite fever, trachoma, acne and skin and soft tissue infections. In a country like South Africa where the main causes of morbidity and mortality, particularly in the rural, under-served areas, are communicable diseases (Gilbert et al, 1996), this might be a significant contribution towards the provision of

health care services to combat them, when considering that most of the patients treated by the permit holders used the pharmacy as a first port of call.

Basic demographic data about the permit holders was obtained in a pilot survey (Van Niekerk and Botes, 1995). Their mean age is 40.21 years, which raises doubts with regard to the appropriateness of their original training. However, the fact that on average their practical experience was more than 12 years, gives them the benefit of long practical exposure in a pharmacy. Nevertheless, 75% of them indicated that access to higher scheduled medicines should only be permitted to pharmacists who undertake structured, compulsory training, thus emphasising the indisputable link between role extension and undertaking of additional training.

What is a community pharmacist?

What characterises the transitional role of community pharmacy is a multiplicity of components, different dimensions as well as a lack of clarity with regard to its boundaries (Gilbert, 1995b). The dominant perception of what is meant by referring to the role of the 'community pharmacist', is thus of utmost importance in the context of this paper.

To assess the prevailing perception of "what is a community pharmacist?" among this group, they were asked to rank the different components which theoretically make up

the role of a community pharmacist, in order of importance from 1 (most important) to 7 (least important). In table 1, their responses are compared to responses of a random sample of community pharmacists (Gilbert, 1995a) and final-year pharmacy students[6], who were asked to do the same.

[6] The survey of final year students at the University of the Witwatersrand formed part of the larger study. More details are available in Gilbert L., The role of training in transforming community pharmacy in South Africa. (In press Journal of Social and Administrative Pharmacy).

Table 1. Responses to "What is a community pharmacist?"							
Role component	**Percentage distribution of rankings**						
Pharmacists with a permit	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health Care Professional	**88**	8	0	0	0	0	4
Health educator	4	**58**	25	0	13	0	0
Clinician	0	17	**29**	**29**	17	8	0
Manager	0	4	**29**	**29**	17	21	0
Businessman	4	13	13	21	**42**	4	4
Scientist	0	0	4	17	8	**54**	17
Technician	4	0	0	4	4	13	**75**
Community Pharmacists in Johannesburg	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health Care Professional	**74**	19	4	2	2	0	0
Health educator	25	**47**	15	9	2	2	0
Clinician	6	13	**30**	13	15	6	17
Manager	13	8	21	**26**	23	8	1
Businessman	25	11	11	17	**23**	4	9
Scientist	0	0	4	8	4	**38**	46
Technician	0	4	2	9	11	21	**53**
Students	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health Care Professional	**92**	5	3	0	0	0	0
Health educator	3	**66**	21	11	0	0	0
Clinician	0	18	**45**	18	18	0	0
Manager	5	3	11	19	**49**	14	0
Businessman	0	8	13	**40**	24	13	3
Scientist	0	0	5	8	8	**40**	40
Technician	0	0	3	5	3	32	**58**

It seems that the professional perception of the pharmacists with the special permit is less ambiguous than that of community pharmacists in Johannesburg; it in fact has more in common with the students' vision of the professional role. The general perception is that the pharmacist is least of all a technician (75%), and primarily a health professional (88%). What might be of interest is the identical ranking of importance allocated to 'clinician' and 'manager' by this group, signalling perhaps that an independent practice of this nature requires managerial skills as well as clinical ones.

Nature of daily activities

The questionnaire included a list of activities likely to be performed by community pharmacists, and pharmacists were asked to indicate to what extent they engage in these activities. In order to present a summarised and simplified version of the responses, the different activities have been grouped into "Traditional" and "New", and only the percentage of positive responses has been presented. Table 2 presents the responses of pharmacists with a special permit in comparison to those of community pharmacists in Johannesburg.

Table 2. Extent to which pharmacists engage in various activities.

Activities	Percentage of positive responses*	
Traditional activities	**Pharmacists with special permit**	**Community pharmacists**
Dispense according to a doctor's prescription	91.7	96.3
Counsel patients about the prescribed drug	100.0	88.7
Discuss the prescription with the doctor	20.8	11.3
Manage the pharmacy	91.7	83.0
Counsel patients about OTC drugs	95.8	90.5
Sell OTC drugs	87.5	84.9
Advise patients with regard to their personal health	79.2	75.5
Assess the patient's problem and refer to other health professionals	50.0	60.3
Provide drug information to other health professionals	20.8	11.4
Educate consumers (STD's, diet)	70.8	64.1
Attend to emergencies \ casualties	29.2	16.9
Average	**67.0**	**62.1**
New Activities		
Blood Pressure Monitoring	91.7	39.6
Cholesterol Monitoring / Testing	45.8	22.6
Glucose Monitoring / Testing	58.3	20.7
Train home-care patients	8.3	1.9
Monitor drug therapy of chronic patients	58.3	39.7
Prescribe in case of acute illness	91.7	13.2
Order laboratory tests	16.7	1.9
Immunisation	33.3	13.2
Developmental screening	16.7	0
Administer injections	70.8	11.3
Prescribe / Administer contraceptives	58.3	43.4
Participate in health promotion programmes in the community	29.2	18.9
Average	**48.3**	**18.9**

* For this table, the top two responses - " most of the time", and "very often" - were combined.

On the whole, the level of engagement of pharmacists with the special permit is higher in a wider range of activities. However, when all "traditional activities" are combined, their engagement seems similar to that of community pharmacists in Johannesburg. This is not evident when the "new activities" are concerned. On average, 48.3% of the pharmacists with the permit fully engage in the new activities, while only 18.9% do so among the community pharmacists in Johannesburg. The main differences between the two groups are with regard to "prescrib[ing] in case of acute illness" (91% vs 13.2%), which is the main activity that distinguishes between the two groups on legal grounds. Differences were found in other activities as well, particularly those concerned with monitoring of chronic conditions and the provision of basic primary health care (table 2).

What emerges quite clearly from this table is that the daily activities of pharmacists with the special permit differ from those without it. The nature of the activities mostly performed by those with the permit is more clinical on one hand, and more comprehensive on the other, allowing the pharmacists a wider range of activities with greater responsibility. A corollary to this, is that their clientele is able to access a wider range of primary health care services from the pharmacy.

Contact with other health professionals

A similar theme was explored in the survey of a random sample of community

pharmacists in Johannesburg, which drew the conclusion that contact with other health professionals was minimal and its nature unsatisfactory (Gilbert, 1995a). The results of the survey of permit holders, however, reveal a different scenario (table 3).

Table 3. Permit holders contact with other health professionals

Health Professional	Percentage distribution of Frequency of Contact				
	Every Day	Once a week	Once a month	Less than that	None
General Practitioner	58	25	13	4	0
Specialist	13	42	21	25	0
Nurse	42	38	4	17	0
Other	13	17	13	4	54

Fifty eight percent reported having daily, and 25% weekly contacts with the general practitioner. A high percentage also had at least weekly contact with a specialist (54.2%). As far as nurses are concerned, 42% employ one in the pharmacy, thus having daily contact, while the rest have at least weekly contacts. This is also quite different from the general pharmacy with no permit (Gilbert, 1995a). Most of them favour the idea of employment of a nurse (82%), maintaining that "it is a must in a primary health care orientated pharmacy", as articulated by one of the pharmacists with a permit.

It is clear that these contacts with other health professionals are more frequent and meaningful than the ones taking place in a pharmacy without a permit. However, the permit holders indicated that it still is not enough; 73% would have liked to have more contact, primarily because they feel that they don't have enough data about the patients (52%), and that closer contact would facilitate a better flow of information.

Patient information

Although most of the permit holders feel that by taking the patients' history they have sufficient information to proceed with treatment, some feel that it is not enough. It was suggested that patients should carry a card where all information is kept, or that a computerised system would allow them to link to the doctor's data system. All of these suggestions seem impractical in the SA context, and particularly in the rural areas, where most of these pharmacies operate. It seems that the best solution to this problem, as articulated by some of the respondents, is to have a "group practice" or a "health centre", where there is a central source which can provide the patients profiles and thus facilitate real team work. This is confirmed by the permit holders' wish to have more contact with other health professionals.

Mrtek and Catizone (1989) argue that the lack of access to complete patient records is one of the main barriers hindering the implementation of a more meaningful role for the pharmacist in the community. This study seems to support this argument by

highlighting that although pharmacists have access to higher schedules medicines, they still feel that in order to fully utilise their potential as care-givers, they would like to have the same access to patients' profiles as other health professionals such as nurses and doctors.

Future of community pharmacy

As evident in this study, the pharmacists with a special permit were granted an opportunity to practice pharmacy as envisaged for the future. For this reason, it was important to elicit their responses with regard to the nature of their experiences and the suitability of extending this kind of permit to all community pharmacists in SA.

Most of the respondents (71%) felt that all pharmacists should be given the opportunity to practice pharmacy as provided according to their permit. The reasons given were mainly that it facilitates "better and cheaper treatment of minor ailments", is a way to provide "cost-effective primary health care", and for the pharmacist it "increases one's responsibility and makes it more exciting". However, in most cases, a concern with regard to the "training and competence level" were expressed, and qualifications were made that "training is essential before access is granted" or that permits should only be given "if they are trained and competent". Similar apprehensions were evident among the respondents who were against the extension of this kind of practice to all pharmacists.

The way most of the respondents envisage the role of the pharmacist in the future health care system in SA, is expressed as " a member of a health team", as well as "a provider of primary health care" and "pharmaceutical care". The declining role of the "dispensing only" pharmacists, referring to the traditional community pharmacy practice, was mentioned as a component to be addressed in the future scenario. This, "unless changes in legislation take place" and "appropriate education and training is provided".

Major problems mentioned related to the State and its role in regulations and the "intervention and prescription" of medical aid schemes, specifically in relation to cost of medications. Lack of recognition of the pharmacist's ability and competition from "postal services" as well as "dispensing doctors and nurses" were additional issues to arise.

DISCUSSION AND CONCLUSION

Holloway et al maintain that "the social construction of divisions within and between occupations ... has to be seen as a historical process" (Holloway, Jewson and Mason, 1986:331). Following this notion, it is argued that although the legislation and registration of the various professional groups determine their boundaries, they can, in principle, be altered at any time. However, this would involve a fundamental restructuring of the overall medical division of labour and "involve processes

extending beyond the day to day occupational strategies of practitioners" (Holloway, Jewson and Mason, 1986:331).

The attempts at role expansion of community pharmacy in South Africa, as presented in this paper, need to be viewed in both the historical as well as the social context, so that the situation is not seen in isolation, but rather as part of a dynamic process in a society in transition.

The rationale behind the attempts to extend the role of the pharmacist in SA, was to fill in the void in the pharmacists' range of activities in order to better utilise their expertise. Associated with it were, on one hand, the need to alleviate the doctors' load of dealing with minor ailments and, on the other hand, to provide the consumer with access to a wider range of primary health care services currently not available to them (Gilbert, 1996).

This study demonstrates pharmacy's thrust towards an extended and more meaningful role. In its analysis, however, a clear distinction needs to be made between the role extension concerning a wider range of activities and that of granting additional powers to prescribe medications. It seems that the transition towards embracing additional professional tasks within the pharmacy, either by the pharmacist or with the assistance of a nurse, is relatively smooth and is gaining momentum (Gilbert, 1997b), with no serious resistance from the medical profession. An explanation to the lack of conflict

here might be provided by the fact that these tasks have been neglected by the medical profession, and are not considered to be their exclusive domain. This is not the case with regard to the extension of discretionary powers to prescribe. As predicted by Halperin, "the most likely area for physicians to exert their political and professional muscle will be in the newly emerging role of the pharmacist prescriber" (1989:427). This reality was reflected in the editorial of the SA Journal of Pharmacy Practice, which stated that "the long-standing debate between the pharmacy profession and the organised medical profession on the issue of the pharmacist's right to diagnose and prescribe medicines has been intensified by the proposed changes to the general regulations of the Medicines and Related Substances Control Act 101 of 1965, which will allow pharmacists to prescribe specified schedule 3, 4 and 5 medicines, under certain defined conditions. The role of both professions concerning their respective rights to dispense medicines appear to overlap" (1994, 1:4). Note should be made in this context that although doctors have almost exclusive control over prescribing, pharmacists do not have exclusive control over dispensing, as a substantial number of doctors all over the world, and particularly in SA have rights to dispense (Britten, 1994; Gilbert, 1995a).

In the USA and the UK, the extension of the pharmacist's role has been more successful in hospital settings than in the community, mainly because it could be controlled by the medical practice as a form of delegation (Turner, 1987). This, however, cannot take place in separate community practices. Nevertheless, even in the

hospital, "some of the trends alarm organised medicine. Pharmacists are a welcome addition to the clinical team, but the physician has the legal and moral responsibility for managing the patient" (Strickland, 1991:42). This monopoly is strongly kept, and enforced by the doctors' feeling that "if you want to get into clinical management of patients, you ought to go to medical school before you do that" (Strickland, 1991:42).

The threat posed to the medical profession by enabling legislation for pharmacists to prescribe, is further illustrated in some of the protests in Florida and the suggestion to a solution as articulated by the editor of the Journal of the Florida Medical Association: "A rational way to have solved this problem could have involved the creation of a joint committee to find those prescription drugs which could be made nonprescription, so that pharmacists could counsel store customers on their usage, rather than authorising pharmacists to behave like physicians, which they are not ... While physicians are educated and licensed to diagnose, operate, prescribe and dispense, it must be emphasised again that it is not within the education or training of pharmacists to examine patients, and to make diagnoses and prescribe" (Feinstein, 1985:1027).

This study confirms the claims made in the introduction that the opposition from the medical profession is particularly fierce when it comes to the pharmacist's "ability to prescribe". Permitting pharmacists to prescribe, as proposed in the changes to legislation, automatically grants them the ability to diagnose patients, and this right is

at the centre of the battle, as articulated by Mumford (1983).

The authority to prescribe has been granted to non-physicians in the USA, such as special categories of nurses, physician assistants and pharmacists in some states. However, it is granted by physicians in all cases, and requires additional training and some sort of supervision by the medical profession (Meyer, 1994), clearly illustrating the professional dominance of medicine mentioned earlier.

The successful granting of special permits to a selected group of pharmacists to practice an extended role can be explained by the fact that it was restricted to rural, under-served areas and therefore did not threaten the doctors, who in any case tend not to practise there (Gilbert, 1996). This might be similar to the scenario described by Nettleton (1995) when analysing the dual closure strategy with regard to women midwives. Birth-giving is time-consuming and not particularly 'exciting' to medical men, and most women who called upon midwives were poor. There was thus no significant monetary or other gain to be had from attending to them. This was one of the reasons behind midwifery gaining partial autonomy from the medical profession in the UK.

Larkin (1983:7) argues that "legally recognized closure is one of the most powerful forms of exclusion exercised by an occupation, the ultimate legitimizing of a 'task domain'". The proposed legislation (Act 101) is a direct encroachment on the

boundaries between pharmacists and doctors. In this case, the pharmacists are the ones invading the doctors' turf. Following the framework of professional dominance, it is unlikely that the pharmacists will be on the winning side, unless there is intervention from the State. This is one of the routes to counteract the medical hegemony discussed by Larkin (1983). The reality in SA seems to support it, since the new legislation has yet to materialise. In 1994, the president of the Pharmaceutical Society of SA (PSSA) declared in an interview: "The regulations have been written. They have been approved by the Medicines Control council. I believe the introduction of the regulations has been waiting for the new health care structures to be put in place. Now those structures are in place it should be approved within weeks. However, we have been talking 'within weeks' for years" (Abramson, 1994:10). Not much has happened since then, and nobody seems to know what is going to happen, implying a power struggle behind the scenes.

Considering this context, the development of "health centres" in SA might prove to be an alternative venue for the integration of pharmacists into the health care team (Pharasi and Price, 1993). It provides the pharmacists with the necessary access to patients' records, and interaction with other health professionals, thus facilitating the desired role expansion, and allows the doctors overall supervision, which can then be interpreted as delegation rather than boundary encroachment or loss of tasks.

As mentioned earlier, the extended role of the pharmacist is at the centre of the debate

as far as community pharmacy is concerned. Although it is a discourse that the pharmacy profession worldwide is engaged in, it takes on a unique meaning in the South African context. Unlike in other countries where "the advisory role of the pharmacists to physician and patient is stressed; [and] under no circumstances is the pharmacist to adopt the physician's role in diagnosing illness and prescribing treatment" (Eaton and Webb, 1979:77), the SAPC has been saying that "the dispensing of medicine without the prescription of an authorised prescriber forms an integral part of the pharmacist's profession" (Van Niekerk, 1994:4). The Registrar SAPC further reiterated that "it would likewise be incorrect to say that a pharmacist is not entitled to treat a patient on own initiative" (Van Niekerk, 1994:5).

The developments to date signify a partial success on the part of pharmacy towards its role extension. However, one can predict that it will remain limited due to the forces operating against it. Since doctors seem to define their domain as encompassing all areas of health and disease (McGhan, 1989), it is expected that they will continue to resist attempts by pharmacists to encroach on the traditional roles of prescribing and diagnosis.

Following the principles of the "social power" model (McGhan, 1989), it has been recommended that the pharmacy profession continue to increase its control over drug therapy as well as drug knowledge, but remain within its traditional task domain. This might explain the more recent public expressions, which are less militant in their tone,

as demonstrated in the latest speech of the president of the South African Pharmaceutical Society (SAPS), when referring to the expanded role of the pharmacist as "a role ... which enhances clinical skills and is vitally necessary, and one which should not enable him to be a barefoot doctor, but rather allow him to make an educated assessment of when a patient needs to be referred to a doctor. He needs to know what he doesn't know. He needs to know where his sphere of responsibility ends and where someone else's starts" (Ambler, 1996:300). Whether this signals a change of strategy by the pharmacy profession in SA, and an admission of defeat with regard to their chances to change the legislation as proposed, remains to be seen.

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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CHAPTER V

IS THE PHARMACIST THE 'POOR MAN'S DOCTOR'? - A STUDY OF UTILISATION OF COMMUNITY PHARMACIES IN JOHANNESBURG, SOUTH AFRICA

ABSTRACT

"The pharmacist was the 'poor man's doctor' and in the days before the labouring classes qualified for a medical aid system, he was for many the first line of defence in the maintenance of personal and family health". The aim of this paper is to reflect on the above statement and similar perceptions by examining the changing role of pharmacists and the way they are utilised in the South African context. The study consists of a survey of a random sample of 53 community pharmacies in the municipal boundaries of Johannesburg. The data were collected by means of a structured interview with the pharmacist and with the 'users' of the pharmacist's service.

This study provides further evidence that urban community pharmacies are utilised mostly by the White population group. Due to their location, primarily in White residential areas, most of the customers are White females in possession of a doctor's prescription. Thus, with regard to this population, the pharmacist continues to fulfill the limited role of dispenser of medicines. However, a different pattern emerges with regard to the utilisation of community pharmacies by the Black population. As the study reveals, pharmacies in town and inner-city, mostly poorer areas, tend to have a higher proportion of Black clients. Among those, a higher percentage uses the pharmacist as a medical adviser without prior consultation with a doctor. Although the services provided by the pharmacists are not free, they are often cheaper and more accessible than those of medical practitioners.

INTRODUCTION

"The pharmacist was the 'poor man's doctor' and in the days before the labouring classes qualified for a medical aid system, he was for many the first line of defence in the maintenance of personal and family health" [1].

It is the aim of this paper to reflect on the above statement and similar perceptions by examining the changing role of community pharmacists and the way they are utilised in the South African context.

The development of industrialisation, the large-scale manufacturing of medical products, medical specialisation as well as increased medical technology have resulted in a substantial loss of functions to the pharmaceutical profession, creating a void in the pharmacist's professional role. Pharmacists have found themselves acting primarily as dispensers of medicines prescribed by doctors. As a result, the profession has been engaged in a debate about the future direction that it should take [2,3,4], and the chief response to this loss of meaningful functions has been a movement toward 're-professionalisation'[5]. The main component in this process has been an attempt to engage in more clinical or caring roles, and shift the emphasis from the product to the patient [6,7,8].

In South Africa, several reports have suggested that the future of the profession will

be determined by its ability to become re-professionalised and to shift its emphasis to a professional health-care service function, based on its specific expertise [9]. A document of the Department of National Health and Population Development [10] states: "The community pharmacist (private sector) plays an important role in the provision of health services to the essentially first-world component of the population. This role must naturally be entrenched and even extended where indicated. The way in which this role is interpreted must however be continually adapted to meet the changing needs of the population. The community pharmacist's professional activities cannot therefore be limited to the confines of his pharmacy, but must be extended in particular to the community in which he practices. If this principle is acceptable, then the pharmacist's involvement in primary health care, with the focus on third-world component or socio-sub-economic groups of the population, can become a reality". This statement is consistent with the recommendations made earlier by the Commission of Inquiry into Health Services[11], which dealt with "extending the functions of the pharmacist and his role in Primary Health Care".[1]

The most significant characteristic of community pharmacists is their potential accessibility. They are available to the public throughout the working day with no need for appointments, no receptionists or any other barriers for help-seekers. They are therefore readily available to provide advice on health care, and there is clear evidence

[1] A more in depth discussion on this issue can be found in Gilbert L. (1996) Community Pharmacy in South Africa - A Changing Profession in a Society in Transition. Paper presented at the 9th International Social Pharmacy Workshop, Madison, Wisconsin, USA.

that despite some problems, they offer a service that many general practitioners and consumers both value and use [12, 13, 14, 15].

In South Africa, community pharmacies are the main source of medicines for consumers in the private sector[2], and most pharmacists (64%) are employed in community pharmacies. However, they are not accessible to the greater section of the population as they are concentrated in the mainly White centres of the metropolitan areas[16].

As is widely known, South African society is characterised by its gross inequalities, which manifest themselves primarily along racial lines. Due to the Population Registration Act of 1950, all South Africans were classified into a population group at birth, and assigned a status as White, Indian, Coloured or Black (African)[3]. A person's social reality was thus determined in relation to their membership of a certain group. More specifically, it dictated where people could live, which schools they could attend, what jobs were available to them as well as what kind of facilities they could use, and with whom they could be sexually involved. Although this act was repealed in 1991, its social effects will remain present for a long time to come and for this reason, statistics in this paper will be presented according to population groups or race

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[2]For further details see Simpson D., Pharmacy in South Africa. The Pharmaceutical Journal, 1994, 253:685-692 and Van der Merwe P.R., Pharmacy in South Africa, International Pharmacy Journal. 1994. 8:79-81.

[3]For this reason reference to the different 'population groups' is made in Capital letters.

where appropriate [4].

Health care delivery in South Africa, until the recent process of democratisation and universal franchise, was characterised by a two-tier system: on the one hand, private health care funded by medical schemes, which covered up to 20% of the country's population, the vast majority of whom were from the White section of the population; and on the other, a public sector which was characterised by fragmentation (no less than 14 national health authorities). This situation resulted in irrational use of resources, poor working conditions as well as inadequate infrastructure. As it has been argued, "the pharmaceutical sector, as a component of the health sector, reflected its deficiencies, most notably the lack of equity in access to essential drugs, with a consequent impact on quality of care" [17].

The quote presented at the beginning of this article[1] is based on historical evidence from the time that it was written. In 1982, it was estimated that in South Africa 86% of the White and 4% of the Black population group enjoyed medical aid facilities. The latest available figures are that approximately 17% of the total population is covered by a medical scheme[18] . Since the White population comprises 12.8% of the total population and most of it is covered by medical schemes, it is reasonable to deduce

[4]A fuller discussion on this issue can be found in Chikte U.M.E., Gilbert L., Brand A.A and Lewis H. Racial Classification in Dental literature - Is it Always Necessary? *Journal of the Dental Association of South Africa* **44**, 337-463, 1989.

that the 17% covered includes a small percentage of the Black population[5].

Of relevance to this paper is the **urbanisation process** taking place in South Africa. By 1985, about 57% of South Africa's population was urbanised, mainly in the major metropolitan areas. The population of the cities is predicted to double by the year 2010, creating an enormous challenge for planners of health, housing and other social services. Most of the people coming to the cities are Blacks[6] seeking greater opportunities, but mostly ending up living in poverty[18, 19].

The general scenario in this context is that on the one hand, there are large numbers of people with limited access to inefficient public health care services, who according to available data[18] suffer from high rates of mortality and morbidity. On the other hand, there are professionals (pharmacists) who are willing to expand their professional activities and thus fill in the gaps created by the inability of the state to provide adequate health services. Although the services provided by the pharmacists are not free, they are often cheaper, and more accessible than those of medical doctors[8,20].

This is the background against which the utilisation patterns of pharmacists by the population in Johannesburg will be examined.

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[5]Due to the poor state of national statistical data, this information was not available.

[6]The percentage of urbanised Black people is expected to increase from 35.8% in 1993 to 75% in 2000, according to the South African Health Review 1995, p.28 (18).

METHODOLOGY

This study consists of a survey of a random sample of 53 community pharmacies in the municipal boundaries of Johannesburg[7]. The data[8] were collected by means of:

(I) structured interview with the pharmacists, based on a questionnaire.

(ii) structured interview with the user of the pharmacist's service, based on a questionnaire.

RESULTS & DISCUSSION

Interviews with pharmacists

In order to provide information on the general characteristics of the pharmacies visited, an attempt has been made to distinguish between the different pharmacies according to the type of pharmacy and the area they serve.

Most of the pharmacies visited were in residential, middle- class areas. This reflects the national statistics with regard to the distribution of community pharmacies[16]. It seems that all pharmacies serve a large number of people daily. Only 28.9% see fewer than 50 patients a day, while the rest see more. This confirms findings cited in the

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[7] At the time the study was conducted.

[8] Note should be taken that this paper deals only with one section of the study as related to the issues concerned

literature that the pharmacist is in direct contact with substantial numbers of the population.

All prescription medicines in South Africa are classified into schedules by the Medicines Control Council. The pharmacist can administer only Schedule 1-2 drugs, while for the higher schedules they require a doctor's prescription. Although the proposed regulations are to change some of these restrictions, the current reality is that in order to obtain medicines in the higher schedules, a patient needs to see a doctor first and only then come to the pharmacist with the prescription. In light of the issues raised earlier, it was therefore of importance to investigate to what extent this process is bypassed and the pharmacist approached directly. Tables 1 and 2 give some indication in this regard.

Table 1. Distribution of Customers Without a Doctor's Prescription

% of customers without prescription	Frequency	Percent
Less than 20%	8	15.1
20% - 40%	20	37.7
40% - 60%	13	24.6
60% - 80%	8	15.1
More than 80%	4	7.5

Table 2. Distribution of Patients Coming for Advice Only

% of patients coming for advice only	Frequency	Percent
Less than 20%	12	22.6
20% - 40%	18	34.0
40% - 60%	12	22.6
60% - 80%	7	13.2
More than 80%	4	7.6

It is apparent from the above tables that a substantial number of patients seek advice from the pharmacist without being in possession of a doctor's prescription. However, if one examines the type of pharmacies in relation to the above, it becomes more evident that the pharmacies in town (the Central Business District) are used mainly by customers who come without a doctor's prescription to ask for advice.

Of the 11 pharmacists interviewed in town (CBD), six reported that 60%-80% or more of their customers came without prescriptions to seek advice. Correspondingly, pharmacists in the CBD and inner city reported lower percentages of customers coming with doctors' prescriptions than those in residential areas.

Although the sample of CBD pharmacies is small, the data clearly identifies a pattern of utilisation of the pharmacists. Since most of the pharmacies in Johannesburg and,

for that matter, in the rest of the country are situated in the CBD or in affluent, mostly White, residential areas, they are likely to be used mostly by residents who are on medical aid and in possession of a doctor's prescription[16]. Taking the SA background into consideration, it would be reasonable to surmise that the pharmacies in the CBD are the only source that can be used by people working in or passing through the CBD, in the absence of pharmacies in their area of residence. This means that these pharmacies are used mostly by Black people to seek advice without having to go to a doctor first. The result is that the pharmacist serves as medical adviser mostly for people who do not have access to organised medical care, which in the South African reality is mostly Black people. It is obvious that this hypothesis requires further in-depth examination, which is beyond the scope of this study. Nevertheless, further evidence to support the above is provided throughout the study.

Each pharmacist was asked to describe the profile of his/her customers according to a number of dimensions, including race and gender. Fifty three percent of the pharmacists reported that more than 60% of their clientele is White, while 71.7% reported that less than 40% of their customers are Black. Although these numbers are based on the pharmacists' estimates, they indicate that most of the pharmacies are used mainly by White people, thus confirming the inaccessibility of pharmacies to most of the Black population, mainly due to their geographical maldistribution[16].

The South African social reality is reflected more clearly in the utilisation patterns of

the pharmacies. Pharmacies in high-class, affluent areas report serving mostly White patients: 7 out of 17 serve between 60% - 80% and 6 more than 80%, while in the poor areas, the percentage of reported Black customers is higher.

An analysis of the type of pharmacy in relation to the **population group/race** of its customers reveals that the residential pharmacies serve mostly White customers, while the pharmacies in town serve mostly Black customers. Five out of 11 in town mentioned that 40%-60% of their customers were Black; three, 60%-80%; and one said that more than 80% were Black. This confirms the above mentioned point that the pharmacists in the CBD are used mainly by Black people with no access to organised health care, thus acting as a substitute for a doctor. An additional aspect of this phenomenon is the fact that the pharmacists, who are mostly White, are often referred to by the Black customers as "doctors".[9]

According to the reported **gender** distribution of clients, it seems that more women than men use pharmacies, thus verifying the general pattern reported in international as well as South African literature. The latest study in South Africa reveals that among all population groups, the "household member responsible for health" was a female, 87% for White and 93% for African[121].

The pharmacists were asked to indicate the most common **health problems** presented

[9] This is based on observations made in the pharmacies visited.

to them by ranking them from 1 (the most common) to 7 (the least common). Table 3 gives a summary of their replies.

Table 3. Distribution of the Most Common Health Problems Presented to the Pharmacist*

Health Problems	Percentage mentioned as most common
Colds and Flu	84.9
Allergies	41.5
Gastric Problems	37.8
General aches & pains	32
Minor injuries	18.8
Gynaecological/ contraceptives	1.9
STDs/AIDS	0
Diet-related problems	0

* For the purpose of simplification, the percentages refer to a combination of the first three rankings.

The table indicates that colds and flu are the most common health problems that pharmacists are presented with. It is significant to mention that the vast amount of medication available for the treatment of colds and flu lies within the range of the pharmacist's legal authority to offer without prescription (schedules 1 -2). One can

therefore assume that the pharmacist's expertise is sought in this regard. The second and the third most common health problems are gastric and those related to allergies and general aches and pains respectively, where the above applies as well.

At first glance it might seem strange that STD's and AIDS do not feature as major health problems dealt with by pharmacists. However, given the lack of privacy in most pharmacies, and the fact that STD and AIDS clinics are more freely available, it would be reasonable to speculate that customers who suffer from the above, tend to avoid the pharmacist in these matters. However, this issue requires further investigation.

All the pharmacists interviewed said that, when necessary, they referred patients to other health professionals. A detailed account of the **referral patterns** shows that most of the patients were not referred to other health professionals. However, it seems that most of the referrals that took place, were to a general practitioner or hospital.

Interviews with 'users' of pharmacies

One of the aims of this study was to establish who used the services provided by the pharmacists, and for what reason. For this purpose a short, structured interview was conducted with at least five users (customers/ clients or patients) in each of the pharmacies visited. A total of 283 interviews were completed.

The analysis of the interview with pharmacists revealed that a substantial number of people went to pharmacies without a doctor's prescription, particularly in the CBD. It was, therefore, interesting to see whether the interviews with the user population supported the above findings. The main issue, as alluded to earlier, focuses on the use of the pharmacist as a first port of call, thus a set of questions probed the pattern of utilisation of the pharmacy in this regard. What can be said based on the data is that although 43.1% went to the pharmacist with a doctor's prescription, an even greater proportion went without one to seek advice (14.1%) or to buy Over The Counter (OTC) medication (36.7%). This supports the previous evidence in this regard.

This information, when presented in cross tabulation with the 'type of pharmacy' (table 4), and 'area of pharmacy' (table 5), reveals that all pharmacies are used for all purposes.

Table 4. Type of pharmacy by purpose of visit.

	Buy medicine with script	Buy medicine without script	Ask for advice	Buy cosmetics
Town / City	34%	38.3%	14.9%	21.3%
Innercity	36.5%	40%	23.5%	10.6%
Residential - suburbs	46.2%	36.1%	9.2%	11.8%
Shopping centre	62.5%	28.1%	6.3%	3.1%

Table 5. Area of Pharmacy by Purpose of visit

	Buy medicine with script	Buy medicine without script	Ask for advice	Buy cosmetics
High class / affluent	30.8%	34.6%	11.5%	30.8%
Middle class	48.9%	36.2%	13.2%	8.6%
Poor area	34.9%	38.%	16.9%	13.3%

In pharmacies in town and inner-city, the percentage of people coming without a doctor's prescription is higher than in the suburbs and shopping centres. More customers come to ask the pharmacist for advice in town and the inner-city. The pharmacies in town also seem to be a source for buying cosmetics, more than pharmacies in residential areas.

In light of the issues discussed earlier, it is of interest to examine the differences between utilisation patterns of White and Black people.

Table 6. Population Group/Race* of Client by purpose of visit

	Buy medicine with script	Buy medicine without script	Ask for advice	Buy cosmetics
White	50.3%	29.9%	10.7%	13.6%
Black	27.8%	53.2%	17.7%	10.1%

*Other population groups were omitted due to their small number in the sample.

Table 6 clearly indicates that while most of the White customers use the pharmacy to get medication based on a doctor's prescription, a higher percentage of Black people go to the pharmacist to buy medication without visiting a doctor first. This would thus provide further evidence to support the earlier claims that the pharmacist is used as a medical adviser mainly by the Black or poor population. In contrast, in the case of the White population, where most people are covered by medical schemes, the pharmacist acts primarily as a dispenser of medicines as prescribed by the doctor.

With regard to the most common **health problem** dealt with by the pharmacists, a similar scenario emerged, in which colds and flu, various allergies, general aches and pains and gastric problems were the dominant reasons people went to their pharmacists for help. As indicated in studies in other countries[22], these conditions lend themselves to the bypassing of a consultation with the doctor in favour of a visit to the pharmacist.

To establish the reasons for the utilisation of the pharmacists the following question was put to the user: "Why did you decide to come to the pharmacist?" It seems that convenience (17.5%) and proximity to where people lived (15.4%) were important factors in people's decision to use the pharmacy instead of other medical services. Additional factors were that people work (8.9%) or shop (3.7%) in the area as well as proximity to doctors' rooms (7.3%). On the whole, all these factors can be categorised as related to the convenience of using the pharmacy due to its easy access.

These results echo those of previous studies conducted in Britain [23, 24], the USA [25, 26], Nigeria[27] and elsewhere [28].

The **main characteristics of the user population** according to the two population groups represented in the study, namely Whites and Blacks are summarised in Table 7. A general profile of the clientele utilising the pharmacy is outlined.

Table 7. Characteristics of users by population group/race

	On Medical Aid	Has a family doctor	Live in area of pharmacy	Work in area	Shop in area
White	75.1%	84.7%	66.7%	22.6%	15.8%
Black	39.7%	54.4%	34.2%	41.8%	22.8%

Seventy five percent of the White customers in this study are on medical aid, which corresponds with the percentage of Whites in the general population who belong to medical schemes. However, the 39.7% of the Black customers who are on medical aid is higher than the percentage of Blacks who belong to medical schemes in the general population. This might be due to the fact that 41.8% of Blacks work in the area and thus most of them are on medical aid. This is further supported by the higher than expected percentage of Blacks who have a family doctor (54%). These findings indicate that the Black sample in this study is not representative of the total Black population in South Africa. Based on this, one can speculate that those among the Blacks who use the community pharmacies in Johannesburg constitute a selected group

of the population who, relative to the rest of the Black population, enjoys greater resources. Therefore, it seems that the poor and unemployed are two further groups that need to be further investigated in this context. A rough conjecture would be that they are the ones for whom the existing pharmacies and pharmaceutical services are out of reach. According to the latest Reconstruction and Development Programme (RDP) report[19],"nearly all poor are African", which in this context means that the majority of those who do not benefit from pharmacists' services are Black.

Due to the fact that most pharmacies are in White areas, the percentage of White customers living near pharmacies is higher. A combination of the percentage of Black clientele working (41.8%) or shopping (22.8%) in the area provides us with additional support for the point raised earlier that most pharmacies in the town and inner-city are the main source of medical supplies for the Black population since they are conveniently situated near places of work.

Females seem to comprise a higher proportion of the general user population (67.4%) with most of them (113 out of 155) living in the area of the pharmacy. This is due to the fact that most pharmacies are in residential areas where women still tend to do the shopping and take care of their families' health needs. However, a separate examination of the White and Black group shows some differences. Among the White customers, 71.8% are females where as among the Blacks the percentage is only 55.4%. This might be related to the higher percentage of Black male customers who

work in the area of the pharmacy.

To complete the users profile, Table 8 presents the clientele according to population groups or race.

Table 8. Population Group/Race of Client

	Frequency	Percentage
White	177	63.4
Indian	10	3.6
Coloured	13	4.7
Black	79	28.3

This information is consistent with that obtained from the interviews with the pharmacists. Most of the customers/clients are White, probably because of the location of the pharmacy as previously discussed. Note should be taken of the fact that the Whites constitute only 12.82% of the total population, while Blacks make up 76.09%. Due to the above, future research should address whether, and to what extent, people who don't have pharmacies where they live (mostly Blacks) use the services provided by the pharmacist elsewhere.

It appears that although most pharmacists said that they referred users to other health professionals, this did not happen in reality. Out of 283 clients, only 11 (3.9%) said they had ever been referred. This has been raised as a concern by other researchers and

is one of the issues often argued by doctors in opposing the role expansion of the pharmacist[10].

An important point is that 96.4% of customers interviewed were satisfied with the service provided. This is congruous with the findings of other studies, where there was satisfaction with the service provided by the pharmacist.

CONCLUSION

As stated in the introduction, the Department of National Health and Population Development in 1990 was aware of the fact that the community pharmacist plays an important role in the provision of health services to the essentially first-world component of the population[10]. This study reinforces the fact that community pharmacies are utilised mostly by the White population group. Due to their location, mainly in White residential areas, most of their customers are White females in possession of a doctor's prescription. Thus, with regard to this population, the pharmacist continues to fulfill the limited role of dispenser of medicines.

However, a clear pattern emerges with regard to the utilisation of community pharmacies by the Black population. As the study reveals, pharmacies in town and *inner-city, mostly poorer areas, tend to have a higher proportion of Black clients.*

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[10]*For more information see: Gilbert L. (1997) Dispensing doctors and prescribing pharmacists - A South African Perspective. Social Science & Medicine. (In Press)*

Among those, a higher percentage uses the pharmacist as a medical adviser without a prior consultation with the medical practitioner.

The general scenario, where large numbers of people have limited access to inefficient public health care services on the one hand, and the availability of pharmacists who are willing to fill in the gaps created by the inability of the state to provide adequate health services on the other hand, is responsible for the reality as exposed in this study. Although the services provided by the pharmacists are not free, they are often cheaper and more accessible than those of doctors. This is true in particular for people without medical aid cover: mostly Blacks, as shown earlier.

This study provides further evidence as to the inequity of access to pharmaceutical services[16, 17] through its implication that the very poor people are not represented among the users of community pharmacies. A reflection on the quote that the pharmacist is considered to be the poor man's doctor in this context acquires an added significance with regard to the current situation in South Africa. Based on evidence from this study, pharmacists do not reach most of the 'poor men'; however, for the better off among the poor men, pharmacists manage to fulfil a more extensive role as medical advisers. Considering this reality in the South African context, it would be more accurate to speculate that the pharmacist is the working Black man's doctor.

Pharmacists are consulted mostly on common health problems, primarily because of

convenient access. However, due to the general inaccessibility of pharmacies to the majority of the population[116] in South Africa, this necessitates a specific stipulation: only in places where community pharmacies are available, and only for those who can afford their services, do they seem to provide a convenient first port of call for people seeking medical advice or acquisition of medication after consultation with a doctor.

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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CHAPTER VI

THE ROLE OF TRAINING IN TRANSFORMING COMMUNITY PHARMACY- A CASE STUDY OF PHARMACISTS AND STUDENTS IN JOHANNESBURG, SOUTH AFRICA

ABSTRACT

Pharmacy in South Africa is in the midst of transformation which, to be successful, needs to be accompanied by the relevant training. The aim of this paper is to focus on the new vision of the profession as presented by the South African Pharmaceutical societies and the South African Pharmacy Council, as well as to examine how training is perceived by faculty, students and pharmacists as equipping them appropriately to engage in the range of activities required of them in terms of this new professional vision. A combination of qualitative and quantitative methods was employed to gather the information. There is full agreement that the community pharmacist is first of all a "health care professional", with students articulating it most strongly (92%), faculty (86%) and community pharmacists (68%) following. More respondents in all groups felt that their training was adequate where the 'traditional' activities were concerned and less felt so when considering the 'new' activities. The official professional vision lies in the direction of a complete paradigm shift towards an 'extended' role for the pharmacist. However, the real challenge is to translate the vision into reality by effecting simultaneous multidimensional changes concentrating on the profession, training and education in a wider societal context.

INTRODUCTION

There is an abundance of literature dealing with pharmacy as a 'profession in transition' [1,2]. Associated with this transitional status are an uncertainty and an ongoing debate with regard to its desired professional roles and public image [3,4,5,6]. This lack of clarity is present not only among the pharmacists themselves, but also among members of other health professions, as well as the public [7,8,9].

A major feature of the debates about the future of pharmacy is the consensus that changes in professional roles depend on, among other things, appropriate training of newcomers to the profession [10,11]. Through the process of professional socialisation, students learn about the professional role of the pharmacist, and develop their perspective of a professional identity based on that role as well as the ideologies which underpin the profession [12]. However, this task is made much more difficult since appropriate training is meant to fit in with clearly defined aspired outcomes, which are lacking in pharmacy due to its transitionary and continuously changing nature [2, 3,13,14].

Although education is seen as a vital resource in preparing the pharmacists for their 'new' role, Kronus maintains that "a perennial issue concerns the fate of occupational identities after the socialisation process is over". For this reason, it is imperative to pose the question, "how are these values affected by the pressures of the work

setting?" [13:304]. Cognisance needs to be taken of the fact that a "gap between the theory and science of the discipline and the novel activities and roles of a vocal and well-organised sector of its practising graduates has been increasingly acknowledged within the schools of pharmacy" [15:75]. Similar sentiments have been echoed in other studies [16, 17]. What seems to emerge is the difficulty in matching the training process with a blurred and changing professional role. In the USA, 73 percent of the pharmacists thought that pharmacy schools prepared them well for their professional activities [18], while only 12 percent felt that this was the case in Israel [19].

Zellmer states that "Flexner believed that the way to change the practice of medicine was to change medical education, and I believe that pharmacy practice can be changed by the same method" [20:108]. Hepler extends this notion by emphasising the need to concentrate on recruitment, reeducation and resocialization, stating that "the basic definition of pharmacy and its definition of general practice will influence who is recruited to pharmacy" [21:413], and further adding that "pharmacy may not be able to recruit enough students motivated towards patient care until it changes its professional standing with the public, but it may be unable to change its professional standing until it agrees on its social object" [21:415]. Pendergast et al maintain that "in a profession in as much flux as pharmacy, the variability in how pharmacists conceptualize their role is potentially great as is the range of role behaviours exhibited by members of the profession" [22:558]. Based on a study which examined predicted versus observed changes in pharmacy practice, Norwood argues that "there is little

reluctance for pharmacists to assume new roles if suitable mechanisms and rewards are provided"; however, "simply expounding on roles which pharmacists should be acquiring without providing for mechanisms and rewards will establish little" [3:661]. He comes to the conclusion that "training a pharmacist to assume roles without first determining which roles are truly wanted and needed by the consumer is analogous to manufacturing a product without first determining if there is a market for it" [3:661]. And thus he claims that "although futurists have elaborated on possible roles, the indications are that this has not resulted in any notable changes in the pharmacist's function" [3:662].

The complexity outlined above is further exacerbated in the South African situation, where professional transformation takes place against the background of a society in transition, as well as changing philosophies and structures of health care delivery towards an increased emphasis on primary health care [23,24]. However, there are no studies which examine these issues in the South African context, a gap which is addressed in this paper.

Following the main arguments in the literature, the perceptions of the 'newcomers' to the profession will, to a large extent, influence the changes envisaged. It is for this reason that it is important to concentrate on the 'latest product' of the socialisation process - final year students - and their vision of the profession.

In order to give the reader a broader understanding of the role of training in transforming community pharmacy, this paper will focus on the new vision of the profession as presented by the South African Pharmaceutical societies and the South African Pharmacy Council. It will also examine how training is perceived by faculty, students and pharmacists as equipping them appropriately to engage in the range of activities required of them in terms of this new professional vision.

METHODS

To gain a better insight into this complex question, a combination of qualitative and quantitative methods was employed, which included the following[1]:

*Documentary search and content analysis of official documentation and publications. These included Governmental reports such as commissions of inquiry, policy outlines as well as documents produced by the South African Pharmaceutical Society and the South African Pharmacy Council. These included minutes of meetings and reports of various working groups.

*Survey of a random sample of 53 community pharmacists in Johannesburg[2].

*Survey of faculty members engaged in teaching pharmacy practice in seven training

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[1]Note should be taken that the data used for this paper were part of a larger study, examining the role of community pharmacy in South Africa.

[2]For more details see: Gilbert L., 1995. The pharmacist's traditional and new roles - A study of community pharmacists in Johannesburg, South Africa. Journal of Social and Administrative Pharmacy 12, 125-131.

institutions in South Africa[3].

*Survey of final year pharmacy students at the University of the Witwatersrand, Johannesburg. Interviews with 38 final year pharmacy students were completed, which represents 76 percent of all students in this year[4].

All the interviews were based on a structured questionnaire which included closed questions which were analysed quantitatively and presented in tables [5], as well as open questions which were subjected to a qualitative analysis. The length of the questionnaire varied from 107 questions in the case of the pharmacists and faculty to 67 questions in the case of the students. The questions dealt with the role of the community pharmacist, the appropriateness of training as well as the future vision.

The following sections are based on information derived from all the above sources.

THE OFFICIAL VISION

The deliberations with regard to the role of community pharmacy are not new in South Africa [25, 26]. Evidence available before the Commission of Inquiry into Health Services (The Brown committee) [26] showed that the pharmacist was of the opinion

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[3]One member in each institution who was responsible for the teaching of "Pharmacy Practice" completed the questionnaire at a meeting to coordinate the teaching in this subject.

[4]Although the intention was to interview all of them, it became impossible to get hold of the outstanding ones.

[5]The quantitative data were analysed using SPSS- Statistical package for Social Sciences.

that he or she could render, and would like to render, extended professional services[6]. However, the appropriateness of the pharmacist's training to provide an 'extended' service has been questioned in this regard. The committee [26:122] suggested that for the pharmacist to fulfil a role in primary health care, he or she "has to be correctly trained". Appropriate changes in training were suggested by Summers [27] as well.

An examination of the latest official publications emerging from the pharmaceutical societies as well as from the South African Pharmacy Council reveals a vision of an "ideal" situation [28] , which is "different, new and better" [29]. According to this vision, community pharmacists should extend their professional role and engage in a wide range of new activities (table IV) as members of the primary health care team [30]. Adopting and implementing the concept of "pharmaceutical care", as developed by Strand and Hepler [31], has been mentioned in this context as well [32]. Attached to it is the acknowledgment that "additional training is needed" [29], and that "pharmacy education could be altered" [32].

Based on the documentation reviewed, there is no doubt that pharmacy in South Africa is perceived to be in the midst of transformation [33]. Its survival as a valuable health profession depends on its ability to adjust to the new circumstances[7], and in particular

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[6]The report did not define the nature of extended services.

[7]The new circumstances include a changed political dispensation with a different philosophy and structure of health care. More about this topic can be found in: Gilbert L. (1997) Community Pharmacy in South Africa - A Changing Profession in a Society in Transition. Health & Place (In Press).

its ability to adapt to changing health needs as well as to the associated modifications in training [34]. Theoretically, this can be successfully achieved if the nature of the desired transformation is clearly defined and there is a good fit or congruence between the professional vision, the occupational reality of its practitioners and the professional socialisation process of new members. However, each one of the above components presents a set of unresolved issues, lack of clarity and great uncertainty which are mutually entwined. For this reason it is important to examine each one of these components.

The official professional vision refers to the "ideal" situation, but its propagators, represented by the South African Pharmacy Council, admit that "it establishes a 'stretch' *[sic]* between what exists now and the realisation of what can be" [35]. Gilbert, in an earlier paper, argues that the occupational reality of community pharmacists is such that most of their daily activities are within the boundaries of the 'traditional role', and their willingness to adopt a 'new' professional role has not been translated into a reality [36].

THE ROLE OF THE COMMUNITY PHARMACIST

As mentioned earlier, what characterises the changing role of community pharmacy is a multiplicity of components and dimensions, and a lack of clarity with regard to their boundaries. The dominant perception of what is meant by referring to the role of

the 'community pharmacist', is thus of utmost importance in the context of this paper; this component was therefore included in the interviews conducted with the various relevant groups surveyed. To assess the prevailing perception of "what is a community pharmacist?", the interviewees were asked to rank the different components which theoretically make up the role of a community pharmacist, in order of importance from 1 (most important) to 7 (least important). The responses of the community pharmacists, faculty members and final year students are presented in table I.

Table I. Responses to "What is a community pharmacist?"							
Role component	**Percentage distribution of rankings**						
Community Pharmacists	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health Care Professional	**68**	22	2	2	2	2	0
Health educator	15	**51**	20	7	5	2	0
Clinician	5	10	**37**	17	17	10	5
Manager	2	0	24	**34**	27	12	0
Businessman	10	15	12	20	**32**	5	7
Scientist	0	0	0	10	5	**44**	42
Technician	0	2	5	10	12	24	**46**
Faculty	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health Care Professional	**86**	14	0	0	0	0	0
Health educator	14	**43**	14	14	0	14	0
Clinician	0	29	29	**43**	0	0	0
Manager	0	14	14	0	**57**	14	0
Businessman	0	0	29	**43**	29	0	0
Scientist	0	0	14	0	14	**57**	14
Technician	0	0	0	0	0	14	**86**
Students	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health Care Professional	**92**	5	3	0	0	0	0
Health educator	3	**66**	21	11	0	0	0
Clinician	0	18	**45**	18	18	0	0
Manager	5	3	11	19	**49**	14	0
Businessman	0	8	13	**40**	24	13	3
Scientist	0	0	5	8	8	**40**	40
Technician	0	0	3	5	3	32	**58**

The results presented in this table demonstrate that there is full agreement that the community pharmacist is first of all a "health care professional", with the students articulating it most strongly (92%), and the faculty (86%) and community pharmacists

(68%) following. Although "health educator" was ranked mostly second by all groups, the degree of agreement varied: a higher percentage of students (66%) than faculty or community pharmacists, ranked it as second in importance. The consistency between them is maintained with regard to the components of "technician" and "scientist" which were ranked last and second last respectively. However, these were singled out more clearly by the faculty. Of interest to the main issue in this paper is that there was lack of consistency with regard to the components of "clinician", "manager" and "businessman", which once again highlights the lack of a distinct definition among the various sections within the profession. This is further illustrated when a comparison is made of the total responses of the three groups. While the faculty's and students' responses point to a somewhat clearer vision of the importance of the different components, the practising community pharmacists' responses reveal a perception where the importance of the different components is less clear, reflecting their ambiguous "professional reality".

APPROPRIATENESS OF TRAINING

One of the objectives of the study was to assess to what extent pharmacists felt that the training they had received prepared them to fulfil the various components of their professional role.

In response to a question probing the appropriateness of their training to fulfil their

current role, 79 percent of practising community pharmacists answered negatively. It is thus clear that the majority felt that their training was not appropriate to what they did as pharmacists. Eighty one percent said they had "learned a lot of things they did not need to perform their professional role", while 94 percent mentioned there were areas missing in their training. An examination of the possible differences among the practitioners in relation to years since graduation, although not statistically significant mainly due to the small sample size in each year (Table II), indicates a trend. It can be said, based mainly on table III, that the perception of training as inappropriate is more frequent among the older graduates.

Table II. Perception of appropriateness of training by year of graduation.

Was your training most appropriate to what you do as a pharmacist?

Year of Qualification	% Yes	% No	Sample Size
1941-1950	0	100	4
1951-1960	20	80	10
1961-1970	29	71	7
1971-1980	10	90	10
1981-1990	24	76	17
1991-	40	60	5
Total	**20.8**	**79.2**	**53**

Table III. Perception of appropriateness of training by year of graduation.

Year of Qualification	Yes	No
Before 1989	16.3%	83.7%
1989-	40%	60%
Total %	20.8	79.2

This table has a p-value of 0.1179 (using a one-sided Fisher's exact test).

The responses to the same set of questions among final year students revealed a more positive perception with regard to the appropriateness of their training, compared to that of the practising community pharmacists. Only 18 percent felt that their training, considered against the anticipated work as a community pharmacist, has been inappropriate. However, there was a feeling among 55 percent that they have "learned a lot of things which they will not need to perform their professional role", which was often justified in the name of "a need in professional education". In addition, 68 percent of the students mentioned that there were areas missing in their training, identifying financial, management, communication and therapeutic skills in this category. A more detailed account of where the inappropriateness lay and where the missing gaps in training could be identified, is provided by Table IV.

Table IV. Perceptions with regard to adequacy of training for the various activities.

Activity	Percentage of positive responses*		
Traditional activities	**Pharmacists**	**Faculty**	**Students**
Dispense according to a doctor's prescription	96	100	86
Counsel patients about the prescribed drug	85	100	89
Discuss the prescription with the doctor	90	86	65
Manage the pharmacy	35	71	30
Counsel patients about OTC drugs	73	100	84
Sell OTC drugs	79	100	89
Advise patients with regard to their personal health	63	100	89
Assess the patient's problem and refer to other health professionals	71	43	64
Provide drug information to other health professionals	85	100	73
Educate consumers (STD's, diet)	71	100	87
Attend to emergencies \ casualties	54	14	87
Average	**73**	**83**	**77**
New Activities	**Pharmacists**	**Faculty**	**Students**
Blood Pressure Monitoring	54	100	97
Cholesterol Monitoring / Testing	42	100	97
Glucose Monitoring / Testing	37	100	100
Train home-care patients	8	29	39
Monitor drug therapy of chronic patients	40	71	73
Prescribe in case of acute illness	39	29	51
Order laboratory tests	11	14	19
Immunisation	17	29	32
Developmental screening	6	71	14
Administer injections	22	0	27
Prescribe / Administer contraceptives	54	86	92
Participate in health promotion programmes in the community	40	86	92
Average	**31**	**60**	**61**

* For this table, the top two responses - "yes, most adequately", and "yes, adequately" - were combined

All three groups were asked to indicate whether they felt that they were "adequately

trained to carry out the various activities". Table IV is a summary of their responses, in which, for the purpose of analysis, the activities have been grouped into 'traditional' and 'new' activities[8].

What emerges quite clearly is that, on the whole, more respondents in all groups felt that their training was adequate where the 'traditional' activities were concerned, while less felt so when considering the 'new' activities. However, it stands out that the practising pharmacists find themselves in a position where their training is not perceived to be adequate to carry out the activities regarded as 'new' in their changing professional role. As can be seen in table IV, on average only 31 percent felt that their training was adequate in this regard, compared with 73 percent who felt so with regard to the activities traditionally performed by the pharmacist. This raises the need for additional training as a prerequisite to the extension of the pharmacist's role, as conceived in the official vision. In addition, it should be noted that some pharmacists felt their training was also inadequate where the traditional activities were concerned, regarding management of the pharmacy in particular. This sentiment is shared by the students as well.

It seems that the perception among more faculty members (60%) and students (61%) was that the training is adequate to carry out the 'new' activities. Of interest are the differences found between faculty and students on one hand and practising community

[8]The range of activities and their grouping was decided on in consultation with the literature as well as the profession in SA.

pharmacists on the other where activities like blood pressure, cholesterol, glucose and drug therapy monitoring are concerned. There is no doubt that the perception among the faculty and students is that the training is adequate to engage in these activities as well as to participate in health promotion programmes in the community, a feeling not shared by the pharmacists in practice (table IV). This could probably be attributed to the changes taking place in the curriculum or to the distance between the academics and students from the "occupational reality" of community pharmacy.

THE FUTURE

Since the changes in the profession are more likely to take place with the 'production' of new members who subscribe to the new vision, it is of great significance to analyse the students' vision of the profession and their anticipated future role.

Only 16 percent of the students expressed their intention to pursue a career in retail or community pharmacy, against 29 percent in hospital or clinical pharmacy and 45 in the pharmaceutical industry. This indicates desires which are somewhat removed from the reality of the profession in South Africa, where the majority of pharmacists (65%) are employed in retail pharmacy [37] and where most of the new positions are available. These findings correspond with those found in other studies, where only 13 percent of graduates wanted employment in retail pharmacy, but where almost 85 percent of the openings were in this field [11, 38, 39]. The reason behind these findings could be

that community pharmacy is not considered to be one of the elite branches of pharmacy, although it offers most employment opportunities [39]. The accompanying uncertainty with regard to its future might be an additional explanatory factor for its lack of attractiveness as a future career.

These career choices are incongruent with the students' vision of the profession based on their responses to the question "how do you envisage the role of the pharmacist in the future health care system in South Africa?". Most of the responses were positive and indicated an increased role to be played by the pharmacist in primary health care. As stated by one of the students: "I see it becoming fairly important in the future as a Primary Health Care Professional *[sic]* especially if new legislation and the National Drug Policy are effective". An additional aspect of the future role was expressed as "providing needed services to the community"; or, as more specifically articulated: "The pharmacists in the future health care system in South Africa will be the primary attendant to the health care needs of the community as they are so easily accessible". Operating as a "team member with other health professionals" and "becoming increasingly involved in the clinical and therapeutic care of patients in the community" are further components evident in the students' perception of the future role of the pharmacist.

Nevertheless, in the midst of the "new" and "bigger" role envisaged for community pharmacy in South Africa as part of the restructured health care services, a sense of

doubt, fear of the challenges, as well as a degree of apprehension can be detected. Students are very aware of the realities of the profession, and mentioned threats like "dispensing doctors", "intervention of medical aids schemes", "slow and difficult legislation", "economic crisis", and the inability of the profession "to show (its) capabilities to the public" as barriers towards the fulfillment of pharmacists' full potential as "health care providers". These anxieties, in addition to the global questioning of the future of community pharmacy, might provide an additional explanation for their career choices.

DISCUSSION and CONCLUSION

The information presented in this paper provides evidence in support of the existence of a cycle of confusion and frustration with the lack of visible transformation in the profession, as alluded to in the literature. Community pharmacy in South Africa is facing uncertain, multiple futures. The official vision and desire is of an "ideal" scenario where the pharmacist plays an extended role in the provision of primary health care. However, the occupational reality of most of the community pharmacists is such that they are not in a position to practice pharmacy according to this vision, partially due to lack of training as well as to the structure of the current health care delivery system. This reality creates an unattractive professional image, which in turn prevents newcomers to the profession from entering community pharmacy as a career of their first choice, as evidenced in this paper. Compounding the barriers towards

change is the lack of acknowledgement by members of other health professions, and medical practitioners in particular [30], of the role that the pharmacist can play in the health care team.

Based on the above, a crucial question to pose is what elements could facilitate a breakdown or collapse of this chain of events. In an attempt to address this question, it seems that the way forward towards successful and desirable transformation will have to concentrate on simultaneous and multidimensional changes.

Ideally the following three components should be included in the quest to reverse the current reality:

I. Changes in the reality of the practice of community pharmacy, which can be achieved by changing legislation, as well as through intensive continuing education; this poses problems of "the amount and type of motivation felt by present practitioners to retrain and to resocialise" [21:414] in order to adopt new skills and values, and to change their mind set to that consistent with the vision. Despite the associated difficulties, the data emanating from this and other studies in South Africa [40], suggest that there is a willingness to do it.

II. A professional socialisation process which, as proclaimed by the manager of education, South African Pharmacy Council, is "consistent with that of the profession", in order to "obtain alignment between the mission of the profession and that of education" [41:15]. According to Chalmers et al, this is made easier with the

transformation of the profession, since "ideally, a homogeneous perspective within the profession promotes consistency in socialization leading to a common identity and ideology among students" [12], which in turn leads to a common definition of the profession. However, since "much of the socialisation process occurs on the job", and "in pharmacy, the gap between the 'ideal' role of the pharmacist advocated by educators and the role actually filled by many practitioners is profound" [22:564], as evidenced in this paper, as long as the transformation of the profession has not taken place, problems such as lack of role models, continuous uncertainty, and the existing social-professional reality will prevent such a socialisation process from successfully taking place.

III. An interdisciplinary approach to the process of change, consisting of consultations and collaboration with other health professionals as well as integrated educational programmes, since "the lack of interaction with other health professionals may have unfortunate consequences" [42:133]. The evidence available from existing programmes [42, 43] supports the idea that "interdisciplinary teams ... provide an excellent environment for pharmacy students to learn to work with other health care professionals" [43:256]. Halperin advocates "changing the educational system from one that teaches facts to one that requires an integrated approach to patient management" [8:430]. This might lead to a scenario as predicted by Sogol and Manasse that "perhaps in a decade from now this inconsistency may decrease as younger health professionals in pharmacy and other related health care fields begin to view the interdisciplinary strengths of health care" [9: 6].

Referring to the professional transition, Brodie is firm that "for the profession of pharmacy as a whole, the central issue will continue to be the acceptance of the fact and reality of change. The alternatives seem obvious: pharmacy either accepts what the future brings or works to shape the future in accordance with what pharmacists want that future to be." [14: 82]. This is succinctly articulated by the Professional Pharmacists Awareness Campaign in South Africa (PPAC): "The greatest challenge facing pharmacy at the moment is the need to change. For the change to be effective it needs to be total change and not verbal or cosmetic change. If the changes don't come from within they may be forced on us from the outside - and these changes may be the ones we like even less" [33:214].

The official professional vision as discussed in this paper is in the direction of a complete paradigm shift towards an 'extended' role of the pharmacist. However, the real challenge is to translate that vision into reality by effecting simultaneous, multidimensional changes concentrating on the profession, training and education in a wider societal context.

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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CHAPTER VII

PHARMACIST AND NURSE: A TEAM APPROACH TOWARDS PRIMARY HEALTH CARE OR A CONVENIENT "THERAPEUTIC ALLIANCE" ?

ABSTRACT

This paper explores the nature of the therapeutic alliance between nurses and community pharmacists in the South African context. To gain a better insight into the relatively new phenomenon, a combination of qualitative and quantitative methods was employed.

The partnership developed in SA between the nurse and the pharmacist allows the pharmacists to expand their professional activities without invading the nurses' professional domain, while allowing them to reap substantial benefits in the process. These include potential increases in profits, enlarging the clientele base and improving the image of the pharmacy by shifting the focus from a place of disease to a place of health, as well as creating the vision of the pharmacist as a team member in providing primary health care. As far as the nurses are concerned, it grants them the possibility to practice their profession in a very convenient set-up and affords them greater professional autonomy.

INTRODUCTION

The role and scope of the pharmacy profession has been contemplated and reconsidered all over the world (Adamcik et al. 1986; Nuffield Foundation Committee of Inquiry 1986), mainly due to a shift in day-to-day activities and loss of meaningful functions (Gilbert 1995b). This process did not bypass South Africa and various suggestions have been made to extend the role of the pharmacist (The Report of the Commission of Inquiry into Health Services 1986; Department of National Health and Population Development 1990). At the same time, due to the changing political dispensation, major developments have been taking place to transform the overall health care provision patterns (Department of Health 1995; Gilbert et al. 1996; National Drug Policy for South Africa 1996), with an emphasis on primary health care accessible and affordable to all.

All the above necessitated further rethinking of the role of community pharmacists, which has been an ongoing process (Historic developments in Primary Care Drug Therapy, 1994). Some of the proposed changes are being implemented at present while others are being met with obstacles, primarily due to fierce resistance from the medical profession, particularly where greater discretionary powers to prescribe are being sought (Gilbert 1995a).

Throughout this process of transition, pharmacists in SA, as in other countries, have

been promoting themselves directly to the public as 'front line' health and drug advisors via campaigns such as "Drug Wise", "Ask Your Pharmacist First" and others[1]. Although pharmacists have been encouraged to become more active in health promotion, and studies suggest that a substantial part of their work consists of dealing and responding to general health advice sought by the public (Smith 1990; Gilbert 1996), the reality is that by and large, "pharmacists are still considered to be only on the fringes of the primary health care team" (Smith 1990a:383).

This statement acquires a unique meaning in the South African transitional context, since the shift in philosophy and structure of health care towards primary health care has been dominating all decisions made by the various health sectors, and pharmacy is no exception in this regard. The profession has been eager to seize the opportunity to fit in with governmental guidelines and at the same time expand the scope of its activities and affirm its role as a "member of the health care team" (The South African Pharmacy Council 1995a).

Consistent with its official declared commitment to primary health care, the South African Pharmacy Council proposed: "One way, therefore, of reforming community pharmacy in South Africa is by pharmacists and nurses working in a therapeutic alliance to provide accessible and affordable primary health care" (The South African Pharmacy Council, 1995b:2). In keeping with the above, the Council maintains that

[1]These are some examples of advertising campaigns undertaken by some of the major chains of community pharmacies in South Africa

"the community pharmacist should see himself, and encourage others to see him as part of a health care team working together for the benefit of the patient" and further that in general they have "the facilities and expertise available to provide for primary health care clinics in collaboration with registered nurses" (The South African Pharmacy Council 1995b:3).

A partnership between pharmacist and nurse has not been a common phenomenon in health care delivery patterns. In fact, a search for evidence of such collaboration yielded scant results. Some available studies investigated potential or existing collaboration between health care team members in a hospital setting (Mesler 1991; Adamcik et al. 1986), hospital patients (Rich 1994; Tice 1993), health centres (Harding 1994) or teaching programmes (Merrow and Segelman 1989), and mostly found it to be of some benefit to the health care team, as well as to the patient. The role of the pharmacist in the primary health care team has been explored by some researchers (Sheppard et al. 1995; Smith a.1990; Sutters and Nathan 1993; Lustig and Zusman 1994), but they did not focus on the partnership with the nurse.

Studies examining similar partnerships between community pharmacists and nurses found very little meaningful contact between them (Smith 1990b), except in the context of specific maintenance programmes (Capen et al 1994; Toelle et al. 1993). However, there is evidence to suggest that the pharmacists would like to have more contact with other health professionals, nurses included (Lustig and Zusman 1994).

It seems that this potential alliance has not been widely implemented and studied. However, in South Africa this partnership "between pharmacist and nurse is developing rapidly and already operates within many community pharmacies" (Pleaner 1996). For this reason, this paper sets out to examine and analyse the nature of this therapeutic alliance in the South African context.

METHODOLOGY

To gain a better insight into this relatively new phenomenon, a combination of qualitative and quantitative methods was employed, which included the following[2]:

*A documentary search and content analysis of official documentation and publications. The documents analysed included government as well as Pharmacy Council publications, minutes of meetings and reports.

* Interviews with all the nurses (15) operating out of pharmacies in the Johannesburg[3] area.

*Interviews with a random sample of 53 community pharmacists in Johannesburg.

*Interviews with 36 final year pharmacy students at the University of the Witwatersrand, Johannesburg.

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[2]Note should be taken that the data used for this paper form part of a larger study dealing with community pharmacy in South Africa.

[3]At the time at which the study was conducted, the municipal boundaries of Johannesburg were in a transitional state. In order to simplify matters, this study has been limited to the old boundaries of Johannesburg.

These interviews were based on a structured questionnaire which included closed as well as open questions which dealt with the role of the community pharmacists as well as the anticipated partnership with the nurse. The open ended questions constituted 20% of the interview while the remaining 80% was based on closed questions. An example of a closed question is provided in Table 1, which is a summary of the nurses' responses to this question: out of a list of possible activities of a nurse in a community pharmacy, the nurses were asked to indicate to what extent they engage in those activities. The options presented to them were: 1. (A lot) most of the time; 2. Very often; 3. Not so often; 4. Seldom; 5. Very seldom; 6. Not at all. When the answer fell in category 5 or 6 , the interviewee was asked why, and the answer was entered next to the activity concerned. Table 2 is also based on an analysis of responses to a closed question. The following question posed as part of the interview provides an example of an open-ended question: "What is your opinion about the incorporation of a nurse into the practice of community pharmacists? Who benefits the most out of it? Problems?" The answers to the questions were written down during the interview and details completed immediately afterwards.

At the same time, observations were carried out in the pharmacy before, during and after the interview in order to ascertain the nature of activities taking place. The observation was based on a structured schedule which included a description of the area the pharmacy is situated, the structure of the pharmacy and in particular a description of the nurses' location and mode of operation within the pharmacy. The

role played by the researcher was that of non-participant observer.

The data was collected mostly by the researcher conducting the study, with the assistance of a well trained interviewer. The potential respondents were presented with the following introduction written on the questionnaire: "This interview is part of a study into the role of "Community Pharmacy" in South Africa. The aim of the study is to explore the existing as well as the potential role of community pharmacists in the provision of health care. The combination of pharmacist and nurse as a "health team" is unique. Learning as much as possible about it is therefore of utmost importance. It would be of great help if you could answer as honestly and as accurately as possible. This will, hopefully, enable us to produce a worthwhile study that can be of benefit to health care in South Africa. We would greatly appreciate your cooperation.". There was no problem in gaining access to the pharmacies since both pharmacists and nurses were fully cooperative.

The following sections are based on information gathered from all the above sources. The quantitative data were analysed using SPSS PC, while the qualitative data based on the observation and open questions from the interviews were analysed by means of grouping and classifying according to the various topics covered, which is the accepted technique for this kind of analysis (Babbie, 1992;Neuman, 1994).

PHARMACY'S DECLARED POLICY

The prevailing atmosphere of a need to transform the role of the pharmacist on the one hand, and the restructuring of the health services with a bias towards primary health care on the other, has led to a series of initiatives by The South African Pharmacy Council (SAPC). Seven projects relating to pharmacy education and practice were accepted by the council for further investigation and implementation during 1995. (The South African Pharmacy Council 1995c). "Pharmacist and Nurse: A team approach towards community health care" was one of these projects, which, according to the SAPC, seemed necessary in the light of "greater need for medicine prescribing by nurses; improving accessibility of pharmacies; the acceptability of nurses in communities and the synergy that can be achieved by combining the knowledge and skills of nurses and pharmacists; bringing health services to all communities; the provision of screening tests and referral systems in community pharmacies; and minimum legal restrictions to implement such a team approach" (The South African Pharmacy Council 1995c:8).

In June 1995 Workgroup 3 submitted a discussion document entitled "Pharmacist and Nurse: A team approach towards primary health care" (The South African Pharmacy Council, 1995b). A final version of this document was published in July 1995 (The South African Pharmacy Council, 1995a). According to its recommendation, the range of services that could be provided to all communities by pharmacists and registered

nurses working in close liaison from pharmacy premises could be summarised as follows: health education and promotion; drug and alcohol abuse prevention; maternal and child health care; immunisation; family planning; chronic disease management; various approved screening tests; emergency medical services; home health care; advice on methods of administration of medicines; advice on storage and safe handling of medicines; and advice on safe and effective use of medicines.

It seems that all these services fall within the Scope of Practice of registered nurses, and they should thus be covered by the various medical schemes. Following on this, the SAPC approved the employment of registered nurses by pharmacists and allowed a registered nurse to conduct a separate practice within the confines of a community pharmacy with, or on behalf of, a pharmacist.

The council further reiterated that "the ease with which pharmacies can be converted to primary health care clinics where the pharmacist and nurse can act together as the 'first line of defence' should be recognised and further developed by community pharmacists." It thus concluded: "Co-operation with specifically the nursing profession is therefore strongly supported by Council" (The South African Pharmacy Council, 1995a:4).

NURSING POLICY

In keeping with the prevailing dominant approach in health care documentation in South Africa, according to the Nursing Council, the primary focus of nursing remained health rather than disease and the idea that the nurse holds a key position in all dimensions of Primary Health Care, as detailed in the WHO Alma Ata Declaration. The reality in SA confirms that "the success and efficiency of Primary Health Care rest[s] largely on nursing" (Co-operation Between Pharmacists and Nurses 1991:33), mainly due to the number of its practitioners and their geographical distribution. This was further recognised in the Government's proposed health policy (Department of Health 1995).

Although the SAPC prohibited the creation of "formal partnerships" between the two professions, the Nursing Council "imposed no such restrictions - in fact, its ethical rules made provision for partnerships between nurses and other health professionals." Professor Kotze, Chairperson of The Nursing Council, further stated that it "had no objection, in principle, to co-operative partnerships between pharmacists and nursing sisters - especially those with specialised knowledge" (Co-operation Between Pharmacists and Nurses 1991:33).

Pursuing this favourable and accommodating approach, a joint committee of both Councils began to look at ways in which such co-operation could be more effectively

implemented, and the final document of the SAPC mentioned earlier is one of the outcomes of this discussion.

THE NATURE OF THE PRACTICE

In order to examine how this concept is being implemented, interviews were carried out with all nurses operating from pharmacy premises, and the pharmacies were observed before and after the interviews. Twenty two pharmacies in the Johannesburg area currently employ nurses on their premises. Since some nurses work in more than one pharmacy, on different days, the 15 nurses interviewed represent all the nurses, except one who refused the interview.

The study confirms some of the assumptions made retrospectively by the Council, revealing that some pharmacies have had nurses on their premises since as early as 1989[4]. This initiative seems to be have been gaining momentum only recently, however, since most of the current 22 pharmacies who have a nurse operating on their premises have been doing so for less than two years.

In an examination of the mode of operation of this collaboration, two main patterns emerge:

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[4]Cape Town preceded Johannesburg with this initiative.

I. The initiative is made by the pharmacy. These pharmacies (usually big chains) employ a full time nurse to provide services (69%). A general clinic provides monitoring of cholesterol and blood pressure, family planning, various medical procedures, injections, as well as counselling for other ailments.

II. The partnership is initiated by a nurse who, during her practice as a 'private nurse practitioner', identified a gap in her ability to provide a comprehensive service, since she didn't have direct access to the vaccines available in the pharmacy. At the same time, due to the opening up of the public 'city council clinics' to all races, they were being overcrowded, which created the need for an alternative more convenient venue. According to an interview with a nurse, who currently employs other nurses in pharmacies, this explains the success of these 'clinics'.These are mostly 'well baby clinics', run as a separate practice (31%).

All the services are provided free to the public, with no appointments needed. However, users pay for medications as well as materials used, both of which are provided by the pharmacist. In addition, all pharmacies are laid out in such a way that products likely to be used by the clinic-attenders are displayed on the way to the clinic, such as baby or other health-related ones, thus increasing the probability that they will be purchased while in the pharmacy.

The advertising of the provision of these services is done mainly in local newspapers

and magazines, as well as in pamphlets distributed in the community and in hospitals. An analysis of some of this material reveals that, in addition to spelling out the kind of services offered, it emphasises its unique characteristics in terms of "a free community service" or "good old-fashioned service". Some even refer to it as a "health centre". In both cases, the nurse operates out of a small room located near the dispensary, which is clearly marked. Some of the rooms are fully equipped with the necessary facilities and provide adequate privacy, while others are lacking in this regard. All nurses suggested that for maximum benefit, the layout requires restructuring and a bigger, fully-equipped room with a waiting room. In fact, their comments imply building a clinic inside the pharmacy premises.

Most of these pharmacies are situated in middle-class residential areas, drawing on clientele living in the vicinity. Some of them are in shopping malls where there is a substantial traffic of shoppers as well as people working in the area. The number of patients seen by the nurse varies, but most of them see between 10 to 30 patients a day. Due to the location of the pharmacies and the social history of South Africa, most of these are White females from middle-class backgrounds. This was 100% in the case of the 'well baby clinics'. In instances where clientele from other population groups[5]

[5]This is a legacy of the previous regime in SA, where people were classified into different population groups. Although this legislation has been repealed, its social consequences are evident and will continue to be for a while. For this reason and its relevance to the issue of who benefits out of this service, it was mentioned in this context. A more in depth discussion on this issue can be found in Gilbert L., Community Pharmacy in South Africa - A Changing Profession in a Society in Transition, paper presented at the 9th International Social Pharmacy Workshop, Madison, Wisconsin. 1996.

were mentioned, they were mainly people working in the area [6].

The ages of people using the service varies according to the nature of practice. In the 'well baby clinics', they are obviously young mothers with their babies, while in the 'general clinics', they are mostly elderly people. A group that can be singled out is of young working Black and Coloured women, who use it for purposes of family planning.

The fact that according to the nurses, at least 95% of their patients belong to a medical insurance scheme, is further confirmation that the service is used mainly by middle-class people and that its clientele is not a reflection of the South African society[7].

THE NURSES' PERSPECTIVE

Ninety two percent of the nurses interviewed have had at least 10 years of working experience and seem to be very confident with their professional expertise and able to operate in an independent manner. The interviews reveal that the motivation to work in a pharmacy is mainly due to its offering better working conditions in terms of wages, regular hours and convenience. The difficult circumstances associated with

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[6]There was one clinic in an Indian area, so it served mainly Indian customers.

[7]Health care delivery in South Africa, until the recent process of democratisation and universal franchise, was characterised by a two-tier system of a private health care funded by medical schemes, which covered up to 20% of the country's population, the vast majority of whom were from the White section of the population.

work in the organised health sector, mainly in the hospitals, was also mentioned in this context.

The range of problems dealt with is clearly related to the type of clinic the nurse is operating. Out of a list of possible activities of a nurse in a community pharmacy, the nurses were asked to indicate to what extent they engage in those activities. Table 1 is a summary of their responses.

Table 1. Percentage of nurses who engage in the various activities.

Activity	Percentage(%)of positive responses*
pregnancy tests	28.6
determination of blood glucose levels	28.6
urine analysis	21.1
immunisation	57.1
lung function tests	14.2
family planning services	28.5
determination of blood pressure	85.7
cholesterol tests	57.1

* For the purpose of this table the responses "most of the time" and "very often" were combined.

It seems that the activities in which the nurses engage are primarily determination of blood pressure, cholesterol levels and immunizations. Since the study did not anticipate the existence of special 'well baby clinics', the questionnaire did not include

specific activities in this regard. Nevertheless, some probing revealed that the activities of these nurses include developmental monitoring, nutritional and general counselling as well as dealing with sleep disorders and minor ailments.

Since this study is concerned with the 'therapeutic alliance' between community pharmacists and registered nurses, it was important to examine the nurses' attitudes towards the collaboration between the two. A list summarising the range of services that could be provided by pharmacists and nurses working in close liaison from pharmacy premises was thus presented to the nurses. They were asked to make a choice and indicate next to each task whether, in their opinion, it should be carried out primarily by the pharmacist, primarily by the nurse, or by neither of them. Table 2 summarises their responses.

Table 2. Team tasks - Percentage distribution of nurses responses to the question, "by whom should these tasks be carried out?"

Tasks	Primarily by Pharmacist	Primarily by Nurse	Neither one of them
health education and promotion	14	79	7
drug and alcohol abuse prevention	43	50	7
maternal and children health care	0	100	0
immunisation	0	100	0
family planning	14	86	0
chronic disease management	36	43	21
various approved screening tests	7	93	0
emergency medical services	14	71	14
home health care	14	71	14
advice on methods of administration of medicines	93	7	0
advice on storage and safe handling of medicines	93	7	0
advice on safe and effective use of medicines	100	0	0

There is general agreement amongst the nurses that the tasks traditionally allocated to the pharmacist in the domain of medicines are to be carried out primarily by the pharmacists. However, when additional tasks are concerned, what emerges quite clearly is that Maternal and Child Health care (MCH), immunisations, various

approved screening tests, family planning, home health care, emergency medical services as well as health education and promotion are perceived to be, by the nurses, the prime responsibility of the nurse. This is of particular significance since the literature dealing with the 'extended' role of the pharmacist considers these same tasks as the "new"' activities to be undertaken by the pharmacist. Thus, it might explain the resistance by some of the pharmacists to the initiative to incorporate a nurse into their practice.

These results reflect the traditional view with regard to the role of nurse and pharmacist, and one might speculate that working together under the same roof with the pharmacist, might have lead to a change in the nurses' perceptions.

All the nurses were very positive about the incorporation of the nurse into the practice of community pharmacists. They saw it mainly as a "community service" where everybody benefits. Particular emphasis was placed on the fact that the service is convenient, free and accessible, and therefore the "patients benefit the most". Often stated was the fact that "the pharmacist makes a profit", and particularly when employed by the pharmacist, some of the nurses mentioned "being exploited to do other things in the pharmacy", which they objected to. The general response, however, was positive towards the pharmacists and their activities, but revealed a negative attitude towards doctors. An additional reason given in support of the alliance was that "the pharmacist is too busy dispensing to have time to do all that a nurse does", and

that by employing a nurse "it takes the load off the pharmacist". The demand for "this kind of old fashioned service, where the nurse has the time to talk to you" was an additional advantage referred to.

It seems that the nurses see this collaboration as an easy and convenient outlet to practice their profession. At the same time, they are also aware that it provides them and the pharmacist with a "united front" against the doctor. As stated by one of the nurses, "instead of waiting for an appointment and going to the doctor, the patient can come here and get the pharmacist and the nurse at once and receive the same or even better treatment for free." The perception by doctors that they are competing with them was also mentioned by the nurses. This was articulated by the nurse running some of the 'well baby clinics': "it all boils down to rands and cents [money]". According to her, she was told by the doctors while distributing pamphlets to 'new' mothers that she is "trading on our territory [the maternity ward]" and that "we are threatened by you".

THE PHARMACISTS' PERSPECTIVE

The study of a random sample of community pharmacists in Johannesburg exposed the professional isolation in which they operate. Not only was the contact with other health professionals minimal, its nature was unsatisfactory (Gilbert a.1995). It was therefore not surprising to find out that they would have liked to change that. Eighty

one percent indicated that they would like to have more contact with other health professionals.

Because the community pharmacist works in isolation from other health professionals, he/she is not able to make any meaningful intervention in the patient's therapy. For the pharmacist to realise a more effective role in the monitoring of drug therapy, a much closer relationship with the prescriber is required, as well as a more thorough knowledge of the patient's history.

In this context, the integration of the pharmacist into primary health care teams has been advocated (Pharasi and Price 1993). The therapeutic advantages of having integral pharmacies in health centres are borne out of two studies conducted in the UK (Harding and Taylor 1986; Harding and Taylor 1990). According to Pharasi and Price (1993:421), "the presence of a pharmacist in a health centre has the potential of enhancing a collaborative approach to health care which has immense benefit to the patient ... and from the pharmacist's point of view offers greater job satisfaction and validates the pharmacist's professional status and training."

Although the development of "health centres" is on the agenda in South Africa, the scenario described above remains in the realms of the future in terms of its implementation. The collaboration with the nurse, however, might be seen as a small development indicating things to come. The issues highlighted here might thus be of

benefit when health centres become a reality in South Africa.

As mentioned earlier, the phenomenon of incorporating nurses into the practice of community pharmacy is quite unique to SA. This would enable the pharmacy to extend its activities and include new activities not traditionally performed by the pharmacist. The pharmacists were required to comment on this by answering whether they would be in favour of the incorporation of a nurse into the practice of community pharmacists.

Although 56.6% were in favour of the idea, the fact that 30% were against it and 13.2% not certain, suggests that the idea has not been fully accepted. The concerns raised by the pharmacist were related mainly to the financial viability of such an option, as articulated by one pharmacist: "to pay the nurse to give free service is not practical".

Some responses included doubts with regard to the nurses' training and ability to contribute, while others expressed fears that it will "usurp the role of the pharmacist" or that "it makes the pharmacist look inadequate". "It can only work if the doctors will approve it, since they monopolise the profession", is an interesting comment related to the role of the medical profession in the success of this alliance. Although this study does not focus on this issue, it might prove to be a significant point.

When a similar question was put to final year pharmacy students, their response was more positive. Two thirds of the students thought that it was a good idea and only 22% did not think so, while the rest were not sure. Their more positive response was further evident in their comments. They saw this as an opportunity to create a "more health-orientated environment" or to afford people a better access to Primary Health Care, as well as attracting them to the pharmacy. As stated by one of the students, "this will make people more positive towards coming to the pharmacy and the integration will ensure enhanced professional services." The potential benefit of the collaboration with the nurse was further developed by others: "it might be a means of showing the public and other health professionals that pharmacy is a Primary Health Care profession."

The negative remarks made by the students were similar to those of the community pharmacists, and included reference to the fact that the pharmacist can perform all the tasks the nurse can, as well as the question of profitability. "The pharmacist will have even less interaction with the patient", was a perceived threat posed by the incorporation of the nurse into the practice of community pharmacy.

DISCUSSION AND CONCLUSION

The underlying rationale for this association was that pharmacy needs to do something to extend its activities and enhance its image. At the same time there was a need to be seen to be doing something in line with the Government's health policies. The

extension in the direction of more diagnosing and prescribing proved to be very difficult due to the resistance of the medical profession. The alliance with nurses thus seemed logical, since it introduces primary health care into the pharmacy practice. Collaborating with a nurse who is accepted by the community and is in touch with the latest developments will enhance the pharmacists' image; in addition, the legal, structural and attitudinal barriers to implement it are relatively few.

On the surface, it seems that this partnership provides a valuable service to the public, with the user gaining easy access to a comprehensive health care facility. Although according to the nurses and the pharmacists, it is beneficial to all, it is quite clear that the potential for financial profit is one of the incentives. In addition, this partnership, which is working well in reality, provides both 'incomplete' professions with the ability to provide a wide range of services, otherwise provided by the general practitioner or a 'public clinic'.

As in other countries (Smith 1990a), most pharmacies in SA are situated in residential areas (Gilbert 1996). It is thus not surprising that the pharmacist's advice is sought on a range of health issues mainly by women. Among the problems presented to the pharmacist, those related to babies and young children feature quite prominently. The nature of the required and appropriate treatment in most of the cases is provision of information regarding child-rearing and problem-solving, all of which fall within the realm of health education and disease prevention. However, according to research,

pharmacists were not found to be active health educators (Smith 1990a), while at the same time they are overloaded with the dispensing of drugs and administration. This reality was assessed by enterprising nurses who identified an opportunity to slot in. For the nurse, the pharmacy provides a convenient and 'popular' location in the community, and the nurse renders the services that the pharmacist is unable to. The outcome is that prospective clients benefit from a comprehensive service not previously available to them. The benefit to the pharmacist is, according to the Executive Director of Community Pharmacists, that "[u]tilising the joint skills of these two professions gives meaningful substance to community pharmacies as Community Health Care Centres" (Pleaner 1996).

Theoretically, it appears to be a good solution to some of the problems of access to basic medical care in SA. The reality in SA, with its maldistribution of pharmaceutical establishments (Gilbert 1996), however, limits the scope of this alliance and its benefits to all. The real beneficiaries are, once again, the same sectors of the population who have always had access to pharmacies in mainly urban, White areas, and who also enjoy membership of medical aid schemes (Gilbert 1997). The pharmacy with a nurse now offers them free services instead of using overcrowded 'public clinics' or having to visit the private practitioner. At the same time, those people lacking access to organised health services, do not live in the vicinity of currently established community pharmacies. These are mostly utilised by people living in the area or working nearby, as stated by the nurses, as well as in previous studies (Gilbert

1997).

According to Harding et al (1994:46), "[t]he 'occupational control' thesis argues that, within the health care division of labour, the medical profession is dominant in relation to other health professional groups, who are deemed to be 'para professionals'. Within the framework of 'boundary conflicts' and dominance of the medical profession, the use of language such as "first line of defence" in this context, can be interepreted as not only the "first line of defence" for the patient against disease but indicate the 'war' situation between the medical profession and pharmacy. Consequently, this alliance grants the nurse and pharmacist more strength by presenting a "united front" against the medical profession.

The partnership which has developed in SA between nurse and pharmacist allows pharmacists to expand their professional activities without invading the nurses' professional domain, while reaping substantial benefits in the process. These include potential increases in profits, enlarging the clientele base, improving the image of the pharmacy by shifting the focus from a place of disease to a place of health, as well as creating the vision of the pharmacist as a team member in providing primary health care. As far as the nurses are concerned, it grants them the possibility to practice their profession in a very convenient set-up, and affords them greater autonomy. This idea is consistent with McGhan's (1988:146) contention that "[n]urses seem to be asserting themselves as the interface between man and health with regard to restoration,

maintenance and promotion of health." The collaboration with the pharmacists provides them with just such an opportunity.

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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CHAPTER VIII

DISPENSING DOCTORS AND PRESCRIBING PHARMACISTS - A SOUTH AFRICAN PERSPECTIVE

ABSTRACT

Adopting an historical and international perspective, this article explores and analyses the relationship and controversy between pharmacists and dispensing doctors in South Africa. In order to gain a better insight into this troublesome relationship, a combination of qualitative and quantitative methods has been employed. The findings reveal a deep ongoing sense of competition, which is manifest in the form of public debate and continuous attempts to protect professional task domains. Most of the pharmacists interviewed in this study mentioned the "dispensing doctor" as the main problem facing the community pharmacist in South Africa. Meanwhile, the medical profession, as a united front, is fiercely protecting its "inherent" right to dispense medicines. Using the South African scenario, issues such as occupational task boundaries, 'business' versus 'professional' systems as well as the role of the state are discussed in relation to professional dominance, jurisdiction and autonomy.

KEY WORDS: Dispensing doctors, community pharmacists, South Africa, professional dominance, occupational boundaries.

INTRODUCTION

"The ancient art of curing the sick by means of medication is as old as life itself" (Ryan, 1986, p. XIII). From the beginnings of history, pharmacy and medicine have been inextricably intertwined. They were, in all practicality, one and the same profession. It was only as scientific knowledge increased that the tasks allotted to each began to diverge, and so it became logical to separate medicine and pharmacy into two independent professions (Angorn and Thomison, 1989). Sometime between 1231 and 1240, Fredrick II, Emperor of the Holy Roman Empire, issued an edict to establish pharmacy as a distinct and separate profession, wholly independent from medicine (Sonnedecker, 1976). Although the edict applied only to a portion of the Empire, in the ensuing years the concept spread and became firmly entrenched throughout continental Europe. In the United Kingdom, however, modern pharmacy has other roots. It developed from an alliance of the spicers and chemists, the purveyors of crude drugs and chemicals (Trease, 1964). It was in nineteenth century Britain that organised pharmacy as we know it evolved into a distinct profession.

According to Angorn and Thomison (1989), the USA was to a great extent influenced by its British heritage. A *laissez-faire* attitude dominated the marketplace, there were no well established pharmaceutical and medical professions, and licensing was practically unknown. From the fourteenth to the nineteenth century relations between apothecaries - whose official function was the dispensing of medicines - and

physicians, were frequently competitive, because of their overlapping skills and functions.

The main rationale for the separation of the prescribing and dispensing functions was both to avoid conflict of interest on the doctor's part who had the potential to profit from the prescription and sale of drugs, and to keep a system of checks by the pharmacist. Nevertheless, despite the division, physician dispensing parallelled the practice of British apothecaries and competed directly with that of pharmacists. The pharmacists, in turn, responded to the competition from dispensing physicians and vendors of patent medicines by engaging in general merchandising (Angorn and Thomison, 1989). Eaton and Webb argue that despite their recognition, "pharmacists never achieved a monopoly over the one area of work - dispensing, which could be said to be a truly pharmaceutical activity" (1979, p.73).

Pharmacists in South Africa are faced with a similar reality, which has serious implications for the definition of their professional boundaries, their relationship with patients as well as with other health professionals, and the image and future development of pharmacy. Despite the magnitude of the problem and the increasing numbers of dispensing doctors, there is very little research on this issue in South Africa. The only studies available deal with the associated clinical aspects (Truter, Wiseman and Kotze, 1995). The nature of the conflict between community pharmacists and dispensing doctors has been identified as a topic that should be

addressed in future research (Gilbert, 1995a). This is of particular importance at this time when policy debates, followed by attempts at transformation of the health care system, are taking place in South Africa. The aim of this paper is, therefore, to explore and analyse the relationship and controversy between pharmacists and dispensing doctors in South Africa against this background. Adopting an historical and international perspective, the paper will analyse issues such as occupational task boundaries, professional versus business systems and the role of technology and the state in relation to professional dominance, jurisdiction and autonomy.

METHODOLOGY

In order to gain a better insight into this troublesome relationship, a combination of qualitative and quantitative methods was employed, which included the following[1]:

* A documentary search and content analysis of official documentation and publications as well as articles published in newspapers[2].

* Interviews with a random sample of 45 dispensing doctors in Johannesburg[3].

* Interviews with a random sample of 53 community pharmacists in Johannesburg.

These interviews were based on a structured questionnaire which included 'closed' as

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[1]Note should be taken that the data reported in this paper form part of a more comprehensive study examining the present and future role of community pharmacy in South Africa.

[2]The latest developments took place at the time of writing this article; newspapers were thus a good source of information.

[3]At the time the study was conducted the municipal boundaries of Johannesburg were in a transitional state. In order to simplify matters, the study was limited to the old boundaries of Johannesburg.

well as 'open' questions.

The discussion and analysis that follow are based on the information derived from the above sources.

THE HISTORICAL PERSPECTIVE

The development of pharmacy in South Africa has been shaped by its strong historical links with Europe, particularly Britain. Apothecaries employed by the Dutch East India Company from 1653 marked the profession's beginnings. At the end of the eighteen century, "elaborately equipped apothecary shops in Cape Town were operated as dispensaries by physicians, surgeons, barber-surgeons and apothecaries - each with their own special remedies." (Ryan, 1986, p.1). It was during the nineteenth century that the function of the pharmacist in South Africa was defined for the first time. Of significance are the two rulings passed by the British Governor in 1807. The first concerned the creation of a Supreme Medical Committee, which consisted of several doctors and one apothecary; this committee advised the Governor as to who qualified for a license to practice pharmacy. The second established that dispensing of prescriptions could legally be performed only by the apothecary; physicians and surgeons were forbidden to vend or prepare medicines. However, as Ryan asserts, "despite this tacit recognition of their status and importance, pharmacists found their livelihood and position being threatened by the Medical Committee which determined

who entered their profession; by doctors who dispensed their own medicines; and by shopkeepers who sold vast quantities of patent medicines and who traded in poisons - a monopoly sought by pharmacists." (Ryan, 1986, p. 9). The struggle to rectify the situation and to defend pharmacists' interests began with the establishment of the first Pharmaceutical Organisations in 1885-87.

The competition from the trading and dispensing doctor was one of the major issues for the pharmacist. In the late nineteenth century the Select Committee on Medical Reform examined "the problem of dispensing by doctors and counter-prescribing by pharmacists", and concluded: "we take it for granted that a man who is competent to prescribe for disease, is also competent to prepare the medicine he requires for the treatment of it" (Ryan, 1986, p.27). This issue has fuelled further debates and has continued to concern pharmacists in South Africa.

DISPENSING DOCTORS[4] IN SA TODAY

A significant development for community pharmacy has been the granting, to medical practitioners, of licences to dispense medicines. Originally, this provision was intended to address the needs of communities where there were no pharmacists. It started,

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[4]Note should be taken that dispensing by doctors is regarded as a typical problem of developing countries which do not have a well controlled system of medicine distribution. The situation in South Africa is somewhat different. However, since this paper is concerned mainly with the relationship between the dispensing doctors and community pharmacists, a general analysis is beyond its scope.

therefore, with a relatively small number of exceptional cases. The current reality, however, is that 80% of practising community doctors are permitted to dispense, not only for their own patients, but also for those of their partners (Axon, 1994).

As can be seen in Table 1, the number of registered dispensing medical practitioners has increased over the years owing to a host of primarily socio-economic factors, as well as to the state's failure to provide adequate health services for all (Gilbert, 1996). Note should be taken that the gap between the total number of pharmacists and dispensing doctors has been narrowing continuously due to the growing numbers of dispensing doctors. Since 1990, the number of dispensing doctors was higher than that of retail pharmacists, who are the main dispensers of medicines in the community. In 1995, dispensing doctors outnumbered retail pharmacists by 2025. This undermines the role of community pharmacists on one hand, while on the other, any changes in legislation threaten the dispensing doctor; this creates ongoing tension between the professions, as will be demonstrated further in this paper.

Table 1. Pharmacies, Pharmacists and Dispensing Doctors

	Retail Pharmacies	Retail Pharmacists	No. Of Pharmacists	Dispensing Doctors
1983	2302	3142	6452	-
1984	2412	3726	6817	-
1985	2515	4179	7238	3594
1986	2551	4879	7557	3989
1987	2623	5066	7929	4423
1988	2680	5314	8311	4724
1989	2735	5611	8649	5228
1990	2784	5820	8930	5713
1991	2843	6209	9106	6882
1992	2861	6435	9277	7456
1993	2877	6021	9388	7981
1994	2930	6109	9511	8218
1995	2922	6276	9622	8301

Source: The SA Pharmacy Council, 1996

Health care reform has been part of the process of political transformation taking place in South Africa. Since the establishment of the new government, various structures have investigated the matter and made a series of recommendations. As a result, the National Drug Policy (NDP) for South Africa, which was published by the Department of Health in February 1996, clearly stated that "only practitioners who are registered with the relevant Council and premises that are registered and/or licensed in terms of the Medicines and Related Substances Control Act (No 101 of 1965) may be used for the manufacture, supply and dispensing of drugs. Medical practitioners and nurses will not be permitted to dispense drugs, except where separate pharmaceutical services are not available" (National Drug Policy for South Africa, 1996, p.6).

According to a statement from the department of health, "problems with dispensing doctors were uncovered during Medicines Control Council (MCC) inspections, and were one of the reasons why the National Drug Policy (NDP) was formulated" (Sowetan, 1996). The problems identified relate to inadequate storage and dispensing facilities, dispensing by untrained people, and the nature of information given to patients. Bada Pharasi, the health department's chief director of registration, regulation and procurement, maintains that "patient safety and drug prices are the main motivations for new controls", and substantiates this by claiming that "surveys have shown that a dispensing doctor gives his patients an average of 2,38 items, compared with 1,67 items for a doctor writing out prescriptions for a pharmacist to fill", and that "dispensing doctors account for 74 percent of total medical aid drug costs" (Leger, 1996).

The proposed regulations based on this policy were published for comment in the Government Gazette of July 12, 1996. The notice stated that "the minister intends to make the changes to the Medicines Control Act in three months' time - on October 12 - and invites interested parties to submit comments by August 20" (Simon, 1996).

In September, after two days of public hearing, the parliament's health committee "proposed the establishment of a working group of public and private practitioners, pharmacists and patients to consider the proposal to stop doctors from dispensing drugs" (Bulger, 1996). All this would be in order "to consult fully with all

stakeholders and report back to the committee" (Bulger, 1996).

The latest developments have raised concerns on the part of dispensing doctors, who have renewed their fight to maintain the status quo, since it seems that their attempts in the past have yielded positive results. Ryan, in his portrayal of the "question of the trading doctor", presents an advertisement for a meeting of The Society of Dispensing Family Practitioners in 1985 entitled: "The Medical Practitioners strike back", in which the "main issue being discussed is the BASIC RIGHT (sic) of the doctor to dispense medicine to his own patients" (Ryan, 1986, p. 29). This line of attack/defence has been magnified since the publication of the National Drug Policy for South Africa. The March 1996 issue of GP Bulletin has been entirely devoted to the topic of "Dispensing - The right of all doctors", and in it, the voices of most of the main stakeholders are heard.

The chairman of the National General Practitioners Group (NGPG), speaking on behalf of the organisation, emphasised that "it is in full support of doctors who dispense medicines as part of their professional service to their patients" (Botha, 1966, p.6). Central to NGPG's presentation of the debate is the idea that "dispensing by doctors is here to stay and it, without doubt, contributes to an improved doctor-patient relationship".

A similar approach was taken by the chairman of the Health Policy Committee of the Medical Association of South Africa (MASA), when discussing the National Drug

Policy in relation to the freedom to dispense: "Curtailing doctors' freedom to provide a dispensing service to their patients, seems totally unjustified. It will limit availability of one stop comprehensive services, and force patients to obtain their prescriptions elsewhere, even when it is less convenient" (McCusker, 1996, p.19).

The situation was best summarised by the chairman of the dispensing committee of the NGPG, when he said: "I find it very ironic to be discussing the future of the dispensing doctor when it is really the future of the pharmacist that is at stake" (Peppler, 1996, p.14). However, the medical profession is united in the notion that "it is the inherent right of the doctor to dispense medicines" (Peppler, 1996, p.16), and it is prepared to fight for its preservation: "The Society would like to re-iterate that it will not allow under any circumstances any restriction on the rights of doctors to dispense medicines to their patients" (The Society of Dispensing Family Practitioners (SDFP), 1996, p.33).

Of significance here is the fact that dispensing doctors feel it necessary to organise themselves into distinct organisations which are geared towards the protection of the rights of dispensing doctors, and which together with the general medical associations act in this capacity. The Society of Dispensing Family Practitioners, dispensing committee of the National General Practitioners Group (NGPG) and the Medical Association of South Africa (MASA), have supported dispensing by doctors in the past and have continued to do so in the latest unfolding of events (Botha, 1966; McCusker,

1996; Pepler, 1996; Sarlie, 1996). This unity has been made quite clear by references in the media such as: "the medical fraternity believes it is united on the issue of doctors being allowed to continue dispensing medicine" (Feris, 1996); and "[m]edical professions have joined forces to ensure that their right to dispense medicine to their patients is maintained" (Sebolao, 1996). This has lead to an establishment of a new forum representing eight national organisations - the National Convention on Dispensing (NCD), which will "seek an urgent meeting with the Government in a bid to stop legislation that will bar doctors from dispensing medicine" (Makhado, 1996).

THE PHARMACISTS' PERSPECTIVE

Like their counterparts in other places in the world (Axon, 1994), South African pharmacists see dispensing doctors as a threat (Van Wyk, 1993; PSSA National Committee, 1994). A survey reported in the SA Pharmaceutical Journal (Survey, 1994) noted that "dispensing doctors" was the most frequently cited issue among the respondents. Of the respondents, 348 felt it was a major issue clouding the future of pharmacy. According to the survey, respondents felt manipulated and threatened by dispensing doctors. In a later survey, Theron found that 75% of respondents have noticed an increase in dispensing by medical practitioners during the last two years, and pointed out "the necessity to create opportunities for community pharmacies to compete with dispensing medical practitioners" (1995, p. 417).

As early as 1993, the president of the Pharmaceutical Society of South Africa urged to "stop the doctors supplying medicine" and concluded that "massive mobilisation of the profession is needed to influence the consumer to take action on the dispensing doctor situation" (Kohn, 1993, p.487). In an open interview, he later reiterated that "the society needed to push forward the role of pharmacy in the dispensing of medicines to the people". In light of the fact that so many doctors dispense medicines, he admitted defeat: "we have fought tooth and nail against dispensing doctors. But because of the statutes that exist, the problem seems insoluble. The doctors say they have an inalienable right to dispense" (Simpson, 1994, p.691).

In line with the above, most of the pharmacists interviewed in this study mentioned the dispensing doctor as the main problem facing the community pharmacist in South Africa. If the reality was to be evaluated merely by a numerical analysis, their fears might be justified (table 1). In the Johannesburg area, there are 274 community pharmacies and 954 medical doctors with a license to dispense.

THE DISPENSING DOCTORS' PERSPECTIVE

A random sample of 45 dispensing doctors in Johannesburg was interviewed in order to explore their perception of the role of the pharmacist, and to assess their motives for dispensing medications to their patients.

Sixty two percent of the doctors interviewed have been in a possession of a licence to dispense for 7 years or less, which mirrors the general growth trend in the numbers of dispensing doctors.

From their replies to a range of questions intended to ascertain how they perceive the role of the pharmacist, it is clear that they see the pharmacists mainly as performing tasks related to medicines. All respondents (100%) indicated that "advice on methods of administration of medicines, advice on storage and safe handling of medicines and advice on safe and effective use of medicines", should be carried out primarily by the pharmacist. Similarly, "dispensing according to a doctor's prescription" was seen by all the doctors (100%) as an activity which is "very appropriate and very important" for a community pharmacist to engage in. Concerning "counsel(ling) patients about the prescribed drug", 80% thought it was " very appropriate and very important" and the rest (20%) that it was "appropriate and important".

The consensus found among the doctors with regard to the pharmacist's role in dispensing medications was not demonstrated where other activities were concerned, clearly revealing that dealing with medicines constitutes, according to them, the core of the pharmacist's role.

These findings present a contradiction when viewed in the light of the issues presented earlier. The dispensing doctors see the main role of the community pharmacist as

confined to medicines, yet at the same time argue that it is a legitimate component of the role of the doctor. This raises some questions with regards to their motives in engaging in dispensing of medicines to their patients.

Only 24% of the doctors interviewed mentioned financial reasons as influencing their decision to seek a licence to dispense, while 42% mentioned reasons related to their desire to offer a convenient, comprehensive and holistic service to their patients. Additional reasons given were that "this was the trend among doctors today" (13%) or that dispensing allowed them to "keep abreast of developments in the pharmaceutical world" (11%).

THE NATURE OF THE PUBLIC DEBATE

The ongoing conflict between pharmacists and dispensing doctors has taken the form of a public debate, and has been prominently reflected in the media. Traditionally, it has taken the form of pharmacists complaining about dispensing doctors, as well as expressing their fears. The dispensing doctors on the other hand defend their "basic right" to dispense medicine to their own patients.

The nature of this public battle is well reflected in caricatures (Fig I), which represent the media's portrayal of the issue. It clearly shows how this competition is viewed by the public, as a fierce battle for control over medicines and the patient. These two

elements are reflected in the current public debate as well.

Discussing "the most troublesome issues facing pharmacy today, the selling of drugs by physicians", Penna, Associate Executive Director, American Association of Colleges of Pharmacy, insists that "the term 'physician dispensing' should be avoided", since according to him, "physicians do not dispense drugs, they simply distribute them to patients". He further emphasises that pharmacists "should not give physicians who engage in such practice the dignity of describing their activities as dispensing" (Penna, 1987, p.2058). Of significance here might be the fact that pharmacists in South Africa refrain from using the term "dispensing doctor" in public and refer to them in alternative ways, primarily as "trading doctors".

Figure I: **The battle between the pharmacist and the dispensing doctor**



Fig. 17 (above) and (below): Competition with the Trading Doctor remains an unresolved issue.
((above) — 2 August 1986 — by courtesy of Wyndard Vosse, *The Argus*)
((below) — 6 March 1983 — by courtesy of *Die Burger*)



Source: Ryan (1986, p. 28)

According to Kohn (1993), concerned pharmacists have very successfully advertised either in their local newspapers, or in the form of pamphlets, to inform the public that it is preferable for the pharmacist to dispense their medicine. In it statements such as "the principle is accepted worldwide that medical practitioners do not themselves supply or sell medicines to patients", or "regulations in SA forbid the doctor to keep an open pharmacy", and "it is important to be aware that it is your right in all cases to be able to request your doctor for a prescription to be filled at a pharmacy of your choice" (Kohn, 1993, p.487), were meant to avert patients from obtaining medications from dispensing doctors. The advertisement went so far as to point out the "advantages of dispensing pharmacists" as opposed to the problems associated with "the other option": among them, that "trading doctors deny the patient the opportunity to utilise services and professional knowledge of the pharmacists and the controlling functions which he provides" (Kohn, 1993, p.487). They even defamed doctors by clearly stating that "[i]nspectors of the Department of National Health have found that an unacceptable percentage of doctors who dispense, commit serious transgressions with regard to the dispensing of medicines". The benefit to the patient was given as the justification for the advice given in the advertisement, since it "was prepared with your health in mind" (Kohn, 1993, p.487).

As depicted in the cartoons (Fig. I), the public debate revealed a scenario where an all-out war is waged between pharmacists and doctors. This is evident from the use of words such as "weapon in our armoury" (Axon, 1994), clearly indicating 'war talk'.

Publicly, however, an effort was made on both sides to present it as an endeavour to offer a better service to the community and to protect patients' rights.

OCCUPATIONAL TASK BOUNDARIES

Abbott's systemic theory of professions (1988), which claims that the shaping force of a profession's history is competition among professions as well as between them for jurisdiction over work, provides a key to analysing some of the issues related to this dispute. Due to the exclusive character of the jurisdiction, it follows that the professions form an interdependent system - an ecology. Therefore, a move by one will affect the others constituting a system around a task field (Schubert, 1992). As a rule, jurisdictions are not 'vacant'. It is for this reason that the claim of jurisdiction will normally lead to competition. The ongoing battle between doctors and pharmacists over exclusive rights to prescribe and dispense (Ritchey and Raney, 1981; Gilbert, 1997b) provides such an example.

Historically the two functions of prescribing medications and the dispensing thereof, have been kept separate in order to maintain a system of checks and balances that helps to ensure a high quality of care. According to Webb (1995), this separation of functions had the support of most professional organisations in both medicine and pharmacy. The main purposes of this system have been avoiding a conflict of interest on the part of the practitioner, who stood to profit from recommending and selling a

prescribed medication, as well as providing a review process to help prevent errors and duplicate records. This separation is strongly advocated by pharmacy leaders in the USA, as clearly pronounced by Penna: "Dispensing is too complex - and too important - to be left to medicine. Physicians don't dispense any more than pharmacists prescribe" (1987, p. 2058).

Theoretically, this separation is valid in SA as well. In reality, however, the efforts of pharmacy to extend its functions into the arena of prescribing for certain conditions (Gilbert, 1995b), coupled with the existence of large numbers of dispensing doctors, raise serious doubts with regard to the separation of functions and its maintenance by both. The results of the interviews with dispensing doctors confirm the apparent overlap.

On one hand, the lack of a clear division of labour was raised as a concern by the pharmacists, since "[i]t seems that in this instance the roles of both professions concerning their respective rights to dispense medicines appear to overlap" (Van Niekerk, 1994, p.4). On the other hand, the long standing dispute between the pharmacy profession and the organised medical profession on the issue of the pharmacist's right to diagnose and prescribe medicines has been intensified by the proposed changes to the general regulations of the Medicines and Related Substances Control Act 101 of 1965, which, if approved, will allow pharmacists to prescribe

specified schedule 3, 4 and 5 medicines[5], under certain defined conditions (Gilbert, 1995b; Gilbert, 1997b).

At the heart of this matter is the issue of 'professional dominance', which refers to the way in which certain professions not only control the content of their own work but can also define the limits of the work of other occupational groups (Freidson, 1970). Linked to it is the degree of 'professional autonomy' or the legitimated control that an occupation has over the content of its own work (Nettleton, 1995). This is confirmed in Kronus's historical analysis of task boundaries between physicians and pharmacists, where she clearly delineates "the relative ability of the occupation to protect its task domain from encroachment, and/or to encroach on others, as the central measure of power" (Kronus, 1976, p. 5).

Turner (1987) argues that medical dominance is maintained by means of three modes of domination: subordination, limitation and exclusion. While subordination characterises the relationship of nursing to medicine, limitation characterises pharmacy since it is restricted to a specific therapy, as well as dentistry, where the restriction is to a specific part of the body (Jones, 1994).

Pascall and Robinson (1993) argue that boundary disputes between occupations and

[5]All prescription medicines in South Africa are classified into schedules by the Medicines Control Council. The pharmacist can administer only Schedule 1-2 drugs, while for the higher schedules they require a doctor's prescription. The proposed regulations are to change some of these restrictions.

competition over work roles are an inevitable component of a complex health care system with an elaborate division of labour and a changing social and technological environment. Work roles are not comprehensibly defined in legal terms, and overlapping responsibilities are common. For this reason, para-medical occupations have had to negotiate boundaries with each other as well as with doctors when establishing spheres of competence and responsibility (Larkin, 1983).

Eaton and Webb (1979) refer to the extended role of community pharmacy as 'boundary encroachment', claiming that it is an attempt to extend the boundaries of pharmacy practice into the territory of the medical profession, the boundary in this case being that between prescribing and dispensing.

Birenbaum maintains that "as leading experts on health care matters, large or small, physicians are both the model for professional autonomy to be emulated by other health care providers and the residing powers who must be convinced of the merit of reassigning tasks and authority if the other occupations are to acquire the same or similar degrees of control over their work in the health field" (1990, p.10).

The outcry and resistance of doctors to attempts from pharmacists to invade their turf (Adamcik et al., 1986), provide the necessary evidence to show that the medical profession exercises tight control over its task boundaries. Larson (1978) argued that the medical profession latched on to medical science in order to convince the state and

the public of their superior service, which was used as a strategy to facilitate and maintain strict occupational closure. Similar strategies were used in the campaign mounted by the Medical Association of South Africa (MASA) against the proposed changes in legislation (Gilbert, 1995b).

The right to dispense is a point of controversy between physicians and pharmacists internationally. This is evidenced by the fact that a special FIP[6] working group on dispensing doctors was constituted "to aid in combatting what is probably the greatest threat to the profession of pharmacy" (Axon, 1994, p.107). The symposium which followed, entitled "Dispensing Doctors and Prescribing Pharmacists - Where is the Borderline ?", organised by the FIP's Section for Administrative Pharmacists at the World Congress of Pharmacy and Pharmaceutical Sciences in Tokyo, 1993, manifests the seriousness of the issue as perceived by the pharmacists (Dispensing Doctors and Prescribing Pharmacists - Where is the Borderline ?, 1993).

Evidence from countries like Japan, the UK, the Netherlands and the USA shows that, despite some differences, dispensing doctors are a common phenomenon all over the world (Abood, 1989; Cowen, 1992; Axon, 1994). It is also apparent that pharmacists are united in their war against it, as expressed by Axon on behalf of the 'FIP's working group': "We must never lose sight of the opportunity to use this (generic substitution) as another weapon in our armoury against the dispensing doctor" (Axon, 1994, p.111).

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[6] International Federation of Pharmacy

Although presently dispensing is clearly the main function of the pharmacist, and its overtaking by the doctors is a clear invasion or boundary encroachment into another profession's jurisdiction, the medical profession has been able to maintain and develop it due to its dominance. Pharmacists in SA have meanwhile been waiting since 1986 to change the regulation to enable them to diagnose and prescribe in a very limited capacity, but as it currently stands, this is unlikely to materialise (Gilbert, 1997b). This once again illustrates the role which occupational power plays in defining and maintaining task boundaries. This South African scenario is an example in which the medical profession's ability to protect its task domain from encroachment can be interpreted as their central measure of power, as articulated by Kronus (1976). The limitations on pharmacists to prescribe drugs and diagnose disease are "the legal and normative barriers which cut off pharmacists' access to physicians tasks" (Kronus, 1976, p.7). However, these limitations are not reciprocal, as embodied by the prevalent phenomenon of dispensing doctors. This underscores the facts that the medical profession has been more successful than pharmacists in protecting their jurisdiction and task territories.

Mrtek and Catizone (1989, p.28) argue that "while society is willing to defer to judgments within the legitimate expertise of professionals, it is quite reluctant to permit any profession to raise its own discretionary powers up to the level of professional autonomy". They claim that "such autonomy would provide professionals with a mechanism to define, control, and monopolize services of other independent

professions"; therefore, "the question then becomes at what point does society intervene?".

The latest developments in South Africa might be construed as such an intervention by the State. The proposed regulations stipulate "that doctors and dentists may only dispense medicines after being authorised by the director general of health, and passing a course in dispensing prescribed by the South African Medical and Dental Council in consultation with the SA Pharmacy Council" (Simon, 1996). According to the chairman of the SA Managed Care Coalition, "this challenges my professional right to do something I'm already trained to do" (Simon, 1996). Bada Pharasi, on behalf of the Government, however, claims that "doctors were not trained in pharmacology and dispensing doctors' premises were not inspected regularly", adding further that "we are not advocating a total ban on dispensing doctors, we just want to ensure they are properly trained to do the job properly" (Rossouw, 1996).

Birenbaum (1990) maintains that pharmacy is engaged in a campaign, which operates on a practical and ideological level, to protect the occupation from downgrading. He claims that this is not an unusual response on the part of the profession under threat, quoting "the prophetic C. Wright Mills (1951)", who wrote: they "seek to monopolise their positions by closing up their ranks; they seek to do so by law and by stringent rules of education and entrance. Wherever there is a feeling of declining opportunity, occupational groups will seek such closure (p.150)'" (Birenbaum, 1990, p.162).

In addition to the State's intervention to clarify professional task domains, the current situation in SA represents a potential reversal of power, where pharmacy is given an opportunity to control the boundaries of doctors' work and strongly protect its own main function, that of dispensing medications.

'BUSINESS' VERSUS 'PROFESSIONAL' SYSTEMS

The legislation concerning the dispensing doctor in most cases states that "the normal situation is that the pharmacist should dispense; and that doctor dispensing is an exception" (Axon, 1994, p.106). Japan, where the law permits physicians to dispense medicines, is an exception in this regard (Takemasa, 1994). The rationale behind most of the legislation permitting doctors to dispense medicines to their patients is that otherwise, these medicines would not be easily available, due to the absence of a pharmaceutical outlet. For this reason, the granting of licenses to dispense is limited to "special cases" and restricted to "specific circumstances" (Trytek, 1988). This is the case in Australia, where currently there are only 69 dispensing doctors who "are almost always located in remote and isolated rural communities where the nearest pharmacy might be hundreds of miles away" (Axon, 1994, p.107). In most other countries, however, the reality differs. As pointed out by Anderson with regard to the situation in the USA, "today, significant amounts of physician dispensing are not occurring in rural areas or emergency situations where access to retail pharmacy may

be severely limited" (Anderson,1994, p.119) . In the UK, there are dispensing doctors "within a stone's throw of several pharmacies" (Axon, 1994, p.107). As demonstrated in this paper, a similar situation exists in South Africa.

The main distinguishing feature of the Australian legislation is that it stipulates that "the dispensing doctor should not make a profit on the medicines supplied" (Axon, 1994, p.108), which might provide an explanation for the small numbers of dispensing doctors there. Axon, as well as others (Anderson, 1994), suggest that the reason for a doctor to dispense is an economic one, and does not pertain to quality of care. Concerns about "the growth of for-profit health providers and the role of the physician as an entrepreneur", were raised in the USA, and it was suggested that "physicians *had* 'conflicts of interest" while engaging in "economic self-dealing transactions for profit" (Rodwin, 1992, p.728). This was further reiterated by Nelson, who argued that "doctors who sell drugs to patients may succumb to financial temptation and over prescribe those drugs they have in stock, whether or not the particular drug is appropriate. The motive then becomes profit first, patient care second" (Nelson, 1987, p.67). Kapil compared the dispensing doctors in contemporary India to the 19th century in England and on this basis claims that "the doctor earns a living by selling medications rather than by charging a consultation fee and writing a prescription; the incentive is to medicate irrespective of the diagnosis" (Kapil, 1988).

Pharmacists make use of this factor in their fight against dispensing doctors by

displaying the now famous logo: "WARNING - DISPENSING BY DOCTORS CAN DAMAGE BOTH YOUR HEALTH AND YOUR POCKET" (AXON, 1994, p. 109). Spencer and Edwards maintain that "antagonism between the professions is perhaps best symbolised by the long standing conflict between dispensing doctors and pharmacists, who are potentially in competition for business" (Spencer and Edwards, 1992, p.1672).

"As far as dispensing is concerned, MASA and the NGPG accept that the choice of prescribed drugs should not have an effect on the income of the doctor" (McCusker, 1996, p.19). This is the official view in South Africa within the medical profession, as expressed by the chairman of the Health Policy Committee. However, although the official representatives of the medical profession emphasise the doctor's intrinsic right to dispense medicines, as well as the benefit to the patient as the main factors in their support of dispensing doctors, an additional factor - "to make profit" (Pepler, 1996, p.16) - was mentioned by the chairman of the dispensing committee of the NGPG, when explaining why doctors dispense. While listing the reasons why pharmacists want to dispense medicines, he repeated: "profit, profit, profit (it is their right as businessmen - doctors do not have business)". This seemingly contradictory approach (or double-standard) was further revealed when he stated that "the fact that pharmacists now want to become community pharmacists [neau (*sic*) dispensing doctors], is not because they are new generation Florence Nightingales, but because they are experiencing market pressure" (Pepler, 1996, p.16). Evidence from the

interviews with dispensing doctors in Johannesburg suggests that economic forces are, among others, responsible for the increasing numbers of doctors who turn to dispensing.

The reluctance to highlight the business aspect with regard to the practice of doctors does not exist where pharmacy is concerned. The Director-General of Health is quoted as saying: "The free market principle should be adhered to - pharmacy is a business like any other" (Schickering, 1996, p.10). It seems, however, that the same principles apply to dispensing doctors. In the medical profession's attempts to fight the restrictions, this was indirectly alluded to in the statement that "it views any action by any party to force patients to obtain their medicines from specific pharmacies or alternative retail outlets as a contravention of the free market principle" (Botha, 1996, p.6). Corroborating this were comments by dispensing doctors who sought the licence to dispense as means of "attracting clientele", to "keep them coming back", or, as succinctly put by one doctor, to "capture and keep".

Attempts to explain this ongoing conflict between dispensing doctors and pharmacists rely on the use of 'theories of professions'[7], some of which were mentioned earlier in the paper. Of particular relevance here are the seemingly contradicting philosophies of 'professions' versus 'business', as identified in the literature (Kronus, 1975). It

[7]Note should be taken that it is not the intention of this paper to present a review and analysis of the current voluminous theoretical research literature on the professions (Brante, 1988; Macdonald & Ritzer, 1988; Brint, 1993, Macdonald, 1995), but rather to use some of its concepts in the analysis of the conflict between dispensing doctors and pharmacists.

appears that the prevailing perception is that "business and professional systems are theoretically incompatible" (Hepler, 1989, p. 409). According to Hepler, this is so since business is expected to pursue its own interest, while the profession's reason for existence is to serve the public interest. This might explain why the "profit" motive to dispense medicines features less in both the doctors' replies as well as in the public debate, while justifications such as the "provision of a comprehensive or one stop service" and "the patients' right to choose" received prominency.

Evidence in this direction is provided in an open debate between dispensing doctors and pharmacists in Britain, where accusations and counter-accusations are hurled (Geddes, Morton-Jones and Pringle, 1992), such as "that doctors prescribe to line their own pockets as the pharmacists would have the uninitiated believe" (Roberts, 1992, p.187) or that there is "considerable disquiet felt by many doctors over the increasingly ambiguous position occupied by pharmacists. Primarily business people motivated by profit, chemists sit apart from other members of primary health care teams, whose first allegiance is to the patient" (Thomas, 1992, p.650).

Similar sentiments are echoed in the South African Medical Journal, in which a statement is made about "the immoral war being waged by a sometimes pious medical profession ... 'immoral' because neither the pharmacists nor the doctors have the patient's best interests at heart, but are rather consumed by their own financial gain". The point is well articulated by Roos, who claims that "this is clearly not a war being

fought in the depths of medical ethics, but in the shallows of naked economics! The bottom line here is the reduction of 'economically insecure GP's' from 'respected professionals' to 'squabbling medical shop keepers', quibbling over profit margins" (Roos, 1994, p.168).

Although not explicit, an examination of the South African scenario reveals that the issue of economic gain is at the centre of the conflict. For the doctor, as this study reveals, it is a way of "making a living"; as articulated by the managing director of Medsolve, "the GP has thus looked to other avenues of revenue and a lot have turned to dispensing and supplemented their income with the profits made from trading commercially in medicine" (Green, 1996 p.26). Corresponding views were expressed by the president of the Pharmaceutical Society in an open interview, in which he claimed that "it was important for pharmacists to show the new government that they were anxious to get medicines to the people. Perhaps the starting point could be primary health care ... but there is no money in it. How did one go to the profession and tell them to get involved in primary health care when there was no money in it?" (Simpson, 1994, p. 689). This accentuates the fact that "the confusion about the purpose of pharmacy is more troublesome because the business and professional systems are theoretically incompatible" (Hepler, 1989, 409).

The solution, according to the PSSA president, lies in changing the scenario: "the focus had to be to bring the people from the dispensing doctors into the pharmacy,

saying, 'Your one stop shop is here in the pharmacy, not at the doctors'" (Simpson, 1994, p.689).

The attempts to affect legislation and extend the pharmacist's legal boundaries are evidence to that effect - their purpose is to give the pharmacists more meaningful roles, while at the same time providing an alternative/competitive venue to seek medical care from, thus 'luring' patients away from the dispensing doctor. The growing development of pharmacies as primary health care centres by incorporating nurses within their practices might be another example for the above (Gilbert, 1997a), under the pretense of the need to provide a comprehensive service for the patients' benefit. It would appear that the State is adopting a similar line, by distancing itself from the business aspects in the debate. As stated by Pharasi, "[t]he most qualified profession must do the task. We move from the premise that medicines and health care are not ordinary commodities of trade" (Medical Correspondent, 1996).

This analysis draws on Ladinsky, who maintains that "professions are simply monopoly occupations, ones that succeeded in using the symbols of professionalism to gain exclusive power and control of their work. To many of those who hold to this power model of professions, the task of analysis is to demystify the professions, to break through the cloak and expose self-serving motivations" (Ladinsky, 1981, p.5-6).

THE ROLE OF TECHNOLOGY

Progress in medical technology and in the medical sciences during the 19th and early 20th centuries has provided the doctor with vastly improved skills for diagnosing disease, while the pharmaceutical revolution of the past 50 years has transformed medical practice and the doctor's ability to cure disease (Kapil, 1988).

In the early twentieth century, the pharmacist's role evolved into that of an expert in drug formulation, while physicians concentrated upon the effects of the drug on the patient (Trytek, 1988). However, the big business of drug manufacturing overtook the pharmacist's role of drug formulation and by the mid-20th century, the dispensing of the pharmaceutical manufacturer's premade prescription drugs remained the main function of the pharmacist (Mrtek and Catizone, 1989). Concentrating on the dispensing of drugs, pharmacists developed the expertise to double-check doctors' prescriptions, thus saving many a patient from the mistakes of doctors. Roberts claims that "this role is rapidly being supplanted by computer technology in doctors' surgeries and dispensaries. Modern software includes essential cross-checks to improve the safety of dispensing, including a complete pharmacopoeia together with side-effects and interactions cross-referenced with the doctors's repeat prescription list and with a patient-disease register" (Roberts, 1988, p.563). This, according to Roberts, makes the dispensing of drugs by the doctor much safer, and the back-up role of pharmacists is thus disappearing. This idea is further supported by the chairman of the Nuffield Foundation Committee of Inquiry (1986), who is quoted as saying: "the dispensing

role of the community pharmacist is in unstoppable decline" (Roberts, 1988, p.563).

Ironically, pharmacy's success in its attempts to extend its role rely on use of and access to the same technology. Since the patient-disease register is confidential, the information can only be held by the doctor, and the pharmacist can never have full access to it. Mrtek maintains that the lack of access to patients' medical records in a community pharmacy is one of the main barriers to the role extension of the pharmacist (Mrtek and Catizone, 1989). The proponents of this role extension, therefore, recommend the facilitation of improved record-keeping mechanisms (Britten, 1994). At the same time, the availability of this latest technology together with the patients convenience and reduced costs, are used by dispensing doctors as the main factors in defence of the superiority of their service delivery. All this can be interpreted as yet another strategy used by the medical profession in order to maintain its occupational dominance by taking over the dispensing function from the pharmacists, since the new technology provides them with the means to do so.

THE ROLE OF THE STATE

Positioning this debate in the context of 'professional hegemony' as presented by Johnson (1972), and further discussed by Freidson (1970a; 1970b), which denotes the dominance of power of the medical profession in its relationship with other health professions, provides a possible explanation to the South African scenario. Johnson

suggests that the State has had a crucial effect in weakening the control of the medical profession by acting as the mediator between profession and client. According to Eaton and Webb (1979), Armstrong and Alaszewski have concurred with this perspective and advanced the argument further, by pointing to the crucial role of the reorganisation of the National Health Service (NHS) in the decline of medical dominance and increased autonomy and independence of the others in the UK. Starr, in his analysis of the social transformation of American medicine, argues that "while the power of physicians to call the shots in health care is not as great as it once was, they have successfully resisted being dominated, as other artisans and craftsman were, by the corporation of the state" (1982, p.25).

In the National Drug Policy for South Africa to be implemented in 1996, the Department of Health clearly indicates which people and what premises may be used for the manufacture, supply and dispensing of drugs. In order to leave no doubt and to avoid confusion, it states that "medical practitioners and nurses will not be permitted to dispense drugs, except where separate pharmaceutical services are not available" (1996, p.6). If this document is to be implemented as proposed, it has the potential to play a crucial role in the decline of the medical profession's hegemony in South Africa as well. This sentiment was echoed by the NGPG, when its chairman declared that "pharmacists are businessmen and did such a phenomenal lobbying that it appears that the Government intend making them the dispensing doctors of the future" (Pepler, 1996, p.14).

However, Eaton and Webb assert that "those who argue that there has been a decline in medical hegemony have paid insufficient attention to the reaction of the medical profession to the activities of professionalising paramedical groups" (Eaton and Webb, 1979, p. 70). The organised attempts by the medical profession to delay and block the amendments to Act 101, which would have meant extending the pharmacists' discretionary powers, as discussed by Gilbert (1995b), indicate that at this stage the decline of its hegemony is only a theoretical possibility. Furthermore, the latest campaign by the mobilised and united medical organisations to stop the Minister from implementing the changes provides additional support to the above. Organised medicine demonstrated its influence by its ability to mobilise wide support for its cause. "Trade unions, medical, dental and consumer organisations united for the first time ... to voice their objections to the planned changes at a meeting with the health department" mainly on grounds that "the proposed regulations ... contradicted the objective of making affordable health care more accessible" (Simon, 1996). Following this, the implementation was further delayed by the recommendation to establish a working group to deal with the matter.

In the latest unfolding of events, the government's plans to regulate the medical profession have been met by opposition from the Interim National Medical and Dental Council (INMDC) who told Parliament's health committee that they are "opposed to clauses in the legislation relating to the licensing of medical practitioners ... to dispense medicines". They said that "it was unacceptable that, in accordance with the

(proposed) bill, the director-general of health ... would regulate the dispensing of medicines by doctors while the council would only oversee other aspects of professional practice", clearly indicating that the INMDC wanted "to maintain the regulation of the medical profession and the licensing of dispensing doctors". It even went further than that, and "objected to proposals that the Pharmacy Council should have an incisive role in training of health professionals falling within the jurisdiction of the council" (Ranato, 1997).

All the above is once again casting doubts on pharmacy's ability to control medicine's tasks domains even through the intervention of the State.

CONCLUSION

A proclamation by the Governor in 1807 which established that dispensing of prescriptions can legally be performed only by the apothecary (Ryan, 1986), has not succeeded in preventing doctors in South Africa from doing it since then. The establishment of the first Pharmaceutical Organisations in 1885-87 was the beginning of the struggle to protect the pharmacist's interests. However, despite the existence of powerful professional organisations, pharmacists in South Africa have not been able to maintain a monopoly over the one function, about which there is no dispute, that constitutes the core of the pharmacist's role.

According to Freidson, "most of medicine's control has not been exercised directly in negotiation with clients or employers, but rather indirectly, through licensing, registering and certifying legislation that establishes constraining limits". Thus, "legislation is a more effective method of controlling the circumstances of work", since, "through their influence on regulatory agencies, the organised professions are often responsible for writing the job description for their members ..." (1981, p.18).

The medical profession in South Africa has demonstrated an ability to curb pharmacy's attempts to prescribe, and to continue dispensing medications, thus providing additional confirmation of its power and professional dominance: it has managed to successfully protect its task domain from encroachment on one hand, while neverthless encroaching on pharmacy's main function, on the other.

This paper confirms Birenbaum's assertion that "the quest to remake the division of labour in health care is set against the social background of professional domination by medicine" (1990, p.11). He refers not only to its ability to control scarce resources, but also to the widely shared belief that medicine can and should deal with matters of *health and illness. This is corroborated by the outspoken support given by the entire medical profession for the dispensing doctor. It would appear that they are claiming to be holding full responsibility for as well as protecting the interests of "their" patients, thus excluding other health professionals from the equation.*

According to Birenbaum, "there is a structure of expectations, constituting society's approval, that the medical profession is expert in matters of health and illness" (1990, p.11). However, the shifts that have occurred in society in relation to health and the subsequent development of the socio-environmental model of health and disease (Gilbert et al., 1996) have attenuated this notion. The growth of the 'New Public Health' movement and the emphasis on Primary Health Care have brought to the fore the ideas that "health care starts with people", and that the people themselves play "a major role in solving multi-faceted health problems" (Gilbert, 1995c, p.118). Theoretically, this framework provides a context where the hegemony of medicine is likely to diminish (Gabe, Kelleher and Williams, 1994).

The current scenario, as presented in this paper, deals with a bid by pharmacy in South Africa to emulate what has been, historically and universally, successfully done by medicine: namely, gaining control over what they consider to be their professional jurisdiction.

Against the above general trends and due to a combination of factors, pharmacy in South Africa has managed to bring the State to intervene by drafting the NDP, and by proceeding in its implementation. The elements which have facilitated this can be summarised as follows:

*A society in transition where institutions are compelled to change structures and mind-sets.

*A health care sector in the process of restructuring itself with a bias towards PHC, which aims to dispose of the traditional domination of physicians and bring health care to the people.

*Circumstances in which, due to the deficiency of the past health care services, large numbers of doctors were forced to dispense medicines to their patients in less than ideal circumstances. This was exploited by drug companies, which encouraged its development in areas where the services were not really needed by facilitating financial gains for doctors. All the above gave pharmacists the ammunition to claim doctors' inadequacy as dispensers on one hand, and as "profit seekers" on the other.

*Pharmacy's unresolved status and role in the health care system and the strength of its professional organisation.

Despite the existence of the above components, which have assisted Pharmacy in achieving its current desirable outcome, it seems unlikely that, in the long term, pharmacy will be successful in its manoeuvre. Nevertheless, there is no doubt that the current state of affairs and the final outcomes provide an interesting case study in the ongoing saga of the battle between medicine and pharmacy.

During this transitionary period of fluid policies, the predictions tend to be that that a "negotiated settlement" (Eaton and Webb, 1979, p.85) will be reached. In other words, pharmacists will ease up on their attempts to trespass on 'sacred' clinical activities such diagnosing and prescribing, in return for doctors' agreement not to

trespass on core pharmaceutical activities such as dispensing. The fact that the structure of health care delivery in South Africa is most likely to develop toward more 'group practice' and 'managed care' is bound to aid this process, since in such a system, the advantages of separating prescribing and dispensing may be less relevant . As put by Webb: "To increase the consistency of care provided and to improve the availability of primary care, prescribing must be transformed into a collaborative process of pharmaceutical care delivered by a multidisciplinary team" (1995, p.1695).

Finally, it would seem that the emphasis on PHC and the multidisciplinarity it implies, as well as other countervailing forces presented in this paper, have the potential to act as a force towards the erosion of rigid boundaries of professional jurisdictions (Soothil, Mackay and Webb, 1995; Johnson, Larkin and Saks, 1995). However, this requires further research, which lies well beyond the scope of this study.

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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CHAPTER IX

THE COMMUNITY PHARMACIST AS A MEMBER OF A PRIMARY HEALTH CARE TEAM IN SOUTH AFRICA - PERCEPTIONS OF PHARMACISTS, DOCTORS AND NURSES

ABSTRACT

The growing emphasis on Primary Health Care (PHC) all over the world and in South Africa in particular, has drawn increased attention to disease prevention and health promotion from many health professionals, among them pharmacists. This paper explores the role of the community pharmacist as a member of the PHC team in SA, through the perceptions of pharmacists, nurses and doctors. A combination of qualitative and quantitative methods was employed to gather the data. The results reveal a scenario where pharmacists are eager to engage in PHC activities, whereas nurses and doctors are more cautious in their support. Although they see them as health professionals, and are of the opinion that they should play a part in the PHC team, doctors and nurses strongly protect their own domains when it comes to allocation of potential tasks. This raises some difficulties with regard to the effective implementation of PHC. Based on the South African reality and the literature review, suggestions are made to develop models of PHC centres which would potentially overcome some of the problems raised.

KEY WORDS: South Africa, Primary Health Care, community pharmacist, doctors, nurses, team.

INTRODUCTION

Today more than ever, there is a recognition that traditional 'disease oriented' services are limited in what they can contribute to improvement of the Nation's health status (1,2). It is for this reason that disease prevention and health promotion, whose common goal is to keep people well, are receiving the attention of many health professionals, among them pharmacists. This follows the move towards an emphasis on Primary Health Care (PHC) all over the world (3), and in South Africa in particular (4), where, despite the difficulties, the new government is committed to the principles of the Primary Health Care Approach (PHCA) and their practical implementation.

Although the PHCA constitutes a general philosophy, this paper will refer to Primary Health Care as care that is mainly provided outside hospitals to people in the community. This is the level at which the patient enters the system for initial evaluation (triage), and at which he should be able to receive a full spectrum of basic services. This primary level of care should also provide a mechanism for the management of chronic problems and the coordination of all services provided to an individual or family (5). In this context primary health care is concerned as much with keeping people well by preventing disease and promoting health, as with treating those who are ill (6). In their pursuit of an extended role with more meaningful duties (7), pharmacists are positioning themselves to play a more significant role in both these areas. It would therefore be useful to make a distinction between these two elements

with regard to the role of the pharmacist in primary health care.

Community pharmacies are ideally placed as 'the first entry point' into the health care system, since most of them are located close to people's homes[1]. The extensive accessibility of the pharmacist during the day, and the fact that consultation with the pharmacist can be obtained without appointment or charge, provide additional justification for the above (8). Traditionally, the most important function performed by the pharmacist is that of triage (5). However, this is changing towards the inclusion of a wide range of functions associated with primary health care (9). The pharmaceutical literature claims that with appropriate incentives and training, the pharmacist, and particularly the community pharmacist, is appropriately situated to provide limited primary health care (5, 10).

A 1975 survey which was undertaken to document the primary health care role of the pharmacist in London Ontario, concluded that "the contribution of pharmacists in primary health care was found to be large, with neighbourhood pharmacies being the most active" (11: p.60). Jinks et al. reported that "because of accessibility, community pharmacists are an excellent and logical resource to promote wellness and disease prevention to individuals. In addition to their traditional secondary prevention roles in

[1]Unfortunately, due to the geographic maldistribution of pharmacies in SA, this applies only to where pharmacies are available - mainly in the urban areas. For more details, see: Gilbert L., 1996, Community Pharmacy in South Africa - A Changing Profession in a Society in Transition. Paper presented at the 9th International Social Pharmacy Workshop, Madison, Wisconsin.

optimizing prescription and non-prescription drug use, community pharmacists are beginning to engage in selected primary prevention activities which involve direct patient intervention and education. These activities include hypertension and diabetes screening, family planning, sexually transmitted disease control, cancer prevention and detection, fluoridation counselling, alcohol awareness, child abuse prevention and promotion of childhood immunization" (12: p.10).

Numerous studies provide examples of the pharmacist's involvement in health education and health promotion activities in the USA (13-17). According to Smith (18,19), an extended role for pharmacists in primary health care is currently being pursued by the pharmacy profession in the United Kingdom. There is additional evidence from other parts of the world that the pharmacist plays a central role in primary health care (20,21).

The American Public Health Association (22) claims in its document outlining the role of the pharmacist in public health, that notwithstanding the evidence outlined above, "the general public, public health agencies, health planning bodies, and other health institutions involved with public health give small consideration to these types of services" (p.213). In support of this statement, Smith maintains that "despite the tradition of the presence of the pharmacist in the community in Britain, they are often considered to be only on the fringes of the primary health care team; for example, it is rare to find any discussion of the community pharmacist in textbooks on the primary

health care team" (19: p.102). In a similar mode, Jepson and Strickland-Hodge argue that "rarely is any significant reference made to the contribution which pharmacy is capable of making when issues such as primary health care teams are discussed in British Government publications or medical journals" (23: p.31).

Since the expansion of the pharmacist's role occurs in the context of a large set of interrelated health care roles, it is important to examine the implications of these current developments. Although pharmacists are often viewed as working in relative isolation (24), even their traditional role in drug therapy is in conjunction with other primary health care workers (25,26), and with physicians in particular. However, "as members of the dominant professional group in health care, physicians have historically exerted effective control of both the activities and scope of practice of all other groups of health workers" (27: p.130), and continue to do so to date (28). This puts the effective implementation of PHC in jeopardy, since prerequisites to PHC are team work and the repudiation of the hierarchal structure of medicine in order to reach the people in the community (4). This is particularly evident in the current South African climate. As Van Rensburg insists, "it must be emphasised that we are moving into a different era where unilateral strategies and monopolies in decision-making by elite interest and power groups are constantly degraded amid an ever-increasing climate of democratisation - sometimes even proleterianisation - of once elitist empires. Health and medical care are also increasingly becoming public affairs" (29: p.594).

Abbott's systemic theory of professions (30), which claims that the shaping force of a profession's history is competition within professions as well as between them over work jurisdiction, provides a key to analyse the kind of occupational change implied by the attempts to include pharmacists in the primary health care team. Due to the exclusive character of the jurisdiction, it follows that the professions form an interdependent system - an ecology. Therefore, a move by one will affect the others constituting a system around a task field (31). As a rule, jurisdictions are not 'vacant', and thus the claim of jurisdiction will normally lead to competition. Examples of this are provided in the ongoing battle between doctors and pharmacists over exclusive rights to prescribe and dispense (32,33,7,28).

Hansen contends that "a well-functioning primary health service demands co-operation among the health professions" (34: p.271). However, factors such as differences in the status, prestige and power of the respective team members as well as poor appreciation of each others' roles, may restrict effective cooperation (35). It is for this reason that there needs to be general agreement on the acceptance of these new roles by the groups affected (36) - in this particular case, community pharmacists, nurses and doctors, since the pharmacist is largely defined through his relations with these groups (34).

In discussing the expansion of the community pharmacist's role in the UK, Taylor and Harding (37) express their hope that "other health professionals will respond positively

to these developments, and regard them not as an erosion of occupational boundaries or one profession attempting to raise its profile at the expense of others, but rather as beneficial developments for patients and health professionals" (p.210). They cite some examples of mutual appreciation among pharmacists and doctors of their professional roles (38). However, other studies have shown that although teamwork among different primary health care professionals is considered the most positive way forward for the delivery of primary health care, the success of these moves has been somewhat questionable (39,40). Nevertheless, the pharmacy profession is talking about "pharmacists ... working collaboratively with physicians and other health workers" (41: p.1775) and the need "for greater cooperation among members of the health team" (42: p.276).

Cunningham-Burley and Maclean (43) claim that the discussion about the role of the pharmacist as part of a professional primary care team has been somewhat neglected by the social sciences. This view is corroborated by Mesler who professes that, relatively speaking, little has changed since Mechanic (24) "noted that sociologists have accumulated a vast amount of information on physicians and nurses, but the literature ... 'is bereft of studies on pharmacists'"(44: p.311).

The aim of this paper is, therefore, to explore the role of the community pharmacist as a member of the PHC team in South Africa, through the perceptions of both pharmacists as well as their most likely partners, nurses and doctors.

METHODOLOGY

To gain a better insight into this relatively new phenomenon, a combination of qualitative and quantitative methods was employed, which included the following:[2]

* A documentary search and content analysis of official documentation and publications as well as newspapers[3].

* A mail survey conducted among pharmacists in possession of section 22A (12) permits[4].

* Interviews with all nurses (15) operating out of pharmacies in Johannesburg[5].

* Interviews with a random sample of 53 community pharmacists in Johannesburg.

* Interviews with a random sample of 45 dispensing doctors in Johannesburg.

These interviews were based on a structured questionnaire which included 'closed' as well as 'open' questions.

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[2]Note should be taken that the data used for this paper form part of a larger study dealing with community pharmacy in South Africa.

[3]The latest developments took place at the time of writing this article; newspapers were therefore a good source of information.

[4]These pharmacists received a special permit to prescribe medications in higher schedules, allowing them to provide a more comprehensive service. For more details see: Gilbert L., Pharmacy's Attempts to Extend its Roles - A Case Study of Amendments to Legislation and Special Permit Holders in South Africa. *Social Science & Medicine* - In press.

[5]At the time the study was conducted the municipal boundaries of Johannesburg were in a transitional state. In order to simplify matters, the study was limited to the old boundaries of Johannesburg.

The sections that follow are based on information derived from all the above sources.

THE SOUTH AFRICAN SCENARIO

Parallel to universal developments, pharmacy in South Africa has been actively engaged over the years in attempts to expand its role in health care (9,7). However, the current wave to reconstruct the role of the community pharmacist is directly linked to the transformation of health care services in SA towards an emphasis on primary health care. This started as early as 1992 and continued with the establishment of the new government. Already, the previous government had "identified a greater role for pharmacists in its primary health care policy" (45). The proposed changes signalled to the public a "[n]ew role for SA pharmacies", as "2 700 retail pharmacies could become part of the primary health care system" (46:p. 5). The force of the Pharmacy Professional Awareness Campaign (PPAC) contributed to the notion that "pharmacists have a significant contribution to make to the 'health for all' goals as described by the World Health Organisation" (47). The Pharmaceutical Society of South Africa called for new functions for pharmacists to be identified, developed and legalised (48). This included training pharmacists to carry out functions currently performed by nurses at clinics, which would involve the pharmacist administering injections, providing preventive care services and caring for the chronically ill. The suggestions are that these functions would be performed by pharmacists in addition to nurses in clinics; this is to fully utilise existing health personnel so as to alleviate the crisis in health care.

Since 1993 over 2500 pharmacists have undergone special training in family planning, and can supply oral contraceptives without a medical prescription, on condition that the recipient sees a medical doctor within six months.

The National Health Insurance System (NHIS) was proposed by the new government at the end of 1995, and based on it, the health minister "plans to have a fully functioning primary health care system in SA in the next five years" (49). In 1996 the Department of Health published the National Drug Policy for SA, which was to be implemented in 1996. It speaks about the role of pharmacists and the fact that "they also have a critical role to play in primary health care and preventive health services" (50: p.18). In addition to the documents published by the Department of Health, the report of the National Commission on Higher Education (NCHE) has made recommendations for changes in tertiary education in order "to prepare personnel capable of giving effect to the PHC approach in the National Health System". It has recommended that curricula should be revised and upgraded to include primary health care approaches, and that training of health professionals should ideally take place within integrated academic health service complexes. This process, according to Moodley (51), involves breaking down individual professional barriers and promoting training that encourages working in multidisciplinary teams.

The enthusiastic response of the Pharmaceutical Society of South Africa (PSSA) to "the role of pharmacy in connection with the National Health System for Universal

Primary Health care" is reflected by its president, who has commented: "It is of utmost importance that pharmacists get involved in every district to confirm the role they can play at grassroots level" (52: p.284).

The developments in this direction include the incorporation of nurses in community pharmacies[6] (53). The latest endeavour is the proposed conversion of more than 400 pharmacies nationwide into private, primary health care centres (54). These 'mini-clinics' will be staffed by a primary health care nurse, supported by a general practitioner and will be using 'managed-health-care-principles'. This move comes in anticipation of mandatory health care for all employees and the urgent need to extend primary health care services. It is also a reaction to a range of factors, such as discounting on prescriptions, mail prescriptions and trading doctors, which are threatening the viability of retail pharmacies in their current form (55). In keeping with this idea, a fully equipped and operational pharmacy was donated to the Department of Pharmacy, University of the Witwatersrand, Johannesburg in order to "investigate models of group practice health care, in line with South Africa's need to develop primary health care systems", as well as "to offer a site for interdisciplinary teaching and research" (56).

It is clear from the above that the future as envisaged in SA will see pharmacists,

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[6]For more information see Gilbert L., 1996, Pharmacist and Nurse: A Team Approach Towards Primary Health Care or A Convenient "Therapeutic Alliance" ? *International Journal of Nursing* 34:367-374.

doctors and nurses working together as a team in the provision of primary health care. There is a paucity of local studies examining the role of the community pharmacist in PHC. One such study in KwaZulu Natal (KZN) examined the role of the public health sector pharmacist in Primary Care Clinics (57); it was found that these services were lacking, and in particular that hospital-based pharmacists did not support pharmaceutical services at Primary Care Clinics in KZN, indicating a dire need for these services.

Based on the issues raised thus far, it is clear that it is of utmost importance to investigate the implications of the incorporation of the pharmacist into the primary health care team. The sections that follow will examine how this move is perceived by the major role players.

THE PERSPECTIVE OF PHARMACISTS, DOCTORS AND NURSES

Importance of various role components

One of the main issues raised is the multiplicity of components that constitute the pharmacist's role. In an attempt to answer the question "what is a community pharmacist?", all interviewees were asked to rank seven role components in order of importance.

The role of the pharmacist as a "health care professional" was ranked first in order of importance by the pharmacists as well as the doctors; however, the percentage differed. Eighty eight percent of the pharmacists with the special permit and 74% of community pharmacists in Johannesburg ranked it first, while only 52% of the doctors did so. The nurses ranked it second in importance with support of 57%.

Of interest is the variation found in the rankings of the pharmacist as "health educator". Eighty six percent of the nurses ranked it as the most important component of the pharmacist's role. The pharmacists saw it as second in importance (58% of pharmacists with special permit; 47% of community pharmacists in Johannesburg), while 11% of the doctors ranked it as second, 21% as third, 25% as fourth, 18% as fifth, 14% as sixth and 11% as seventh. This seems to signify that the doctors in the study do not perceive the community pharmacist as a health educator, while the pharmacists see themselves as such and the nurses fully support it. Note should be taken that since "health education" is one of the major components of primary health care, this finding might affect the way the role of the pharmacist is realised in the primary health care team.

In this context, it may be of significance that 21% of the nurses see the pharmacist mainly as a "businessman", while 29% ranked this option second and 21% as third in importance. At the same time, none of the doctors ranked it as first, but 9% ranked it as second and 30% as third in order of importance in the pharmacist's role. Needless

to say, fewer pharmacists consider themselves as "businessmen".

Activities of community pharmacists

For the purpose of this paper the activities were grouped under the 'traditional' activities of the pharmacist and their 'new' ones, which are those concerned chiefly with primary health care. Table 1 is a summary of the extent to which the pharmacists interviewed engage in the various activities. As can be seen, this table reveals the differences between the activities of 'standard' community pharmacists and those who were specifically positioned to perform primary health care activities. There is no difference with regard to the traditional activities. However, it seems that very little primary health care activity takes place in the average community pharmacy in Johannesburg. The more traditional activities such as "advi(sing) patients with regard to their personal health" (75.5%) and "educat(ing) consumers (STD's, diet)" (64.1%), which have always been performed by the community pharmacist, fall within the realm of primary health care.

Table 1. Extent to which pharmacists engage in various activities.

Activities	Percentage of positive responses[1]		
Traditional activities	**Pharmacists with special permit**	**Community pharmacists**	**p-value**
Dispense according to a doctor's prescription	91.7	96.3	0.379058
Counsel patients about the prescribed drug	100.0	88.7	0.064543
Discuss the prescription with the doctor	20.8	11.3	0.24928
Manage the pharmacy	91.7	83.0	0.283075
Counsel patients about OTC drugs	95.8	90.5	0.393892
Sell OTC drugs	87.5	84.9	0.749864
Assess the patient's problem and refer to other health professionals	50.0	60.3	0.373539
Provide drug information to other health professionals	20.8	11.4	0.255179
Attend to emergencies \ casualties	29.2	16.9	0.19734
Average	**65.3**	**60.4**	
P-value	**0.093186**		
Primary health care - New Activities			
Advise patients with regard to their personal health	79.2	75.5	0.70761
Educate consumers (STD's, diet)	70.8	64.1	0.54370
Blood Pressure Monitoring	91.7	39.6	0.00001
Cholesterol Monitoring / Testing	45.8	22.6	0.03120
Glucose Monitoring / Testing	58.3	20.7	0.00066
Train home-care patients	8.3	1.9	0.16773
Monitor drug therapy of chronic patients	58.3	39.7	0.11025
Prescribe in case of acute illness	91.7	13.2	0.00000
Order laboratory tests	16.7	1.9	0.01313
Immunisation	33.3	13.2	0.03196
Developmental screening	16.7	0	0.00218
Administer injections	70.8	11.3	0.00000
Prescribe / Administer contraceptives	58.3	43.4	0.20193
Participate in health promotion programmes in the community	29.2	18.9	0.29077
Average	**52.1**	**25.2**	
P-value	**0.000866**		

[1] For this table, the top two responses - " most of the time", and "very often" - were combined.

[2] Differences in bold activities are significant at a 5% level - Z test was used.

The same list of activities was presented to the doctors and nurses in the study, and they were asked to indicate to what extent, in their opinion, it was appropriate and important for a community pharmacist to engage in these activities. Table 2 is a summary of their responses.

Table 2. Perceptions among doctors and nurses with regard to the appropriateness and importance of the pharmacist engaging in the various activities.

Activities	Percentage of positive responses*		
Traditional activities	**Nurses**	**Doctors**	**p-value**
Dispense according to a doctor's prescription	100	100	-
Counsel patients about the prescribed drug	100	100	-
Discuss the prescription with the doctor	78.5	86.4	0.46495
Manage the pharmacy	84.6	86.4	0.86207
Counsel patients about OTC drugs	78.5	100	0.00139
Sell OTC drugs	64.3	100	0.00003
Assess the patient's problem and refer to other health professionals	92.8	72.7	0.10518
Provide drug information to other health professionals	85.7	97.7	0.07240
Attend to emergencies \ casualties	69.2	93.2	0.01598
Average	**83.70**	**92.90**	
Primary health care - New Activities			
Advise patients with regard to their personal health	78.5	52.3	0.07414
Educate consumers (STD's, diet)	71.4	25.0	0.00124
Blood Pressure Monitoring	78.6	56.8	0.13146
Cholesterol Monitoring / Testing	71.5	59.1	0.39104
Glucose Monitoring / Testing	78.6	56.8	0.13146
Train home-care patients	21.4	40.9	0.17307
Monitor drug therapy of chronic patients	85.7	79.5	0.59568
Prescribe in case of acute illness	78.6	63.6	0.28332
Order laboratory tests	0	11.4	0.17149
Immunisation	42.9	56.8	0.35004
Developmental screening	42.9	63.6	0.15891
Administer injections	57.1	56.8	0.98379
Prescribe / Administer contraceptives	57.1	68.2	0.43375
Participate in health promotion programmes in the community	85.7	59.1	0.06010
Average	**60.7**	**48.6**	

[1] For these tables, the top two responses were combined

[2] Differences in bold activities are significant at a 10% level - Z test was used.

It seems that there is consensus between the doctors and nurses with regard to the traditional activities undertaken by the pharmacist. However, where the newer primary health care activities are concerned, the responses differ. More nurses than doctors see the activities related to patients' education, advice and monitoring as appropriate and important for the pharmacist to engage in. However, activities such as training of home-care patients, immunisation and developmental screening are seen as appropriate by more doctors than nurses. This is ostensibly due to the fact that traditionally these activities fall within the nurses tasks' domain and they would not like the pharmacist to encroach on their professional boundaries.

Considering the South African scenario, it seems that on a day-to-day basis, the nucleus of the primary health care team will consist of the nurse[7] and the pharmacist. This will apply, in particular, if the plan to convert pharmacies into primary health care centres will materialise. For this reason, a range of services that could be provided by pharmacists and nurses working in close liaison from pharmacy premises has been compiled. The doctors and nurses in the study were asked to indicate, according to their opinion, by whom these services should be primarily carried out. Table 3 is a summary of their responses, which also act as an additional gauge of their perceptions of the pharmacist's role in the primary health care team.

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[7] The human resources committee has recommended the nurse as a core of the primary health care team. However, where an alliance with a pharmacist exists, they can form the necessary team.

Table 3: Percentage distribution of doctors' and nurses' responses to the question, "by whom should these tasks be carried out?"

Tasks	Primarily by Pharmacist		Primarily by Nurse		Neither one of them	
	doctors	nurses	doctors	nurses	doctors	nurses
Health education and promotion	43	14	57	79	0	7
Drug and alcohol abuse prevention	32	43	64	50	5	7
Maternal and children health care	0	0	96	100	5	0
Immunisation	0	0	82	100	18	0
Family planning	7	14	82	86	11	0
Chronic disease management	61	36	2	43	36	21
Various approved screening tests	5	7	73	93	23	0
Emergency medical services	27	14	73	71	0	14
Home health care	5	14	96	71	0	14
Advice on methods of administration of medicines	100	93	0	7	0	0
Advice on storage and safe handling of medicines	100	93	0	7	0	0
Advice on safe and effective use of medicines	100	100	0	0	0	0

This table reflects the conventional view of labour division in the health team. On the one hand, it is clear that there is full agreement among doctors and nurses that the pharmacist's main role is in the area of medication. On the other hand, maternal health, immunisation and family planning are perceived as services to be provided primarily

by nurses. With regard to some of the newer services suggested, there are some doubts and differences between doctors and nurses. Screening tests are an example where pharmacists are hoping to play an active role, and in some cases already do. However, 73% of the doctors and 93% of the nurses expressed their view that these tasks should be carried out mainly by nurses. Twenty three percent of the doctors thought that they should not be carried out by either of them, but only by doctors. Chronic disease management is another service provided by pharmacists as part of primary health care services, but only 36% of nurses and 61% of doctors were of the opinion that it should be provided primarily by pharmacists. Forty three percent of the nurses suggested it be provided chiefly by nurses, while 21% of them and 36% of the doctors indicated that neither nurses nor pharmacists should be fulfilling this task. Health education and promotion, although having been earmarked as an additional activity of the pharmacist in primary health care, received varied responses. It seems that nurses in particular see it as their main task in PHC, while the doctors are divided on this issue.

THE DIFFERENT PERSPECTIVES - ANALYSIS AND DISCUSSION

Numerous studies have examined attitudes of doctors, nurses and consumers towards the extended role of the pharmacist in primary health care (58), and they present a varied scenario. Early studies by Knap, Knap, and Edwards (59), who were concerned with the perceived occupational roles of pharmacists, showed that the role of the pharmacist was perceived as being closer to a technician than a health professional.

The information in this study, however, provides a different perspective, according to which there is no dispute among the various groups that the pharmacist is a "health professional" and not a "technician".

Norwood, Seibert and Gagnon (60) examined the attitudes of rural consumers and physicians and concluded that the expansion of the pharmacist's role beyond the boundaries of an advisory role concerning drugs, is viewed with much scepticism by both groups. They found that "neither consumers nor physicians viewed the provision of general health information as an activity in which the pharmacist should be engaged", and that they " view the pharmacist's role as comprising primarily the drug spectrum of health care" (p.554). Corresponding viewpoints emerged in a study by Lambert et al (61), who surveyed a wide range of health workers such as physicians, social workers, osteopaths, nurses and others. It would appear, therefore, that the medical profession is divided as to whether and how pharmacists should be seeking to extend their role (62,63,64,19,65).

The findings in this study are consistent with the literature where the role of the pharmacist is seen as confined to drug therapy or drug information. These findings can be explained as a set of strategies to maintain the medical dominance discussed elsewhere (7,28). Turner (66) argues that medical dominance is maintained by means of three modes of domination: subordination, limitation and exclusion. While subordination characterises the relationship of nursing to medicine, limitation

characterises pharmacy, since it is restricted to a specific therapy, and dentistry, where the restriction is to a specific part of the body (67). In this context, Harding, Taylor and Nettleton claim that "whilst the content of pharmacists' work may be changing they have not challenged the medical profession's authority to define the agenda" (35: p. 47).

Rappaport (68) has examined primary care roles of pharmacists as perceived by consumers, and it has emerged that although "dispensing expertise and medication-use counselling by pharmacists may be more realistically viewed as pharmacists' roles by consumer representatives than are non-drug preventive and primary health services ..., the study suggested that pharmacists may still believe themselves capable of assuming the newer preventive and primary health care roles" (p.162). This has been confirmed by the American Public Health Association (22), but the profession continues to talk about the responsibilities of the pharmacists in primary health care (69). Again, the results of the current study appear to be supporting the point that pharmacy's attempts to enter the primary health care arena do not necessarily coincide with the vision of other health professionals.

An extended study by Adamcik and co-researchers (70) assessed the legitimacy of expanded roles for pharmacists with pharmacists, physicians and nurses. Similarly to this study, it clearly emerged that pharmacists were most supportive of these roles. Physicians and nurses were more antagonistic toward role extension in the community

than in the hospital setting, which might explain the relative success of clinical pharmacy (7). Nevertheless, even in hospital settings there is no agreement on the acceptance of the extended role of the pharmacists among physicians (71,72,32,33,73,74). Studies from Australia show corresponding results (75). As in this study, differences between doctors and nurses were reported in several studies (76,77). The data in this study support the notion raised by Adamcik et al (70) that nurses will approve new roles when the activity does not threaten their turf and withhold approval when it does encroach on their territory.

A study exploring the views of general practitioners on the roles and activities of community pharmacists in New Zealand, concluded that general practitioners accept several aspects of the current role of pharmacists in providing primary health care, while rejecting others. They noted specifically, however, that there is room for improvement in communication between them (78).

More recent studies, in the UK in particular, demonstrate an increasing acceptance of pharmacists' extended roles by physicians (79), culminating in discussions about integrating pharmacy fully into the primary care team (80) as well as attempts to increase collaboration (81). Based on surveys conducted in Great Britain, Jepson and Strickland-Hodge conclude that "the reality of inter-professional co-operation should lead to more effective teamwork and the better utilisation of pharmacists' expertise and their contribution to improving the integration and continuity of patient care" (23:

p.31).

Although the Nuffield inquiry into pharmacy (82) recognised the potential for conflict between the pharmacist's code of ethics and the commercial environment of the pharmacy, it found no evidence that this was a problem in practice. However, some doctors believe that the business environment of the pharmacy precludes the pharmacist being a member of the primary health care team (83,64). Sheppard et al (84) report that "the Royal College of General Practitioners is in favour of only those recommendations relating to improving doctors' prescribing practices", but "is not at present prepared to include pharmacists in patient management and appears reluctant to accept pharmacists into the primary health care team" (p. 181). The use of the pharmacist as a source of information on drug related matters by physicians and nurses seems to be both logical and desirable. Nonetheless, studies do not report substantial reliance, by physicians in particular, on advice and counsel on drug-related matters (85).

The contradictions which emerge from this study as well as the literature review, indicate that although there are serious intentions to implement PHC and the team work it implies, the reality in the field is that doctors and nurses still hold conventional views with regard to the role of pharmacists. Although they see them as health professionals, and are of the opinion that they should play a part in the PHC team, when it comes to allocation of potential tasks, doctors and nurses strongly protect their

own domains.

GENERAL DISCUSSION and CONCLUSION

Studies from other parts of the world indicate that interactions between community pharmacists and doctors are related to practice setting (86) and the degree of exposure (32,33,87). Although this paper does not deal with specific practices, it concerns itself with a primary health care setting which is most likely to occur within a general framework of a 'group practice' or 'health centre'. According to Harding and Taylor (10), general practitioners working closely with pharmacists in health centres, tend to develop a more collaborative approach to health care.

The American Public Health Association (22) urged the necessity "to support the inclusion of pharmacists in the composition of the team of primary care practitioners" and "to support the inclusion of pharmacists in the definition of public health practitioners" (p.215). However, as demonstrated in this paper, this is a complex undertaking. Barriers such as relationships with doctors and other health providers due to 'jurisdiction disputes', as well as fear of economic competition, might impede the process.

Unfortunately, much of the economic incentive for practising primary health care by

the community pharmacist is indirect (53), and preventive health involvement continues to be perceived as an altruistic endeavour by community pharmacists (12,88). The professional incentives for community pharmacists to provide preventive health services are stronger than the economic incentives in the majority of cases. Pharmacists actively promoting wellness and showing genuine and rational concern for patients, will attract visibility and elevated esteem from patients, peers, and other health professionals (12: p.25).

An additional issue likely to cause tension is the existing stratification of health care occupations, which "is a major variable in determining the roles or patterns of behaviour of the occupants of the system (89: p.157). According to Dunphy et al., "the entrance of pharmacists to the group practice or institution setting as primary care providers probably derives from physicians as gatekeepers to the functions performed. If pharmacists are not viewed as contributing to the care that physicians provide in the setting or are not viewed by the institution as cost-effective in filling needs, there is likely to be no primary care role for pharmacists. The acceptability by patients is also likely to derive from the pharmacist's association with physicians and institutions which are viewed by patients as having sanctioned the pharmacist's activities" (5: p.56).

The adoption of primary health care and the multidisciplinary teams associated with it, represent the changing philosophy and structure of the new health system in South

Africa. It is vital to take cognisance of the fact that these changes are taking place with existing health personnel, who went through the traditional channels of professional socialisation, experienced their working environment under the previous structures and who reflect the 'old' philosophy. It is, therefore, reasonable to expect "role stress" (90) associated with the increased rate of social change in the health sector. Contributing to the problem is the fact that the primary health care role of the pharmacist as a health generalist is poorly perceived and underdeveloped by community practitioners and is not emphasised in training (91).

The future of the pharmacist's role in primary health care relies to a great extent on perception of other health professionals as well as the "willingness and initiative of the pharmacist to become more actively involved as a member of the primary health care team" (92: p.173). This may be facilitated by changes in pharmacy undergraduate education and greater involvement in suitable postgraduate education programmes. The need for ongoing professional socialisation is highlighted by Lum (93). It is thus proposed to include primary health care training and emphasis on multidisciplinary training as part of this process. Leininger (94) discusses the movement in the USA toward the development and implementation of multidisciplinary professional health education programs within university settings. However, she makes it clear that "there are problems about role definition, role practice, education and professional norms"; in particular, "there are urgent problems related to the need to clarify the role expectations of the various health professions practitioners so that their potential

contributions can be recognised and used appropriately" (p.268-269).

The means to overcome some of the difficulties mentioned is to develop models of primary health centres. Dunphy et al. (5) claim that, traditionally, pharmacy schools have played an important part in the development of role models in the area of primary care. These models seldom deal with the financial aspects and adaptability required in the "real world", which gives them the relative freedom to explore possible functions and identify needed competencies, which can be applied later into emerging systems for delivering care. Another advantage of these models has come through the exposure of students to clinical experience. By working together with other health professionals in providing team care, students acquire a broader appreciation for all of the patient's primary health care needs. This exposes medical and nursing students to the capabilities of pharmacy students, as well as to their own capabilities in providing primary health care. It thus increases the likelihood of producing physicians more willing to consider expanded roles for pharmacists as well as pharmacists who are encouraged to become more involved. A useful educational example in this direction is provided by Poirier et al. in their description of pharmacy in interprofessional training, where the primary goal of the course is "to foster a climate for greater cooperation and sympathy among the various health professions ... through the examination of the team concept in health care" (95: p. 133).

As demonstrated in this study, although clarity traditionally exists with regard to the

boundaries of professional task domains, it would appear that the growing emphasis on PHC and team work has tended to obfuscate them and imply 'vacancies' in jurisdiction. Universally, but in South Africa in particular, pharmacy as a profession in transition in search of greater responsibilities, recognises this as an opportunity to redefine its role within this framework.

Community pharmacists represent an existing network of health care providers. They are traditionally noted for well-developed bonds of trust with their clients (96). The opportunity to extend and enhance the role of the pharmacist represents a potentially critical link in achieving a low cost, yet effective means of providing primary health care where community pharmacists are available. It has been predicted that "many pharmacies ... will evolve into health centers, employing a full cadre of health professionals" (97: p.431). The current trends in the transformation of health care in South Africa have the potential to make it a reality, provided that the obstacles outlined in this paper are appropriately dealt with.

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The issues raised in this chapter will be drawn together and discussed in the concluding chapter.

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GENERAL CONCLUSION

Note: The mode of submission of this thesis was as nine independent manuscripts, each of them with a separate section of **discussion and conclusion**, which focussed on the specific issues raised in **each manuscript**.

This section aims to:

- review the focus and findings in each of them;
- identify emerging problems and concerns for further discussion; and
- offer a broad synthesis of the thesis as a whole.

In the section which follows the **"way forward"** is highlighted and areas for further research identified.

In this thesis the **present and future role of community pharmacy** is explored, taking into account universal debates regarding the role of pharmacy, the rise of the **new public health** movement as well as the unique South African circumstances. A research strategy combining various qualitative as well as quantitative methods has been employed in order to gain a better insight into the complex phenomena in question.

The thesis begins with an examination of changes that have occurred in society, health and medicine leading to the formulation of the socio-environmental model of health and disease. The development of public health and primary health care with its links to sociology are discussed subsequently, drawing on international examples as well as focusing on its history in South Africa. The **"New Public Health"** in South Africa and the potential role Sociology can play in its research, training and practice are dealt with at this stage.

As a multidisciplinary field of research, the **'new' public health** is required to be highly adaptive to changing conditions. Therefore one of the main features of public health in the past and today in particular is its dynamic nature, which in turn compels its core disciplines to remain "on the ready". **Sociology** as a discipline in the centre of the study of society and change is therefore well situated to contribute to this necessary feature of constant adjustability and adaptability to changing circumstances. This is particularly relevant to South Africa as a society

in transition. It is conspicuous that sociology can and has been making a contribution to public health. The very definition of public health research involves an effort to achieve interdisciplinary integration. Although there is great variety in the understanding and implementation of public health, there is wide agreement that the challenges to public health today are as serious, if not more so, than those at the end of the nineteenth century. This is probably more poignant in the South African context.

In this thesis, for the first time, an attempt has been made at utilising the potential of sociological research in an integrated manner in the study of community pharmacy in the context of the new public health in South Africa. What has emerged in this process bears testimony to some of the thorny issues raised in the general discussion about the links between Sociology and the 'new' Public Health.

From a sociological perspective, community pharmacy as a profession in transition is analysed against the background of a society in transition. As mentioned in the introduction, the 'extended' role of the pharmacist and the moves towards "reprofessionalisation" are at the centre of the debate as far as community pharmacy is concerned. Although it is a discussion in which the pharmacy profession worldwide is engaged, it takes on a distinctive meaning in the South African context. This is mainly due to the general background of

inadequate health services and the transition associated with the officially declared emphasis on **Primary Health Care,** the pending changes in legislation, combined with the urgent need to provide basic promotive, preventive and curative services to all people.

Since one of the main functions of the pharmacist is to dispense drugs and receive payments in return, the question of what the major motivator is - the patient's need, or the need for profits - has featured widely in the debate around the **role ambiguity** of the pharmacists. This is at the core of the conflict the community pharmacists find themselves in South Africa. The SAPC and the Pharmaceutical Society of South Africa vigorously encourage pharmacists to gear up towards role expansion, they themselves are willing to do so, but their **"occupational reality"** is incongruent with the envisaged changes. They continue to do what they have always done, mainly dispensing medication prescribed by a doctor or dealing with over the counter (OTC) medications for minor ailments, for a "fee for product", and at the same time trying to make a living in a climate of economic hardships and competition from dispensing doctors and supermarkets. It is clear that the existing reimbursement mechanism, which is based on the sale or dispensing of a drug, is providing little incentive for the pharmacists to engage in patient-orientated services, as expected of them according to the new paradigm. Only when pharmacists are rewarded for providing professional pharmaceutical services, whether or not a drug is sold or dispensed, would they be in a position

to pay greater attention to patient-orientated services as proposed in the paradigm shift towards the extended role of the pharmacist.

Positioning this discussion against the background of an unequal society and the maldistribution of health and pharmaceutical resources (Chapter II), raises serious doubts with regard to its relevance in the SA context, and the ability of community pharmacy to transform itself to be able to play the role envisaged by the SAPC.

The maldistribution of community pharmacies in SA as highlighted in Chapter II, presents a paradox. On one hand, although being the main source of medicines for consumers in the private sector, they are not accessible to the greater section of the population in need. On the other hand, they seem to provide a source of cheap and accessible medical advice to the same people deprived of adequate access to organised health care, mainly in the Central Business Districts, and at the same time they also have the potential to extend their contribution by providing limited primary health care services. This raises another anomaly, since one of the main arguments for the role expansion of community pharmacists is their accessibility which, as demonstrated, in the SA context is of dubious benefit to the majority of the population. It is thus important to reiterate the point that unless a more equitable distribution of community pharmacists is to be achieved, their role expansion will remain of limited value to the provision health services.

The presentation of relevant societal features, and some of the complexities associated with the existing as well as the potential future role of community pharmacy in the context of **changing health services**, leads to the conclusion that the changes in community pharmacy and the role it can play in the provision of Primary Health Care to all the people of South Africa are linked to the greater transition in society and its future health care services.

Following the presentation of the general framework, a more detailed investigation into the nature of the **"Traditional Role"** and **"New Role"** as perceived by the pharmacists themselves is pursued. Tensions in the profession, as reported in the literature, are confirmed in this investigation: on the one hand we have the community pharmacists who perceive themselves mainly as **"health care professionals"**, who would like to see their role expansion followed by more **professional freedom and autonomy**, and who are willing to undergo further training to achieve this goal. On the other hand, however, their occupational reality in South Africa is such that most of their daily activities are within the boundaries of the traditional role for which, consistent with the literature, they are **overtrained and underutilised**, resulting in despondency, frustration and general dissatisfaction with being a community pharmacist. The proposed expansion to the pharmacist's role or **re-professionalisation** is the profession's solution to the problems pharmacists in South Africa are facing. However, barriers in the form of the current fee structure (fee for product), legal restrictions, resistance from

medical practitioners as well as their own admission of inadequate training to fulfil the **"new role"** obstruct the process and prevent them from reaching this goal.

Nevertheless, the process continues and the shift towards **re-professionalisation** is taking the form of making the changes in legislation a reality; adjusting pharmacy curricula in training future pharmacists to fit in with the new vision, as well as retraining existing pharmacists to be able to expand their role. Here, once again it becomes clear that the examination of community pharmacy in South Africa can only be fully understood when done against the background of a **society in transition** - rapid urbanization, the deficiencies and lack of resources in the existing health services and the attempts of the previous government at restructuring of the services with an emphasis on Primary Health Care and the health policy of the new government[1].

The theme of **pharmacists' attempts at role extension** is carried forward in the examination of the **special permit holders**[2] and the proposed amendments to legislation. The rationale behind the attempts to extend the role of the pharmacist in SA, was to fill in the void in the pharmacists' range of activities in order to better utilise their expertise. Associated with it were, on one hand, the need to

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[1] Some of these issues will be further addressed in "The way forward".

[2] Note should be taken that this study included **all pharmacists in SA in possession of the special permit**, most of them in rural areas. Although the response rate to the mail survey was not as high as I had hoped for, in conjunction with all the documentary evidence, it contributed to the general discussion on this topic.

alleviate the doctors' load of dealing with minor ailments and, on the other hand, to provide the consumer with access to a wider range of primary health care services currently not available to them.

This study demonstrates pharmacy's thrust towards an extended and more meaningful role, making a clear distinction between the role extension which grants additional powers to prescribe medications, and that of a wider range of activities. It seems that the transition towards embracing additional professional tasks within the pharmacy, either by the pharmacist or with the assistance of a nurse, is relatively smooth and is gaining momentum, with no serious resistance from the medical profession. An explanation for the lack of conflict here might be provided by the fact that these tasks have been neglected by the medical profession, and are not considered to be their exclusive domain[3]. This is not the case with regard to the extension of discretionary powers to prescribe. It confirms previous claims that the opposition from the medical profession is particularly fierce when it comes to the pharmacist's ability to prescribe. Permitting pharmacists to prescribe, as proposed in the changes to legislation, automatically grants them the ability to diagnose patients, and this right is at the centre of the battle.

[3] This point is further developed in the analysis of the therapeutic alliance between the nurse and the pharmacist.

The successful granting of special permits to a selected group of pharmacists to practise an extended role can be explained by the fact that it has been restricted to **rural, under-served areas**. The developments to date signify a partial success by the pharmacy profession in efforts towards role extension. However, this is likely to remain limited due to the forces operating against it. Given this context, it is conceivable that the development of **"health centres"** will provide alternative sites for the integration of pharmacists into the health care team. It has the potential to grant the pharmacists the necessary access to patients' records, and to allow a more meaningful interaction with other health professionals, thus facilitating the desired role expansion. At the same time the doctors will retain the authority and responsibility of overall supervision, which can then be interpreted as delegation rather than boundary encroachment or loss of tasks.

From the **public health** perspective, questions such as "who benefits from the services provided by the pharmacist?" and "what is the nature of these services?" are of major importance. Answers to these questions are found in the interviews with the **'users' of the services**, which provide further evidence that community pharmacies are utilised mostly by the White population group. Due to their location, primarily in White residential areas, most of the customers are White females in possession of a doctor's prescription. Thus, with regard to this population, the pharmacist continues to fulfill the limited role of dispenser of medicines. However, a different pattern emerges with regard to the utilisation of

community pharmacies by the Black population. As the study reveals, pharmacies in town and inner-city, mostly poorer areas, tend to have a higher proportion of Black clients. Among those, a higher percentage uses the pharmacist as a medical adviser without prior consultation with a doctor. The general scenario, where large numbers of people have limited access to inefficient public health care services on the one hand, and the availability of pharmacists who are willing to fill in the gaps created by the inability of the state to provide adequate health services on the other hand, is responsible for the reality as exposed in this study. Although the services provided by the pharmacists are not free, they are often cheaper and more accessible than those of medical practitioners.

This study provides further evidence as to the inequity of access to pharmaceutical services through its implication that the very poor people are not represented among the users of community pharmacies. A reflection on the quote that the pharmacist is considered to be the "poor man's doctor" in this context acquires an added significance with regard to the current situation in South Africa. Based on the restricted evidence from this study, pharmacists do not reach most of the 'poor men'; however, for the better off among the poor men, pharmacists manage to fulfil a more extensive role as medical advisers. Considering this reality in the South African context, it would be more accurate to speculate that the pharmacist

is the working Black man's doctor[4].

Pharmacists are consulted mostly on common health problems, primarily because of convenient access. However, due to the general inaccessibility of pharmacies to the majority of the population in South Africa, this necessitates a specific stipulation: only in places where community pharmacies are available, and only for those who can afford their services, do they seem to provide a convenient first port of call for people seeking medical advice or acquisition of medication after consultation with a doctor. This, once again, raises the question whether the role expansion of community pharmacists will have an impact on the nature of health care available to most of the people.

The **training of pharmacists** poses additional problems in the pursuit of reprofessionalisation. Many feel that their training has not been adequate to equip them to fulfil the new activities that would be required of them. In principle, the pharmacists were willing to undergo further training, and some have already done so. This has been strongly advocated and encouraged by the SAPC. However, appropriate training poses serious challenges to all pharmacists as it is extremely difficult to establish a training programme that will meet everyone's needs. The undergraduate curriculum lends itself to easier adaptation than does the training

[4] A more in depth exploration of this issue was beyond the scope of this study, and is one of the areas suggested for further research in "the way forward".

of registered pharmacists. Practising pharmacists not only have different experiences, but there are severe limitations on the amount of time they have to devote to acquisition of new skills. It also raises questions with regard to the feasibility of changing a complete mind-set of practitioners in community pharmacies.

Positioning this discussion against the background of an unequal society and the maldistribution of health and pharmaceutical resources as presented earlier, raises serious doubts with regard to its relevance in the SA context, and the ability of community pharmacy to transform itself to be able to play the role envisaged by the SAPC.

The official professional vision, which lies in the direction of a complete paradigm shift towards an extended role for the pharmacist and maintains that "pharmacy is a profession which should fulfil a socially responsible function and keep abreast of modern developments, and be able to adapt to the changing needs of communities for health care" brings to the fore the significance of the role of training in the process of transforming community pharmacy.

An examination of responses from practising pharmacists, faculty members and final year students reveals that their training is perceived as adequate where the traditional activities were concerned, but its adequateness is questioned when

considering the **new activities**. The data collected provides evidence in support of the existence of a **cycle of confusion and frustration** with the lack of visible transformation in the profession, as alluded to in the literature. Community pharmacy in South Africa is facing uncertain, multiple futures. The **official vision** and desire is of an **"ideal"** scenario where the pharmacist plays an extended role in the provision of primary health care and the occupational reality of most of the community pharmacists is such that they are not in a position to practice pharmacy according to this vision, partially due to **lack of training** as well as to the **structure of the current health care delivery system**. This reality creates an unattractive professional image, which in turn prevents newcomers to the profession from entering community pharmacy as a career of their first choice.

This raises some doubts with regard to the fit between the aspirations of the profession and its reality. It seems that the most obvious and difficult challenge is to translate the professional vision into a reality by effecting **multidimensional changes in pharmacy practice and training as well as education of other health professionals**[5].

Linked to the emphasis on **PHC** and attempts at transformation of community pharmacy, a unique phenomenon of partnership between **nurse and pharmacist** has developed in SA. This **"therapeutic alliance"** allows pharmacists to expand

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[5] This topic is addressed later in this section as way as in "the way forward".

their professional activities without invading the nurses professional domain, while reaping substantial benefits in the process. These include potential increases in profits, enlarging the client base and improving the image of the pharmacy by shifting the focus from a place of disease to a place of health as well as creating the vision of the pharmacist as a team member in providing primary health care. As far as the nurses are concerned, it grants them the possibility to practise their profession in a very convenient set-up and affords them greater professional autonomy. This alliance, although gaining momentum, does not translate at present into a phenomenon of major impact on health care delivery modes and human resource consideration. However, it is important to raise questions with regard to its potential impact on human resources, particularly in the public sector[6].

An additional matter which has emerged in this context is the possibility that this kind of alliance might facilitate the breakdown of professional boundaries, so similar tasks might be performed by different health professions. Although an important aspect to contemplate, this is obviously a topic which requires further investigation which is beyond the scope of this study.

Issues related to professional boundaries and autonomy have surfaced as pivotal in understanding pharmacy's transitional professional status.

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[6] Note should be taken that human resource planning is an important issue to consider in this context. However, a full examination of the implications of the phenomenon discussed, is beyond the scope of this study.

A proclamation by the Governor of the Cape in 1807 which established that dispensing of prescriptions can legally be performed only by the apothecary, has not succeeded in preventing doctors in South Africa from doing it since then. Despite the existence of powerful professional organisations, pharmacists in South Africa have not been able to maintain a monopoly over the one function, about which there is no dispute, that constitutes the core of the pharmacist's role.

The present high number of dispensing doctors exacerbates the battle over professional domains between the two groups. The findings of this study reveal a deep ongoing sense of competition, which is manifest in the form of public debate and continuous attempts to protect professional task domains. Most of the pharmacists interviewed in this study mentioned the dispensing doctor as the main problem facing the community pharmacist in South Africa. Meanwhile, the medical profession, as a united front, is fiercely protecting its "inherent" right to dispense medicines. Within the South African scenario, issues such as occupational task boundaries, 'business' versus 'professional' systems as well as the role of the state[7] have been discussed in relation to professional dominance, jurisdiction and autonomy in an attempt to gain a better insight.

The dominance of the medical profession and its structure of expectations,

[7] The role of the state received attention in this study, however, it seems that only after completion of this study, it came to the fore as a force which is likely to shape the future transformation not only of health care in SA, but the nature and power structure of the various health professions - it is thus suggested as an area for future research in "the way forward".

constituting society's approval, that the they are the main experts in matters of health and illness is emphasised in this analysis. However, the shifts that have occurred in society in relation to health and the subsequent development of the socio-environmental model of health and disease have attenuated this notion. The growth of the **'New Public Health'** movement and the emphasis on Primary Health Care have brought to the fore the ideas that "health care starts with people", and that the people themselves play "a major role in solving multi-faceted health problems". Theoretically, this framework provides a context where the hegemony of medicine is likely to diminish[8].

The current scenario, as presented in this paper, deals with a bid by pharmacy in South Africa to emulate what has been, historically and universally, successfully done by medicine: namely, gaining control over what they consider to be their **professional jurisdiction[9].**

During this transitionary period of fluid policies, the predictions tend to be that that a **"negotiated settlement"**will be reached. In other words, pharmacists will ease up on their attempts to trespass on 'sacred' clinical activities such **diagnosing and prescribing,** in return for doctors' agreement not to trespass on core

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[8] The latest legislation curtailing the granting of licenses to dispensing doctors (which took effect after the study was completed) bears testimony to this envisaged trend.

[9] The fact that the legislation with regard to the granting of licenses to dispensing doctors has been approved (after the completion of this study) provides the necessary evidence that, at least in the short term, they have been successful in their endeavour.

pharmaceutical activities such as **dispensing.** The latest unfolding of events with regard to legislation which curtails the granting of licenses to dispensing doctors, bears testimony to the above.

The fact that the structure of health care delivery in South Africa is most likely to develop toward more **'group practice'** and **'managed care'** is bound to aid this process, since in such a system of anticipated interdisciplinary cooperation, the advantages of separating prescribing and dispensing may be less relevant .

Finally, one could speculate that the emphasis on **PHC** and the **multidisciplinarity** it implies, as well as other countervailing forces, have the potential to act as a force towards the erosion of rigid boundaries of professional jurisdictions. However, as mentioned earlier with regard to the therapeutic alliance with the nurse, this requires further research, which lies well beyond the scope of this study.

The ability and willingness of the community pharmacists to join the **Primary Health Care Team** on one hand and the willingness of doctors and nurses to accept them on the other, are the keys to their successful integration. It is for this reason that **perceptions of pharmacists, doctors and nurses** on this matter were sought, revealing a scenario where pharmacists are eager to engage in PHC activities, whereas nurses and doctors are more cautious in their support. Although

they see them as health professionals, and are of the opinion that they should play a part in the PHC team, doctors and nurses strongly protect their own domains when it comes to the allocation of potential tasks. This raises some difficulties with regard to the effective implementation of PHC. As demonstrated in this study, although clarity traditionally exists with regard to the boundaries of professional task domains, it would appear that the growing emphasis on PHC and team work has tended to obfuscate them and imply **'vacancies' in jurisdiction**. Universally, but in South Africa in particular, pharmacy as a profession in transition in search of greater responsibilities, recognises this as an opportunity to redefine its role within this framework.

The adoption of primary health care and the multidisciplinary teams associated with it, represent the changing philosophy and structure of the new health system in South Africa. It is vital to take cognisance of the fact that these changes are taking place with existing health personnel, who went through the traditional channels of professional socialisation, experienced their working environment under the previous structures and who reflect the 'old' philosophy. It is, therefore, reasonable to expect **"role stress"** associated with the increased rate of social change in the health sector. Contributing to the problem is the fact that the primary health care role of the pharmacist as a health generalist is poorly perceived and underdeveloped by community practitioners and is not emphasised in training.

Finally, in theory, the move towards the **'extended role'** sounds positive, in that it will allow the pharmacist to provide a more comprehensive professional health service to the masses. It falls into the essential and long overdue theme of **Primary Health Care** and gives legitimacy to statements that community pharmacy delivers a good health-care service to the public. In reality, however, there are serious barriers to the implementation of the changes, such as the existing restrictive legislation, current mode of reimbursement, public perceptions, economic demands and attitudes of other health professionals.

The most serious encumbrance is the fact that most community pharmacies are not easily accessible for the majority of the population due to their concentration in urban areas. This reality makes it difficult to consider them as sources of adequate primary health care delivery for the population at large. At the same time, a legitimate question in the South African context is whether the pharmacist is the most appropriate health-care worker to be trained in the future to deliver this kind of care[10].

Despite the problems mentioned and discussed at length in each of the manuscripts, the possibility of extending and enhancing the role of the pharmacist represents a potentially critical link in achieving a low cost, yet effective means

[10] The Human Resources for Health Committee (1995) in its unpublished document, dealt with some of these questions.

of providing primary health care in places where community pharmacists are available. The current trends in the transformation of health care in South Africa have the potential to make it a reality, provided that the obstacles outlined in this thesis are appropriately dealt with.

Lastly, the significance of this thesis lies in its attempts to cross disciplinary boundaries in order to produce a **comprehensive analysis of the present and future role of community pharmacy in South Africa**, using data from national as well as Johannesburg sources. It provides, for the first time in SA, an examination of the complexities of the forces operating within the professional as well as the inter-professional health arena against the background of a society in transition. It is my hope that by doing so, it has succeeded in further contributing to the available body of knowledge as well as breaking new ground, informing future policies and stimulating further research.

THE WAY FORWARD

"NEW PUBLIC HEALTH" IN SOUTH AFRICA - WHERE DOES COMMUNITY PHARMACY FIT IN?

One of the main questions which has emerged in the course of this research concerns the position of community pharmacy in the context of the new public health. To a certain degree, this thesis has put this question forward and has attempted to deal with it. However, some of the issues which have surfaced lie beyond the scope of this thesis. Addressing this question in a more comprehensive manner will, therefore, require further research in the following areas:

1. Utilisation patterns of community pharmacies

The current findings indicate that the Black sample of users of community pharmacies in this study is not representative of the total Black population in South Africa. Based on this, one can speculate that those among the Blacks who use the community pharmacies in Johannesburg constitute a selected group of the population who, relative to the rest of the Black population, enjoys access to greater resources and services. Therefore, it seems that the poor and unemployed are two groups that need to be further investigated in this context. A rough conjecture would be that they are the ones for whom the existing pharmacies and pharmaceutical services are out of reach.

This study has concentrated on utilisation patterns of community pharmacies in Johannesburg, an urban area. To complete the national picture, a similar study of rural pharmacies would be necessary. Although this study has engaged in a typology of pharmacies and their utilisation patterns, answering some of the questions raised from the public health perspective will require further research and investigation.

2. The place of the profession in the District Health System

The establishment of a new democratic government in 1994 has granted South Africa the unique opportunity of restructuring its health sector. During this period a number of macro-level policies of significance to pharmacy have been developed by the Department of Health, including those dealing with the implementation of a National Health Insurance system, the District Health System and, finally, the National Drug Policy.

A study dealing with the above policy issues and focusing particularly on the implementation of the DHS and the role pharmacy will play in its context, is an additional area for future research ensuing from the more general findings of this thesis.

3. The integration of pharmacists into health care teams

The analysis produced in this thesis has predicted that the development of Primary Health Care Centres in one form or another, has the potential to facilitate greater integration of pharmacists in health care teams. Of great importance to public health would be future research which will further probe this prediction and its implications.

4. Hierarchies among the health professionals

The relative power relations among health professionals is not a new topic. However, as has emerged in this thesis, it acquires new dimensions in the new, restructured health services. The emphasis on PHC and the rise of the NPH imply the shifting of resources from the traditionally powerful areas of tertiary and secondary health care to the primary, less powerful level. Does it also indicate a future shifting of power? In addition, will the restructuring affect the existing health hierarchies as well as the hierarchies among the health professionals? It seems that the current thesis has acted as the catalyst to pursue some of these questions further.

5. The role of the State in determining professional boundaries and hegemony

As stated earlier, the aim of this thesis has not been to produce a full sociological analysis of community pharmacy as a profession. However, it has raised some weighty issues related to professional boundaries and hegemony. This is of special relevance in South Africa due to the transformation taking place and, in particular, the role of the State in this process, which seems to come to the fore as a force to be reckoned with in its attempts to transform health services as well as the nature of health professionals. Thus, further research would be of great value on the theoretical level as well as on the practical one as an informer of policy.

6. Public health pharmacists

According to the American Public Health Association (1981), "there is no formal group known as public health pharmacists as there are public health physicians and nurses. Nevertheless, there are some pharmacists engaged in public health activities. Many of these pharmacists do not recognize they are doing public health work" (p.213). A similar situation is apparent in South Africa. It would therefore be of great benefit to explore this phenomenon further, and in particular to monitor how this will be changing with the restructuring of the health services.

7. Towards a shift in terminology

This thesis, in an innovative manner, attempted to link the discussion on community pharmacy to public health. However, traditionally, the lack of association between them is evident in the terminology available or, more precisely, the lack of it. In the same manner that there are no public health pharmacists, there is no mention of "community pharmacy" or "public health pharmacy" in a similar context to its equivalent of "community medicine" or "public health medicine". To effect a change in the role of pharmacy in public health, a shift in terminology is therefore imperative parallel to the emergence of the discipline. At the same time, once the profession begins to fully engage in public health issues on the macro level, and transforms as envisaged, the existence of **"Community Pharmacy"** as a professional and conceptual entity will indeed become a reality.

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APPENDIX I

QUESTIONNAIRES

A STUDY OF COMMUNITY PHARMACY

This interview is part of a study into the role of "Community Pharmacy" in South Africa. The aim of the study is to explore the existing role and the factors that shape it, as well as the potential role of community pharmacists in the provision of health care in the future. This study is being carried out in the Department of Sociology, University of the Witwatersrand and is supported by a grant from the Centre for Science Development (CSD).

Your pharmacy has been included in the sample of pharmacies in Johannesburg through a process of random selection.

It will be of great help to us if you could answer as honestly and as accurately as possible. This will, hopefully, enable us to produce a worthwhile study that can be of benefit to the profession as well as to the health provision in South Africa.

Some of the questions will require information about your background as well as about your patients/clients. We would like to know what you do and in some cases what you would like to do; how you feel with regard to your training and its appropriateness to what you do and what you can do in the future; as well as what kind of changes you envisage and would like to recommend.

We would greatly appreciate your cooperation.

Leah Gilbert
Department of Sociology
University of the Witwatersrand, Johannesburg.

A. GENERAL INFORMATION:

Name of interviewer:

Date of interview:

Name and address of Pharmacy:

Name of pharmacist interviewed:

B. DESCRIPTION OF PHARMACY: (*based on observation and JHB statistics, consultation with pharmacist*)

1. Type of pharmacy:

1. Town/city - casual clients
2. residential innercity - mainly regular clients
3. residential suburb/neighbourhood - regular clients
4. shopping centre
5. other:

2. Area where pharmacy is situated: (*give a short description*)

3. Structure of pharmacy:(*describe the layout and facilities*)

4. Labour division: (***who*** *works* ***in the pharmacy*** *and* ***how is the work*** *divided/* ***who*** *does what- observe and* ***ask for information)***

B. DEMOGRAPHIC DATA of PHARMACIST:(*part of the interview*)

5. Gender:

1. male

2. female

6. Age:.....

7. Year of qualification:.....

8. Institution where qualified:.....

9. Other useful information:(*anything else that might be of use to the study)*

.....

.....

C. INFORMATION with regard to CLIENTS/PATIENTS

As this section aims to examine the nature of the pharmacist's clientele, it will be useful to gain accurate information. Since it is not always possible an estimate will suffice.

10. Number of patients per day:(*average/estimate*).....

11. What is the proportion of patients: (*rough percentages*)

1. with a doctor's prescription?.....

2. without a doctor's prescription?.....

3. other?.....

12. What is the racial distribution of patients? (*rough percentages*)

1. White:.....

2. Indian:.....

3. Coloured:.....

4. Black:.....

13. What is the gender distribution of patients? (*rough percentages*)

1. male:.....

2. female: .....

14. What is the age distribution of patients? (*rough percentages*)

1. babies, young children:.....

2. adolescents, young adults:.....

3. adults:.....

4. elderly:.....

15. What percentage of the patients are on medical aid? (*rough percentages*)

.....

16. What is the range of health problems of the patients that come to you first (without prescription)?

Please mention them in order from 1(the most common) to 8(least common)

1.....

2.....

3.....

4.....

5.....

6.....

7.....

Would you like to add anything to this topic: patients' problems and complaints?

.....

.....

.....

.....

27. Do you refer any patients to other health professionals?

1. yes, specify.....

2. No, why? specify.....

28. What percentage of the patients without prescription do you refer to other health professionals?(*rough percentages*)

1. General Practitioner (G.P.):.....

2. Clinical psychologist/Psychiatrist:.....

3. Social worker:.....

4. Hospital:.....

5. Other:.....

Any additional information on the topic of referral to other health professionals.

.....

.....

.....

D. THE ROLE OF THE PHARMACIST

This section deals with the role of the pharmacist, present and future.

29.The pharmacist's role consists of many components. In your opinion

"What is a Pharmacist?"

Rank the following role components from 1 to 8 in order of importance.

Health care professional.....

health educator.....

clinician.....

manager.....

businessman.....

scientist.....

technician.....

38. The following is a list of possible activities of a community pharmacist. We would like to know to what extent you as a community pharmacist engage in the following activities?

(Read each activity and assign the appropriate answer to it, based on these categories:)

1. (a lot) most of the time
2. very often
3. not so often
4. seldom
5. very seldom*
6. not at all *

*(*if the answer falls in this category (5 or 6) ask why and then classify the answer accordingly next to the item or just write it in and classify later .)*

1. legal reason - I am not allowed to do it by law
2. financial reason - it does not pay me to do it
3. there is no demand for it
4. insufficient training - I don't feel qualified to do it
5. other.....

39. dispense drugs according to a doctor's prescription.....

40. counsel patients about the prescribed drug.....

41. discuss the prescription with the doctor.....

42. manage pharmacy (eg. finances, personnel, purchasing etc.).....

43. counsel patients about over the counter (OTC) drugs.....

44. sell over the counter (OTC) drugs.....

45. advise patients with regard to their personal health.....

46. assess the patient's problem and refer to other health professionals.....

47. provide drug information to other health professionals .....

48. educate consumers (STD, diet etc.).....

49. blood pressure monitoring.....

50. cholesterol testing/monitoring.....

51. glucose testing/monitoring .....

52. train home care patients (eg. stoma care or peritoneal dialysis).....

53. monitor drug therapy of chronic patients .....

54. prescribe in case of acute illness (eg. antibiotics).....

55. order laboratory tests.....

56. immunisation.....

57. developmental screening (for babies).....

58. administer injections.....

59. prescribe/administer contraceptives.....

60. attend to emergencies/casualties.....

61. participate in health promotion programmes in the community.....

.....

.....

Think about your training against the work you currently do as a pharmacist. What would your response be to the following statements: *(specify where possible)*

62. My training was most appropriate to what I do as a pharmacist.

1. correct:.....

2.incorrect:.....

3. other:.....

63. I have learned a lot of things which I do not need to perform my professional role.

1. correct:.....

2. incorrect:.....

3. other:.....

64. There are areas missing in my training which are important to what I do.

1. correct:.....

2. incorrect:.....

3. other:.....

67. I think that the following should be included in the training of pharmacists in the future:

.....

.....

Have you been <u>adequately trained</u> to carry out the following activities?

*(Read **each item** again and assign the appropriate **answer to it**, based on **the** following categories.)*

1. yes, most adequately
2. yes, adequately
3. I am not sure
4. no, not adequately*
5. no, not at all*

(If the answer is 4 or 5 ask why and write/specify next to item.)

68. dispense drugs according to a doctor's prescription.....

69. counsel patients about the prescribed drug.....

70. discuss the prescription with the doctor.....

71. manage pharmacy (eg. finances, personnel, purchasing etc.).....

72. counsel patients about over the counter (OTC) drugs.....

73. sell over the counter (OTC) drugs.....

74. advise patients with regard to their personal health.....

75. assess the patient's problem and refer to other health professionals.....

76. provide drug information to other health professionals .....

77. educate consumers (STD, diet etc.).....

78. blood pressure monitoring.....

79. cholesterol testing/monitoring.....

80. glucose testing/monitoring .....

81. train home care patients (eg. stoma care or peritoneal dialysis).....

82. monitor drug therapy of chronic patients .....

83. prescribe in case of acute illness (eg. antibiotics).....

84. order laboratory tests.....

85. immunisation.....

86. developmental screening (for babies).....

87. administer injections.....

88. prescribe/administer contraceptives.....

89. participate in health promotion programmes in the community.....

90. attend to emergencies/casualties.....

91.Is the way your pharmacy is built/structured convenient to perform MOST of the activities mentioned earlier?

1. yes
2. no, why?, specify.....

What changes would you recommend?

.....

.....

92.Does the current "health structure" encourage you to perform these various activities?

1.yes
2.no, why?, specify.....

What changes would you recommend?

.....

.....

93.Is the legal position such that you can perform most of activities?

1. yes
2.no, why? specify.....

What changes would you like to recommend?

.....

.....

E. CONTACT WITH OTHER HEALTH PROFESSIONALS

We would like to know how much contact you have with other health professionals. PLEASE answer as fully as possible:

(probe for answers - frequency: every day, every week, every month, very seldom.....)

94. General Practitioner:

1. frequency:.....

2. nature of contact:.....

3. who usually initiates the contact?.....

95. Specialist:

1. frequency:.....

2. nature of contact:.....

3. who usually initiates the contact?.....

96. Nurse:

1. frequency:.....

2. nature of contact:.....

3. who usually initiates the contact?.....

97. Dentist:

1. frequency:.....

2. nature of contact:.....

3. who usually initiates the contact?.....

98. Social worker:

1. frequency:.....

2. nature of contact:.....

3. who usually initiates the contact?.....

99. Physiotherapist/Occupational therapist:

1. frequency:.....

2. nature of contact:.....

3. who usually initiates the contact?.....

100. Staff of institutions - old age homes or other:

1. frequency:.....

2. nature of contact:.....

3. who usually initiates the contact?.....

101. Would you like to have more contact with other health professionals?

1. yes, why? specify.....

2. no, why? specify.....

102. In your opinion, is there a need for private counselling areas in a community pharmacy?

1. yes, why? specify.....

2. no, why? specify.....

103. What is your opinion about the incorporation of a NURSE into the practice of community pharmacists?

.....

.....

Anything else on this topic?

.....

.....

.....

F. CHANGES IN THE PROFESSION

104. Are you familiar with the proposed changes in legislation?

1. yes
2. no

105. Are you in favour of the changes?

1. yes, why?.....

.....

.....

2. no, why?.....

.....

106. Would you be prepared to undergo further training to extend your current activities?

1. yes, why?.....

2. no, why?.....

107. How do you envisage the role of the pharmacist in the future health care system in South Africa?

.....

.....

.....

.....

.....

.....

Thank you again for your cooperation.

A STUDY OF COMMUNITY PHARMACY - USER'S QUESTIONNAIRE

This questionnaire is part of a study into the role of "Community Pharmacy" in South Africa. The study is being carried out in the Department of Sociology, University of the Witwatersrand and one of its aims is to find out who makes use of the services offered by the pharmacists and for what purposes. Your cooperation is therefore of utmost importance and we would greatly appreciate it.

Leah Gilbert
Department of Sociology
University of the Witwatersrand, Johannesburg.

Circle the appropriate answer

1. What was the purpose of your visit to the pharmacist?

1. To get medicine/s - I had a doctor's prescription.
2. To buy medicine/s - without a doctor's prescription.
3. To ask the pharmacist for advice.

2. What was the nature of the problem?.....

3. What was/were the reason/s that made you decide to come to the pharmacist?

.....

4. Are you visiting this pharmacist on a regular basis?

1. yes, always when I have a doctor's prescription.
2. yes, always when I need advice.
3. yes, quite often.
4. no.

5. Are you on Medical Aid?

1. yes
2. no

6. Do you.....?

1. live in this area.
2. work in this area.
3. usually shop in this area.

7. Do you have a family doctor?

1. yes
2. no

8. Are you satisfied with the service received?

1. yes
2. no, why?.....

Thank you for your cooperation.

This section should be filled in by the interviewer after the interview.

9. Name and address of pharmacy:

10. Gender of client:

1. male
2. female

11. Age group of client:

1. adolescent, young adult
2. adult
3. elderly
4. advice or treatment sought was for baby/young child.

13. Race of client:

1. White
2. Indian
3. Coloured
4. Black

General comments about the interaction between client and pharmacist:

.....

.....

.....

Was the client referred to another health professional?.....

Other comments.....

.....

Name of interviewer:.....

No:.....

A STUDY OF COMMUNITY PHARMACY - Section 22A(12) Permit

Please circle the suitable answer or fill in the appropriate information where required.

1. Gender:

1. male
2. female

2. Year of qualification:.....

3. Institution where qualified:.....

As the following section aims to examine the nature of your clientele, it will be useful to gain accurate information. Since it is not always possible, if you provide us with an estimate it will suffice.

4. Number of patients per day:(*average/estimate*).....

5. What is the proportion of patients: (*rough percentages*)

1. with a doctor's prescription?.....

2. without a doctor's prescription?.....

3. other?.....

4. What is the racial distribution of patients? (*rough percentages*)

1. White:.....

2. Indian:.....

3. Coloured:.....

4. Black:.....

5. What is the gender distribution of patients? (*rough percentages*)

1. male:.....

2. female: .....

6. What is the range of health problems of the patients that come to you first (without prescription)?

Please mention them in order from 1(the most common) to 5(least common)

1.....

2.....

3.....

4.....

5.....

7. Do you refer any patients to other health professionals?

1. yes, specify.....

2. No, why? specify.....

8. What percentage of the patients without prescription do you refer to other health professionals?(*rough percentages*)

1. General Practitioner (G.P.):.....

2. Clinical psychologist/Psychiatrist:.....

3. Social worker:.....

4. Hospital:.....

5. Other:.....

The following section deals with the role of the pharmacist, present and future.

9.The pharmacist's role consists of many components. In your opinion "What is a Pharmacist?"

Rank the following role components from 1 to 7 in order of importance.

Health care professional.....

health educator.....

clinician.....

manager.....

businessman.....

scientist.....

technician.....

The following is a list of possible activities of a community pharmacist. We would like to know to what extent you as a community pharmacist engage in the following activities?

(Read each activity and assign the appropriate answer to it, based on these categories:)

1. (a lot) most of the time
2. very often
3. not so often
4. seldom
5. very seldom*
6. not at all *

if the answer falls in this category (5 or 6) specify why it is so.

10. dispense drugs according to a doctor's prescription.....

11. counsel patients about the prescribed drug.....

12. discuss the prescription with the doctor.....

13. manage pharmacy (eg. finances, personnel, purchasing etc.).....

14. counsel patients about over the counter (OTC) drugs.....

15. sell over the counter (OTC) drugs.....

16. advise patients with regard to their personal health.....

17. assess the patient's problem and refer to other health professionals.....

18. provide drug information to other health professionals .....

19. educate consumers (STD, diet etc.).....

20.*blood pressure monitoring.....

21. *cholesterol testing/monitoring.....

22. *glucose testing/monitoring .....

23. *train home care patients (eg. stoma care or peritoneal dialysis).....

24. *monitor drug therapy of chronic patients .....

25. *prescribe in case of acute illness (eg. antibiotics).....

26. *order laboratory tests.....

27. *immunisation.....

28. *developmental screening (for babies).....

29. *administer injections.....

30. *prescribe/administer contraceptives.....

31. attend to emergencies/casualties.....

32. *participate in health promotion programmes in the community.....

33.Is the way your pharmacy is built/structured convenient to perform MOST of the activities mentioned earlier?

1. yes
2. no, why?, specify.....

What changes to the structure of the pharmacy would you recommend?

.....

.....

34.Does the current "health structure" encourage you to perform these various activities?

1.yes
2.no, why?, specify.....

What changes to the "health structure" would you recommend?

.....

.....

We would like to know how much contact you have with other health professionals. PLEASE indicate your answer with an X:

Health professional	Frequency of contact			
	every day	once a week	once a month	less than that
General practitioner				
Specialist				
Nurse				
Other.....				

38. Would you like to have more contact with other health professionals?

1. yes, why? specify.....

2. no, why? specify.....

39. Do you feel that you have enough information about you patients health status?

1. Yes, explain where you get it from:.....

2. No, why?.....

40. What, in your opinion, could be done to give you access to more information about the patients?

.....

41. Do you have a private counselling area in your pharmacy?
1. yes
2. no, why? specify.....

42. Do you have a nurse working in your pharmacy?
1. yes
2. no, why? specify.....

43. What is your opinion about the incorporation of a NURSE into the practice of community pharmacists?

.....

44. In your opinion, should all pharmacists be given the opportunity to practice pharmacy as provided according to your permit?

1. yes, why?.....
2. no, why?.....

45. How do you envisage the role of the pharmacist in the future health care system in South Africa?

.....

.....

.....

46. What are the major <u>problems</u> and <u>challenges</u> facing pharmacy in South Africa?

.....

.....

.....

Thank you again for your cooperation.

Leah Gilbert
Senior lecturer
Department of Sociology
University of the Witwatersrand, Johannesburg.

No:.....

A STUDY OF NURSES IN COMMUNITY PHARMACY

This interview is part of a study into the role of "Community Pharmacy" in South Africa. The aim of the study is to explore the existing as well as the potential role of community pharmacists in the provision of health care.

The combination of pharmacist and nurse as a "health team" is unique. Learning as much as possible about it, is therefore of utmost importance. It will be of great help if you could answer as honestly and as accurately as possible. This will, hopefully, enable us to produce a worthwhile study that can be of benefit to health care in South Africa.

We would greatly appreciate your cooperation.

Leah Gilbert
Department of Sociology
University of the Witwatersrand, Johannesburg.

A. GENERAL INFORMATION:

Name of interviewer:

Date of interview:

Name and address of Pharmacy:

Name of nurse interviewed:

B. DESCRIPTION OF PHARMACY: *based on observation*

1. Type of pharmacy:

1. Town/city - casual clients
2. residential innercity - mainly regular clients
3. residential suburb/neighbourhood - regular clients
4. shopping centre
5. other:

2. Area where pharmacy is situated: *give a short description*

.....

.....

3. Structure of pharmacy: *describe the layout and facilities*

.....

.....

4. Description of the nurse's location: *where does she consult? how is it related to the dispensary? Is it clearly marked?*

.....

.....

5. For how long has there been a nurse in this pharmacy?.....

C. DEMOGRAPHIC DATA of NURSE:

6. Year of qualification:.....

7. Are you employed by the pharmacist? or independent?.....

8. For how long have you been working in a pharmacy?.....

9. Why did you decide to work in a pharmacy?.....

.....

.....

D. INFORMATION with regard to the NURSE'S CLIENTS/PATIENTS

As this section aims to examine the nature of the nurse's clientele, it will be useful to gain accurate information. Since it is not always possible an estimate will suffice.

10. Number of patients per day:(*average/estimate*).....

11. What is the racial distribution of patients? (*rough percentages*)

1. White:.....

2. Indian:.....

3. Coloured:.....

4. Black:.....

12. What is the gender distribution of patients? (*rough percentages*)

1. male:.....

2. female: .....

13. What is the age distribution of patients? (*rough percentages*)

1. babies, young children:.....

2. adolescents, young adults:.....

3. adults:.....

4. elderly:.....

14. What percentage of the patients are on medical aid? (*rough percentages*).....

15. What is the range of health problems of the patients who come to you ?
ask the nurse to mention them in order from 1(the most common) to 4(least common)

1.....

2.....

3.....

4.....

16. Do the patients come directly to you or after referral?

1. Directly to the nurse

2. Referred by the pharmacist

3. Referred by other health professional, specify.....

4. Referred by somebody else, specify.....

E. NURSE'S ROLE

The following is a list of possible activities of a NURSE in a community pharmacy. We would like to know to what extent you engage in the following activities?

*Read **each activity and assign the appropriate answer to it, based on these categories:***

1. (a lot) most of the time
2. very often
3. not so often
4. seldom
5. very seldom*
6. not at all *

****if the answer falls in this category (5 or 6) ask why and add the answer next to the activity***

17. pregnancy tests.....

19. determination of blood glucose levels.....

20. urine analysis.....

21. immunisation.....

22. lung function tests.....

23. family planning services .....

24. determination of blood pressure.....

25. cholesterol tests.....

26. Other activities, specify.....

27. Do you refer patients to other health professionals?

1. yes, specify.....

2. No, why?.....

F. THE NURSE'S PERCEPTION OF THE ROLE OF THE PHARMACIST

This section deals with the role of the pharmacist as perceived by the nurse.

28.The pharmacist's role consists of many components. In your opinion

"What is a Pharmacist?"

Rank the following role components from 1 to 8 in order of importance.

Health care professional.....

health educator.....

clinician.....

manager.....

businessman.....

scientist.....

technician.....

The following is a list of possible activities of a community pharmacist. We would like to know to what extent, you think it is appropriate and important for a community pharmacist to engage in the following activities?

Read each activity and assign the appropriate answer to it, based on these categories:

1. very appropriate and very important
2. appropriate and important
3. appropriate, but not so important
4. appropriate, but not important at all*
5. completely inappropriate*
if the answer falls in this category (4 or 5) ask why and add next to the activity

29. dispense drugs according to a doctor's prescription.....

30. counsel patients about the prescribed drug.....

31. discuss the prescription with the doctor.....

32. manage pharmacy (eg. finances, personnel, purchasing etc.).....

33. counsel patients about over the counter (OTC) drugs.....

34. sell over the counter (OTC) drugs.....

35. advise patients with regard to their personal health.....

36. assess the patient's problem and refer to other health professionals.....

37. provide drug information to other health professionals .....

38. educate consumers (STD, diet etc.).....

39. *blood pressure monitoring.....

40. *cholesterol testing/monitoring.....

41. *glucose testing/monitoring .....

42. *train home care patients (eg. stoma care or peritoneal dialysis).....

43. *monitor drug therapy of chronic patients .....

44. *prescribe in case of acute illness (eg. antibiotics).....

45. *order laboratory tests.....

46. *immunisation.....

47. *developmental screening (for babies).....

48. *administer injections.....

49. *prescribe/administer contraceptives.....

50. attend to emergencies/casualties.....

51. *participate in health promotion programmes in the community.....

F. A team approach - *this section aims to examine the nurses attitudes towards the collaboration between community pharmacists and registered nurses in the provision of primary health care clinics.*

The following is a list summarising the range of services that could be provided by pharmacists and nurses working in close liaison from pharmacy premises.

Please, indicate next to each activity if, according to your opinion, it should be carried out **1.primarily by the pharmacist**
2.primarily by the nurse
3.it is nether the pharmacist's nor the nurses job, but (*specify*).....

52. health education and promotion.....

53. drug and alcohol abuse prevention.....

54. maternal and children health care.....

55. immunisation.....

56. family planning.....

57. chronic disease management.....

58. various approved screening tests.....

59. emergency medical services.....

60. home health care.....

61. advice on methods of administration of medicines.....

62. advice on storage and safe handling of medicines.....

63. advice on safe and effective use of medicines.....

64. Is the way the pharmacy is built/structured convenient to perform MOST of the activities mentioned earlier?

1. yes
2. no, why?, specify.....

65. What changes would you recommend?

.....

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66. What is your opinion about the incorporation of a NURSE into the practice of community pharmacists? Who benefits the most out of it? (*Nurse, pharmacist, patient, cost etc.)* Problems?

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67. How do you envisage the role of the pharmacist in the future health care system in South Africa?

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Thank you again for your cooperation.

NO:.....

A STUDY OF COMMUNITY PHARMACY - STUDENTS

This questionnaire is part of a study into the role of "Community Pharmacy" in South Africa. The aim of the study is to explore the existing as well as the potential role of community pharmacists in the provision of health care in the future.

Since you will soon become a new member of the profession, it is important to ascertain your opinion on some of the major issues. For this reason it will be of great help if you could answer as honestly and as accurately as possible. This will, hopefully, enable us to produce a worthwhile study that can be of benefit to the profession as well as to health care in South Africa.

We would greatly appreciate your cooperation.

Leah Gilbert
Department of Sociology
University of the Witwatersrand, Johannesburg.

Please note that this questionnaire is anonymous.

Circle the suitable answer or fill in the appropriate information where required.

1. Gender:

1. male
2. female

3. What do you intend to do in your professional career in the next 5 years?

.....

.....

4.To what extent, do you think that community pharmacists refer patients to other health professionals?

1. yes, very often
2. yes, often
3. yes, sometimes
4. very seldom
2. Not at all

5. What, do you think, is the range of health problems of the patients who come to the community pharmacy first (without prescription)? Please mention them in order from 1(the most common) to 5 (least common)

1.....

2.....

3.....

4.....

5.....

6.The COMMUNITY pharmacist's role consists of many components. In your opinion

"What is a COMMUNITY Pharmacist?"

Rank the following role components from 1 to 8 in order of importance.

Health care professional.....

health educator.....

clinician.....

manager.....

businessman.....

scientist.....

technician.....

The following is a list of possible activities of a community pharmacist. We would like to know to what extent YOU THINK that community pharmacists engage in the following activities?

Read each activity and assign the appropriate answer to it, based on these categories:

1. (a lot) most of the time
2. very often
3. not so often
4. seldom
5. very seldom*
6. not at all *

if your answer falls in this category (5 or 6) state why it is so

7. dispense drugs according to a doctor's prescription.....

8. counsel patients about the prescribed drug.....

9. discuss the prescription with the doctor.....

10. manage pharmacy (eg. finances, personnel, purchasing etc.).....

11. counsel patients about over the counter (OTC) drugs.....

12. sell over the counter (OTC) drugs.....

13. advise patients with regard to their personal health.....

14. assess the patient's problem and refer to other health professionals.....

15. provide drug information to other health professionals .....

16. educate consumers (STD, diet etc.).....

17. *blood pressure monitoring.....

18. *cholesterol testing/monitoring.....

19. *glucose testing/monitoring .....

20. *train home care patients (eg. stoma care or peritoneal dialysis).....

21. *monitor drug therapy of chronic patients .....

22. *prescribe in case of acute illness (eg. antibiotics).....

23. *order laboratory tests.....

24. *immunisation.....

25. *developmental screening (for babies).....

26. *administer injections.....

27. *prescribe/administer contraceptives.....

28. attend to emergencies/casualties.....

29. *participate in health promotion programmes in the community.....

Think about your training against the anticipated work as a community pharmacist. What would your response be to the following statements: *(specify where possible)*

30. My training has been most appropriate to what I would expect to do as a community pharmacist.

1. correct:.....
2. incorrect:.....
3. other:.....

31. I have learned a lot of things which I will not need to perform my professional role.

1. correct:.....
2. incorrect:.....
3. other:.....

32. There are areas missing in my training which are important to what a community pharmacist has to do.

1. correct:.....
2. incorrect:.....
3. other:.....

33. I think that the following should be included in the training of pharmacists in the future:

.....

.....

Based on what you know about community pharmacy, do you feel that you have been adequately trained to carry out the following activities?

Read each item again and assign the appropriate answer to it, based on the following categories:

1. yes, most adequately
2. yes, adequately
3. I am not sure
4. no, not adequately*
5. no, not at all*

If the answer is 4 or 5 specify why it is so next to item.

34. dispense drugs according to a doctor's prescription.....

35. counsel patients about the prescribed drug.....

36. discuss the prescription with the doctor.....

37. manage pharmacy (eg. finances, personnel, purchasing etc.).....

38. counsel patients about over the counter (OTC) drugs.....

39. sell over the counter (OTC) drugs.....

40. advise patients with regard to their personal health.....

41. assess the patient's problem and refer to other health professionals.....

42. provide drug information to other health professionals .....

43. educate consumers (STD, diet etc.).....

44. *blood pressure monitoring.....

45. *cholesterol testing/monitoring.....

46. *glucose testing/monitoring .....

47. *train home care patients (eg. stoma care or peritoneal dialysis).....

48. *monitor drug therapy of chronic patients .....

49. *prescribe in case of acute illness (eg. antibiotics).....

50. *order laboratory tests.....

51. *immunisation.....

52. *developmental screening (for babies).....

53. *administer injections.....

54. *prescribe/administer contraceptives.....

55. *participate in health promotion programmes in the community.....

56. attend to emergencies/casualties.....

57. In your opinion, are most community pharmacies built/structured in a convenient manner to perform MOST of the activities mentioned earlier?

1. yes
2. no, why?, specify.....

58. What changes to the structure of the pharmacy would you recommend?

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59. Does the current "health care structure" encourage community pharmacists to perform these various activities?

1. yes
2. no, why?, specify.....

60. What changes to the "health care structure" would you recommend?

.....

.....

61. In your opinion, is there a need for private counselling areas in a community pharmacy?

1. yes, why? specify.....

2. no, why? specify.....

62. What is your opinion about the incorporation of a NURSE into the practice of community pharmacists?

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63. How do you envisage the role of the pharmacist in the future health care system in South Africa?

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64. What are the major problems and challenges facing pharmacy in South Africa?

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65. What is meant by "Primary Care Drug Therapy (PCDT)"?

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66. What is meant by "Pharmaceutical Care"?

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67. Have you seen/read the latest document on National Drug Policy for South Africa?

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Thank you again for your cooperation.

Good luck for your exams and best wishes for your future career.

Department of Sociology

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, WITS 2050, South Africa · Telegrams Uniwits · Telex 4-27125SA · Telephone (011) 716-1111

Dear Doctor,

The attached questionnaire is part of a study into the role of "Community Pharmacy" in South Africa. The aim of the study is to explore the existing as well as the potential role of community pharmacists in the provision of health care in the future and the problems associated with it.

You have received this questionnaire due to the fact that you are registered as a "dispensing doctor". For this reason, it is important for us to learn more about what you do and ascertain your opinions on some of the major issues concerning community pharmacy in South Africa.

It will be of great help if you could answer as honestly and as accurately as possible. This will, hopefully, enable us to produce a worthwhile study that can be of benefit to health care in South Africa.

All the information provided will remain confidential and will be used for research purposes only.

We would greatly appreciate your cooperation in responding to this questionnaire.

Many thanks

Leah Gilbert

Leah Gilbert
Senior lecturer
Department of Sociology
University of the Witwatersrand, Johannesburg.

The University of the Witwatersrand rejects racism and racial segregation. It is committed to non discrimination particularly in the constitution of its student body, in the selection and promotion of its staff and in its administration.

No:.....

A STUDY OF COMMUNITY PHARMACY - Dispensing Doctors

Please circle the suitable answer or fill in the appropriate information where required.

1. Year of qualification:.....

2. For how long have you been in a possession of a license to dispense ?.....

3. Why did you decide to seek this license?.....

.....

4. Are you actively engaged in dispensing medicines?

1. Yes, to all patients
2. Yes, but not to all patients
3. Yes, but only to some patients
4. Very seldom
5. No, why? .....

The following section deals with the role of the pharmacist as perceived by the Doctor.

5.The pharmacist's role consists of many components. In your opinion
"What is a Pharmacist?"

Rank the following role components from 1 to 7 in order of importance.

Health care professional.....

health educator.....

clinician.....

manager.....

businessman.....

scientist.....

technician.....

The following is a list of possible activities of a community pharmacist. We would like to know to what extent, you think it is appropriate and important for a community pharmacist to engage in the following activities?

Read each activity and assign the appropriate answer to it, based on these categories:

1. very appropriate and very important
2. appropriate and important
3. appropriate, but not so important
4. appropriate, but not important at all*
5. completely inappropriate*
if the answer falls in this category (4 or 5) ask why and add next to the activity

6. dispense drugs according to a doctor's prescription.....

7. counsel patients about the prescribed drug.....

8. discuss the prescription with the doctor.....

9. manage pharmacy (eg. finances, personnel, purchasing etc.).....

10. counsel patients about over the counter (OTC) drugs.....

11. sell over the counter (OTC) drugs.....

12. advise patients with regard to their personal health.....

13. assess the patient's problem and refer to other health professionals.....

14. provide drug information to other health professionals .....

15. educate consumers (STD, diet etc.).....

16. *blood pressure monitoring.....

17. *cholesterol testing/monitoring.....

18. *glucose testing/monitoring .....

19. *train home care patients (eg. stoma care or peritoneal dialysis).....

20. *monitor drug therapy of chronic patients .....

21. *prescribe in case of acute illness (eg. antibiotics).....

22. *order laboratory tests.....

23. *immunisation.....

24. *developmental screening (for babies).....

25. *administer injections.....

26. *prescribe/administer contraceptives.....

27. attend to emergencies/casualties.....

28. *participate in health promotion programmes in the community.....

A team approach - *this section aims to examine your attitudes towards the collaboration between* ***community pharmacists*** *and* ***registered nurses*** *in the provision of primary health care clinics.*

The following is a list summarising the range of services that could be provided by pharmacists and nurses working in close liaison from pharmacy premises.

Please, indicate next to each activity if, according to your opinion, it should be carried out **1.**primarily by the pharmacist
2.primarily by the nurse
3.it is neither the pharmacist's nor the nurses job, but (*specify*).....

29. health education and promotion.....

30. drug and alcohol abuse prevention.....

31. maternal and children health care.....

32. immunisation.....

33. family planning.....

34. chronic disease management.....

35. various approved screening tests.....

36. emergency medical services.....

37. home health care.....

38. advice on methods of administration of medicines.....

39. advice on storage and safe handling of medicines.....

40. advice on safe and effective use of medicines.....

41. What is your opinion about the incorporation of a NURSE into the practice of community pharmacists? Who benefits the most out of it? (*Nurse, pharmacist, patient, cost etc.)* **Problems?**

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42. How do you envisage the role of the pharmacist in the future health care system in South Africa?

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Thank you again for your cooperation.

Leah Gilbert
Senior lecturer
Department of Sociology, University of the Witwatersrand, Johannesburg.