Pergamon

Health & Place, Vol. 4, No. 3, pp. 273–285, 1998

Printed in Great Britain
1353-8292/98 $19.00 + 0.00

PII: S1353-8292(98)00020-3

Community pharmacy in South Africa: A changing profession in a society in transition

Leah Gilbert

Department Of Sociology, University Of The Witwatersrand, Johannesburg, Private Bag 3, Wits 2050, South Africa

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, the 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. © **1998 Elsevier Science Ltd. All rights reserved**

Keywords: community pharmacy, South Africa, primary health care

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 (Bush, 1983; Nuffield Foundation Committee of Inquiry, 1986; Edwards, 1987; Pharmaceutical Services Negotiating Committee, 1987), tending to stress the need for "re-professionalisation" (Birnbaum, 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 *et al.*, 1984; HSRC, 1986; Reekie and Scott, 1988; Barron *et al.*, 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 *et al.*, 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 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.

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 between 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)[4]. 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[5].

The current demographic profile has been shaped by racial conflicts over many decades. The data presented in *Figure 1* provide a general picture of the different "population groups" in South Africa.

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 50 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

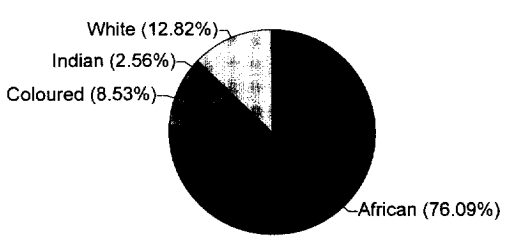

Figure 1. Population groups. Source: Central Statistical Services (1995)

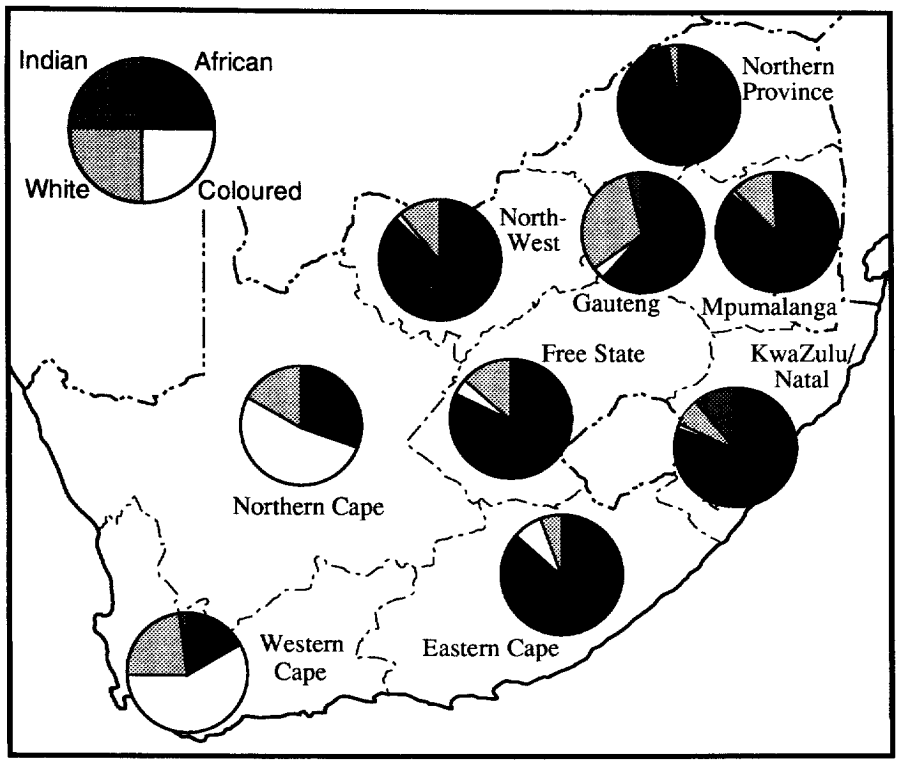

Figure 2. Racial distribution of the provincial population, 1994. Source: Martins *et al.*, Social Profile of the Nine Provinces of South Africa, 1994

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 education 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 2* 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.

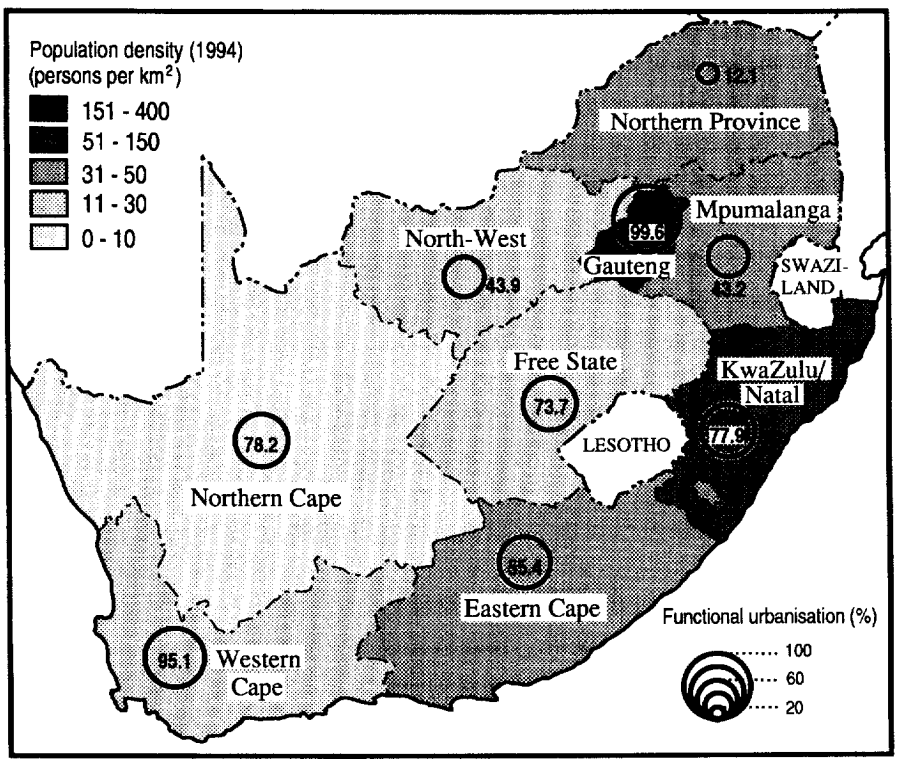

Figure 3. Population density[1] and functional urbanisation[2]. Source: [1]Chimere-Dan in Demographic patterns in South Africa, 1995. [2]Development Bank of South Africa. South Africa's nine provinces: A human development profile, Halfway House (1994)

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 3*.

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 (1994, p. 55) 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 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". 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.

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 4*, 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.

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

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).

An additional dimension of the inequalities outlined is presented in *Figure 5*, 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.

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 10000 population in the magisterial districts sorted by per capita income.

It is distressingly noticeable that the poorer the district's population, the less health workers are

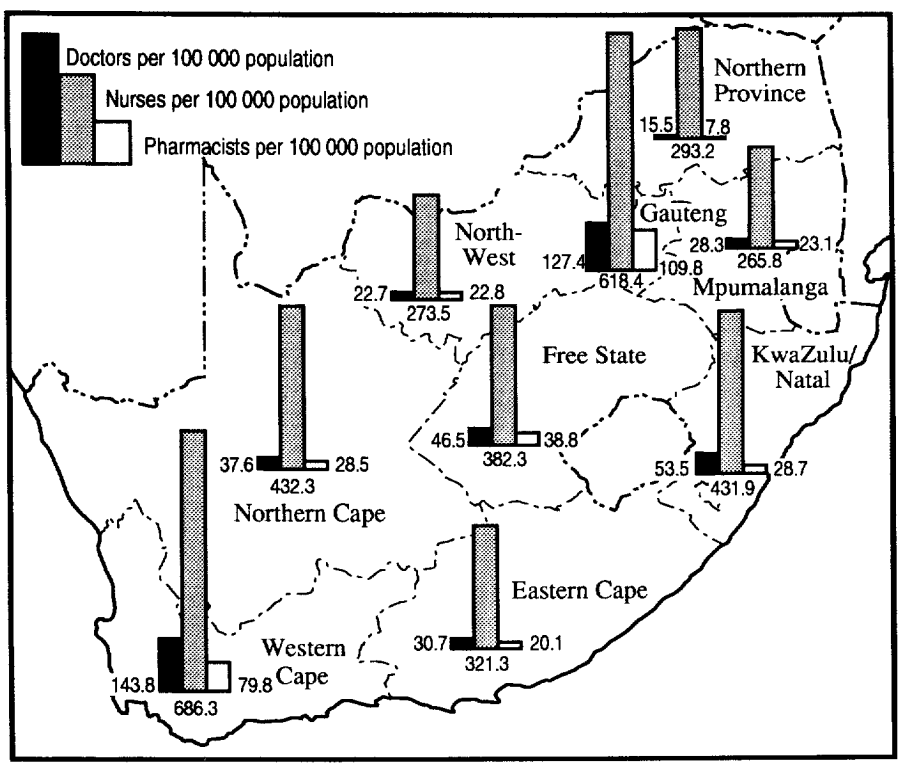

Figure 4. Distribution of health personnel (public and private) between provinces (1992/93). Source: Chetty (1994) and Development Bank of Southern Africa (1994)

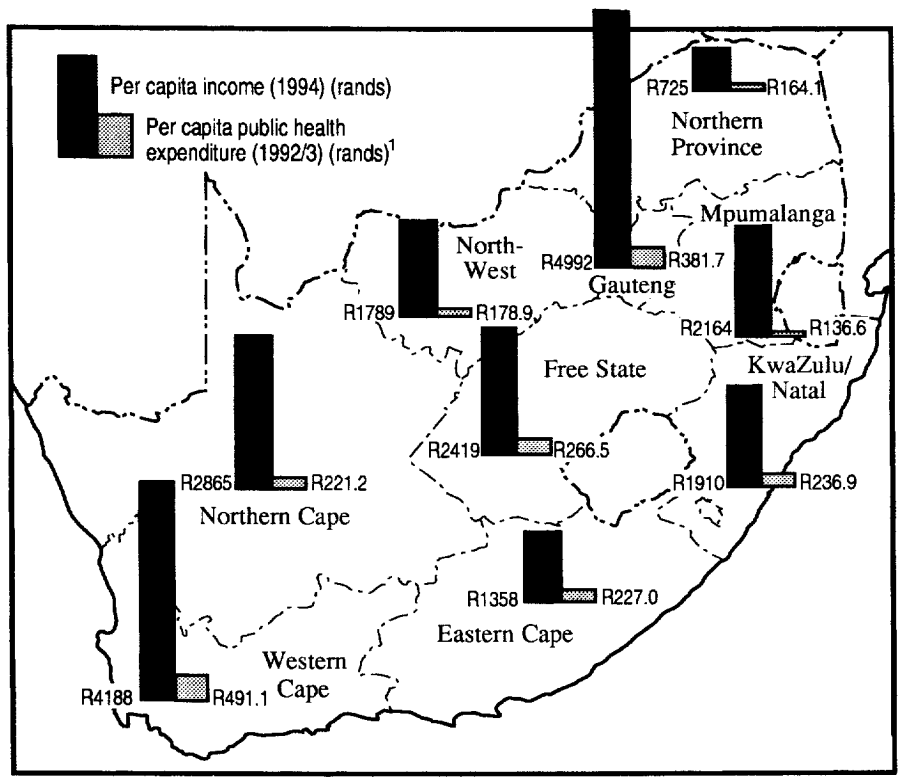

Figure 5. Public health expenditure/per capita income. Source: ReHMIS Survey in Health Expenditure Review. Durban (1995)

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).

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.

Table 3. Pharmacists per population in selected countries

Country	Pharmacists per population
Cameroon (1989)	1:50 000
Canada (1991)	1:1639
Egypt (1991)	1:14 285
France (1989)	1:1101
Korea (1991)	1:1126
South Africa (1995)	**1:3702**
Sweden (1992)	1:2380
UK (1990)	1:1515
US (1993)	1:1500
West Germany (1992)	1:2227
Zimbabwe (1990)	1:33 333

Source: WHO Statistics of Member States (1994) and Overseas Report (1993).

Pharmacists and pharmacies in S.A.

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 between the number of pharmacists per population in selected countries.

Table 3 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 S.A. 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 map in *Figure 6* is an attempt to unpack the general scenario by looking at the number of pharmaceutical establishments per province.

It is apparent that there is a maldistribution of pharmaceutical establishments (*Figure 6*) and pharmacists (*Figure 4*) 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 S.A. reflects the inequalities referred to earlier (Gauteng is the richest province). A similar maldistribution is evident where community pharmacies are concerned (*Table 4*).

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

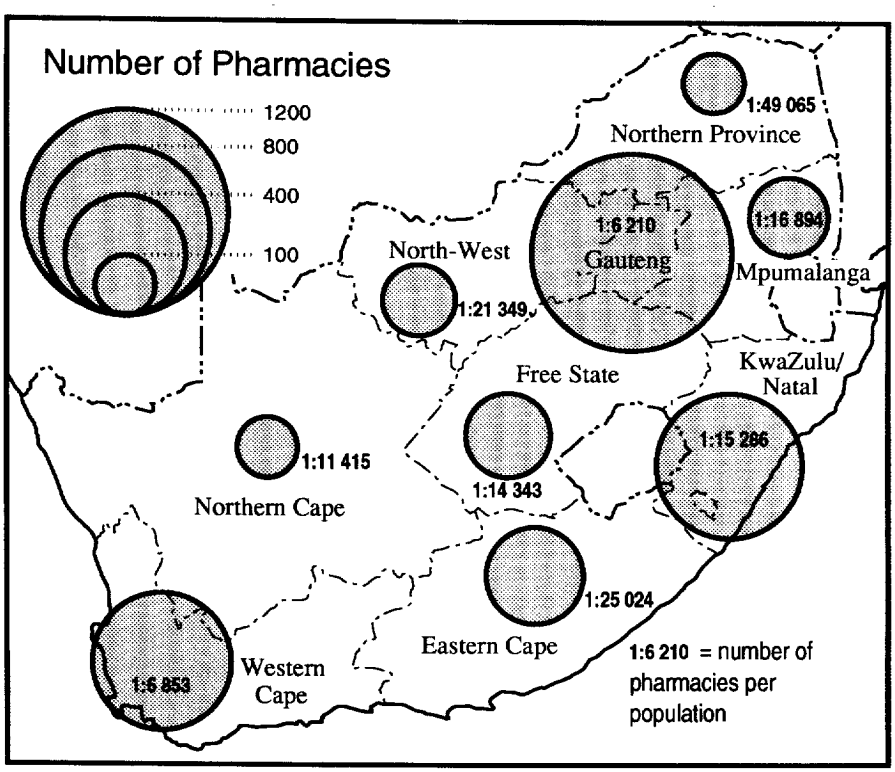

Figure 6. Number of pharmaceutical establishments, 1995. Source: *Pharmaciae* (1995, Vol. 3, p. 22)

Table 4. Distribution of community pharmacies per province

Province	No. of community pharmacies	Population per community pharmacy
Western Cape	444	8472
Northern Cape	46	17 100
Eastern Cape	267	9466
Free State	167	17 416
KwaZulu Natal	453	19 766
Gauteng	1005	7049
Mpumalanga	149	19 999
Northern Province	76	63 427
North Western Province	153	10 638
Total	2760	12 845 (average)

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

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*.

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. 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[6]. 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 S.A. Pharmacy Council (SAPC, 1994). Employment patterns of pharmacists as presented in *Table 6* show that most are employed in community pharmacies.

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 *et al.*, 1994.

Table 6. Employment of pharmacists: 1992

Community	64%
Wholesale	2%
Transmed, administration, education	5%
Manufacturing	5%
Hospital	11%
Other	12%

Source: Summers *et al.*, 1994.

The global debate[7] 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 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?" (Manasse, 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 vs profit!) determines the nature of the advice given. It is only when the pharmacist ignores the merchant role that impartial advice can be given" (Apple, 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 so 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[8], 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 S.A., 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).

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[9]. However, 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 (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[10], 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"[11].

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, 1995, p. 6) 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".

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 S.A. 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 paper aims to explore the existing role of community pharmacy in S.A. 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 S.A. 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 S.A. 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.
- 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 of 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[12].

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[13] 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 (Education, 1995):

> (a) bring about a paradigm shift for pharmacy in S.A. towards patient care; (b) address total health-care needs of all communities in S.A.; (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.

Officially, the pharmacy profession has committed itself to playing a useful role in the provision of health services in S.A. 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 S.A. currently exceeds the state's ability to meet this 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)[14] health initiatives and programmes" (South African Pharmacy Council's submission to the Commission of Inquiry into a National Health Insurance, 1995).

It is vital to note here that the discourse around the expanded role of the pharmacist in S.A. 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.*, 1993). This has been recognised by 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).

Notes

[1]For more about this, see Gilbert (submitteda).

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

[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 this reason reference to the different "population groups" is made in Capital letters.
[5]A fuller discussion on this issue can be found in Chikte *et al.* (1989).

[6]For further details see Simpson (1994) and Van der Merwe (1994).
[7]For further details about the nature of this debate see Gilbert (1995b).
[8]For more details see Gilbert (submittedb).
[9]More on this topic to be found in Gilbert (1995b, Vol. 3, pp. 125–131).
[10]This issue is currently being addressed by proposed changes in the fee structure.
[11]More on this topic can be found in Gilbert (submittedc).
[12]For more details see Gilbert (submitteda).
[13]This question, although important, is beyond the scope of this paper.
[14]The RDP is a programme devised by the government to address the social inequalities in South Africa.

References

Abramson, C. (1994) Interview. *South African Journal of Pharmacy Practice* **1,** 10.

ANC Health Plan (1994) ANC, Johannesburg.

Apple W. (1970) Challenge to pharmacy in the 70s. HEW publication No. 72-3000. Presented at the *Invitational Conference on Pharmacy Manpower*. San Francisco.

Barron, P. M., Ephraim, G., Hira, M., Kathawaroo, S. and Thomas, C. (1989) Dispensing habits of Johannesburg pharmacists in treating acute infantile diarrhoea. *South African Medical Journal* **76,** 487–489.

Bass, M. (1975) The pharmacist as provider of primary care. *Canadian Medical Association Journal* **12,** 60.

Birnbaum, A. (1982) Reprofessionalisation in pharmacy. *Social Science and Medicine* **16,** 871–878.

Bush P. J. (ed). (1983) *The Pharmacist Role in Disease Prevention and Health Promotion*. American Society of Hospital Pharmacy, Bethesda.

Chikte, U. M. E., Gilbert, L., Brand, A. A. and Lewis, H. (1989) Racial classification in dental literature: Is it always necessary? *Journal of the Dental Association of South Africa* **44,** 337–463.

Cunningham-Burley, S. (1988) Rediscovering the role of the pharmacist. *Journal of the Royal College of General Practitioners* **38,** 99–100.

Department of National Health and Population Development (1990) *The Role and Place of the Pharmacist in Health Services in the RSA*.

Department of Health (1995) *National Health System*. Pretoria.

Department of Health (1996) *National Drug Policy for South Africa*. Pretoria.

Dunphy T. S., Batalden P. B. and Davis R. E. (1983) The pharmacist role in primary care. In *The Pharmacist Role in Disease Prevention and Health Promotion*, ed. P. J. Bush, pp. 51–63. American Society of Hospital Pharmacy, Bethesda.

Dreyer, A. C. (1994) *South African Pharmaceutical Journal* **61,** 181.

Education/Practice Projects for 1995 (1995) *Pharmaciae* **14,** 8.

Edwards, C. (1987) The pharmacist in primary health care. *Update* **34,** 134–141.

Gilbert L. (1976) Socialization of pharmacy students in Israel: Changing attitudes toward clinical pharmacy. Unpublished dissertation for the Master of Public Health, Hadassah Medical School, Hebrew University, Jerusalem.

Gilbert L. (1995a) *The Present and Future Role of Community Pharmacy in South Africa: A Study of Retail Pharmacies in Johannesburg*. Centre for Science Development (CSD) Report.

Gilbert, L. (1995b) 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.

Gilbert, L. (1996) Urban violence and health: South Africa, 1995. *Social Science and Medicine* **43,** 873–886.

Gilbert L. (submitteda) *The community Pharmacist as a Member of a Primary Health Care Team in South Africa*.

Gilbert L. (submittedb) *Pharmacy's Attempts to Extend its Roles: A Case Study of Amendments to Legislation and Special Permit Holders in South Africa*.

Gilbert L. (submittedc) *The Role of Training in Transforming Community Pharmacy in SA*.

Gilbert L., Selikow T. and Walker L. (1996) *Society, Health and Disease: An Introductory Reader for Health Professionals*. Ravan, Johannesburg.

Guy J., Sandler G. and Brooks D. (1984) *NHS Data Book*. MTP Press, Lancaster.

Harding, G. and Taylor, K. M. G. (1990) Professional relations between general practitioners and pharmacists in health centres. *British Journal of the General practitioner* **40,** 464–466.

Herson, J. (1995) Friend or foe? *South African Pharmaceutical Journal* **62,** 95.

Human Sciences Research Council Report (HSRC) on Pharmacy (1986) *South African Pharmaceutical Journal* 53, 252–253.

Manasse, H. R. (1989) Medication use in an imperfect world: Drug misadventuring as an issue of public policy. Part 2. *American Journal of Hospital Pharmacy* **46,** 1141–1152.

Mukerjee, D. and Blane, D. B. (1990) Pharmaceutical service delivery by community pharmacies in areas of contrasting medical provision. *Social Science and Medicine* **31,** 1277–1280.

Nuffield Foundation Committee of Inquiry (1986) *Pharmacy: The Report of a Committee of Inquiry Appointed by the Nuffield Foundation*. Nuffield Foundation. London.

Osman, L. (1993) Access to higher schedules. *South African Pharmaceutical Journal* **60,** 332.

Pharasi, B. (1993) Transforming retail pharmacy. *Critical Health* **43,** 69–73.

Pharasi, B. and Price, M. (1993) The role of the community pharmacist in the public and private health sectors in South Africa: Is integration into primary health care teams the way? *South African Pharmaceutical Journal* **60,** 418–424.

Pharasi, B., Price, M. and Goldstein, S. (1993) Act 101 and the pharmacist: Is it appropriate for the pharmacist to prescribe? *South African Medical Journal* **83,** 822–823.

Pharmaceutical Services Negotiating Committee (1987) *The Pharmacist's Charter: Extending the Role of the Pharmacist in the Provision of Health Care to the Community*. Pharmaceutical Services Negotiating Committee, Aylesbury.

Pharmaceutical Society of South Africa (PSSA) (1980) *SYNCOM Report No.1: The Future of Pharmacy*.

Price, M. (1994) The impact of political transformation in South Africa on public/private mix policy debates. *Health Policy and Planning* **9,** 50–62.

Reekie, D. W. and Scott, D. R. (1988) South African health care and the proprietary medicine industry. *South African Medical Journal* **74,** 205–208.

Rispel L. and Behr G. (1992) *Health Indicators: Policy implications*. The Centre for Health Policy, Department of Community Health, Medical School, University of the Witwatersrand, Johannesburg.

South African Pharmacy Council (1994) *Pharmaciae* 1.

Selya, R. M. (1988) Pharmacists as alternative sources of medical care: The case of Cincinnati. *Social Science and Medicine* **26,** 409–416.

Shuval, J. T. and Gilbert, L. (1978) Attempts at professionalization of pharmacy: An Israeli case study. *Social Science and Medicine* **12,** 19–25.

Simpson, D. (1994) Pharmacy in South Africa. *The Pharmaceutical Journal* **253,** 685–692.

South African Pharmacy Council's submission to the Commission of Inquiry into a National Health Insurance (1995).

Summers, R., van der Berg, A. and Summers, B. (1994) Does South Africa have enough pharmacists? *South African Pharmaceutical Journal* 61, 49–54 and 77–79.

Survey. Pharmacy: the pros and cons (1994) *South African Pharmaceutical Journal* 61, 289–291.

Task group 2, Interim Pharmacy Council of South Africa (1995 Interim Pharmacy Council of South Africa) The pharmacist's role in the health care system. *Pharmaciae* **3,** 6.

The Report of the Commission of Inquiry into Health Services (The Browne Report) (1986) *Interim Report on the Pharmaceutical Services*. Pretoria.

Trinca C. E. (1996) The preparation of the pharmacist as a primary health care provider. Paper presented at the *International Symposium on Pharmaceutical and Primary Health Care*. Johannesburg, South Africa.

Turner, P. (1986) The Nuffield Report: A signpost for pharmacy. *British Medical Journal* **292,** 1031–1033.

Van der Merwe, P. R. (1994) Pharmacy in South Africa. *International Pharmacy Journal* **8,** 79–81.

Workgroup 3 (1995) *Discussion document*. The South African Pharmacy Council.