RETAIL PHARMACISTS’ PERCEPTIONS OF FACTORS INFLUENCING THE VIABILITY OF PRACTICE AND BUSINESS IN JOHANNESBURG, GAUTENG PROVINCE

BY

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In accordance with Rule G5.6.3, I hereby declare that the above-mentioned thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

SIGNATURE: [Signature]

DATE: 19 NOVEMBER 2018
ACKNOWLEDGEMENTS

This work is a product of grace. My family and loved ones, who walked the winding path with me, share in the success of this project. My husband and children, I am grateful for you.

The patience and support by Ms Klopper and Dr Knoesen is acknowledged. I thank you. The Lord reigns. He is all I have, all I need.

Nondumiso S Gazi

November 2018

“Those who complete the course will do so only because they do not, as fatigue sets in, convince themselves that the road ahead is still too long, the inclines too steep, the loneliness impossible to bear and the prize itself of doubtful value”

Thabo Mbeki
ABSTRACT

The practice of retail pharmacy has become burdened with service limitations directly or indirectly resulting from influences across the landscape. Influences ranging from legislative bodies to financing bodies have created pressure on retail pharmacies resulting in diminishing numbers of these health establishments. Legislative amendments relating to the ownership of pharmacies, pricing and pharmacy personnel training have had a profound effect on the pharmacy landscape as it presents to date. The dual role, (medicinal procurer and pharmaceutical caregiver), required of retail pharmacists, poses ethical and practical implications. These implications may directly affect the sustainability of retail pharmacy practice.

The aim of this study was to establish the ways in which the pharmacy model is changing and how that change has been perceived by retail pharmacists in Johannesburg, Gauteng.

The research design was qualitative, exploratory, descriptive and contextual in nature. The method utilised for gathering data was individual interviews with pharmacists practising as independent retail pharmacists. At least six (6) independent pharmacists who met the inclusion criteria were approached to participate in the research. Interviews continued until data saturation had been achieved. Data analysis of the transcribed interviews was performed to identify themes and sub-themes.

Key words: Retail pharmacist, independent pharmacist, profitability, sustainability.
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CHAPTER 1

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

A business is defined as an organisation in which the activity of making, buying, selling or supplying goods and services for money takes place (Ashby, 2000:148). The sole purpose of any business is to trade (goods or services) with the intention of generating an income.

Pharmacy is the science and technique of preparing and dispensing drugs. It serves to link the health profession with the chemical sciences. The scope of pharmacies combines the more traditional roles of compounding and dispensing medication with the more modern roles relating to health care, including primary healthcare and the provision of information pertaining to drugs (Moulin, 2013:989).

An establishment where pharmacy is practiced is referred to as a pharmacy (United States) or a chemist (Great Britain and Canada). Pharmacy is a word derived from the root word ‘pharma’ (Greek roots), which often operated from a retail shop. Such a place was known as an ‘apothecary.’ The Greek word “pharmakeia” was derived from pharmakon, meaning drug or medicine (Flannery, 2012:113).

Pharmacies sell medicine, as well as other miscellaneous items such as gifts, toiletries, sweets, chocolates and so forth. Historically retail pharmacies have also been involved in the sale of generic or brand medications and sometimes medical devices as the main source of income (Malangu, 2014:226).

According to the Pharmacy Act 53 of 1974 as amended, (hereafter referred to as the Pharmacy Act), retail pharmacies in South Africa are licensed entities in which compounding, counselling and dispensing of medicinal substances occurs under the supervision of a registered pharmacist. Registration of qualified individuals is with the South African Pharmacy Council (SAPC), a statutory body that regulates the practice of pharmacy in South Africa. This constitutes the practice element of an entity. A licence to practice as a retail pharmacy is issued to a registered company or sole proprietor by the Department of Health (DoH). Consequent to the trade of services
and/or of a commodity for a fee, a retail pharmacy is thus recognised as a business and is also known as a community pharmacy. Although drug procurement and dispensing feature as significant elements of the service offerings, pharmacists have become key in professional service rendition. Retail pharmacy is envisaged as the base point of professional primary healthcare services (Wessels & Luiz, 2003:11).

Retail pharmacies are positioned as the last and pivotal step in medicine procurement. The supply chain begins with the product manufacturer and continues to the wholesaler or distributor and finally the retail outlet (pharmacy). Inversely, a pharmacy is one of the public’s first points of contact with healthcare services, as acknowledged by the National Health Plan Strategy (Department of Health, 2009). Pharmacies and pharmacists are therefore at the forefront of healthcare service provision. Other important role players in the supply chain are prescribing doctors and healthcare funders (also referred to as medical aids). Pharmacists’ contribution to primary healthcare is significant, with numerous ailments resolved by over-the-counter (OTC) recommendations (Gilbert, 1998:273).

The South African Pharmacy Council reports that there are currently 3303 community pharmacies nationally. Fig 1.1 illustrates the distribution of these pharmacies across the nine provinces of South Africa.
Key: EC – Eastern Cape; FS – Free State; KZN – KwaZulu Natal; LP – Limpopo; MP – Mpumalanga; NW – North West; NC – Northern Cape; WC – Western Cape; GP – Gauteng Province.

Source: SAPC annual report, 2014

Figure 1.1: Percentage of community pharmacies per province (n = 3,303)

1.2 MOTIVATION OF THE STUDY

The South African pharmaceutical market (ethical drugs excluding consumer health and animal health) grew by 11.7% in 2013 to reach a value of US $2 billion (Marketline, SA Pharmaceuticals). The compound annual growth rate of the market during the period 2009 to 2013 was 7.3%. In 2018, the South African pharmaceuticals market was forecast to have a value of US $3 billion, an increase of 50% since 2013. The compound annual growth rate of the market during the period 2013 to 2018 was predicted to be 8.3%. According to the World Health Organisation (WHO), pharmaceuticals account for more than 15% of measured global spending on health (WHO, 2012).
The past 10 years have seen substantial changes in the practice of pharmacy resulting from the dynamics arising within industry stakeholders, namely the patient, healthcare funder, health care service provider, health professionals and pharmaceutical manufacturers, as well as legislative amendments mainly relating to (a) the amendment to the Pharmacy Act with respect to pharmacy ownership, which allowed non-pharmacist and legal entities to own pharmacies as of 2003, (b) amendments to the Medicines and Related Substances Act No. 101 of 1965, introducing a single exit price that pharmaceutical manufacturers were to charge wholesalers, which included a distribution cost and (c) a pharmaceutical tiered pricing model (Le Roux, 2013).

The South African Pharmacy Council’s (SAPC) 2015 annual reports indicate statistics that reflect a sharp decline in new community pharmacies opened in the last few years. From 2010 to 2013 an 80% decrease was observed in the number of new pharmacies opened (An increase in the number of pharmacies that closed was also evident, as reflected in Figure 1.2.1 (an increase between 2012 and 2013).

The legislative amendments have had a profound effect on the current pharmacy landscape. Over the past four decades the market has been demarcated by an increase in product focus, (larger front shop versus a smaller dispensary), rather than patient focus. Additionally, there have been increasing trends in the separation of roles of the retail pharmacist as medicine supplier and as patient caregiver or pharmaceutical care giver. Figure 1.3 reflects the number of corporate pharmacies in South Africa.
Figure 1.2: Representation of community pharmacy trends in South Africa

Source: SAPC Annual report, 2015

Figure 1.3: Provincial distribution of corporate pharmacies (3,316)

Gauteng is indicated as the province with the most corporate pharmacies, hence the choice of a subject sample from the Johannesburg population.
1.3 PRIMARY AIM
The aim of this study was to establish the perceptions of retail pharmacists in Johannesburg, Gauteng pertaining to factors influencing the viability of pharmacy retail practice and business.

1.4 RESEARCH OBJECTIVES
- To explore the experiences as well as the resultant effects of practising retail pharmacy in Johannesburg during the last five years.
- To make recommendations to independent retail pharmacies on overcoming the common challenges to best suit the market.

1.5 OVERVIEW OF THE RESEARCH METHODOLOGY
Qualitative research was conducted to explore the perceptions, beliefs and emotions of the participants. The study utilised five one-on-one, semi-structured interviews with independent retail pharmacists in the central, north, south, east and west of Johannesburg to explore the said perceptions, beliefs and emotions of retail pharmacists regarding their viability. Each interview was expected to take 30 to 45 minutes and took place by appointment at a venue selected by the interviewee. Interviewing continued until data saturation was achieved.

Participants’ responses were recorded with their prior written consent. The data was expressed in words, emotions, ideas and actions and was collected to allow for verification and continuity, particularly alignment with the research aim.
CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

The previous chapter provided an overview of the study in which the research problem was identified and the research objective was stated. This chapter presents an in-depth description of the research design and method followed in this study.

2.2 RESEARCH DESIGN

The research design was qualitative, exploratory, descriptive and contextual. Qualitative research entails an in-depth introspection of a subject that is not well understood or that has been minimally explored (Botma, Greef, Mulaudzi & Wright 2010:182). The research subject was not quantifiable. Qualitative research was utilised to assist the researcher in acquiring detail and substance regarding the phenomenon that was lacking in that respect (Botma et al., 2010:182). There are five possible approaches to qualitative research, namely narrative research, phenomenology, grounded theory, ethnography and case studies (Lewis, 2015:67-74).

Table 2.1 A summary of the five approaches

<table>
<thead>
<tr>
<th>Research approach</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative research</td>
<td>Utilises individual stories to develop relevant messages.</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>Assists in determining a participant’s experience of a topic of interest.</td>
</tr>
<tr>
<td>Grounded theory</td>
<td>Identifies causal and intervening factors and also the context of a particular topic.</td>
</tr>
<tr>
<td>Ethnographies</td>
<td>Inform on practices in a cultural context.</td>
</tr>
<tr>
<td>Case studies</td>
<td>Help draft success stories and are used to demonstrate the effectiveness of a programme.</td>
</tr>
</tbody>
</table>

Source: Lewis, 2015:67-74
This study was classified as basic research as the application of the research was secondary to knowledge generation. It was a design suited for comprehensively understanding the phenomenon; the viability of independent retail pharmacists in Gauteng (Botma et al., 2010:82). It was thus imperative that the researcher was closely involved in gathering the data (Botma et al., 2010:82).

Quantitative research enables a researcher to closely examine theory generated by qualitative research. The aim of this study was to establish the perceptions of retail pharmacists regarding factors influencing the viability of pharmacy retail practice and business. A broad research undertaking that was expected to produce an overall sense of the perceptions of retail pharmacists. The exact causes and detail of the perceptions may later be subject to quantitative research. A review of existing literature suggested limited research on the topic.

An exploratory research design is an in-depth exploration of the phenomenon under study (Botma et al., 2010:189). In this research the phenomenon was the retail pharmacists’ perceptions of factors influencing the viability of their practice and business. Given that exploration of the topic has been limited, qualitative research was ideal as it offered an in-depth investigative opportunity to produce a narrative of the topic. The research served to reveal the independent pharmacists’ perceptions of the changing pharmaceutical landscape.

According to Botma et al. (2010:220), in contextual studies the collected data is relevant to a specific context (independent pharmacies in Johannesburg), hence findings cannot be generalised to other contexts. All qualitative studies are contextual. Erlandson, Harris, Skipper & Allen (1993) indicate that much was to be gained by looking, listening, feeling and smelling versus routine conversation. Hence the need to identify people, location and time should be verifiable by more than one source. Merriam’s (1988 observational checklist was a valuable tool as a guide on how to structure observation.

The focus is a single phenomenon that is studied particularly in relation to the context of interest. Data contains detailed contextual descriptions of the research. Such detail is to include the setting in which the research was undertaken, the participants and phenomenon under study as well as the researcher’s personal experiences (Botma et
al., 2010:95). The summative characteristics, as detailed, assisted the researcher to conceptualise the study and this was important in analysing the research results.

2.3 RESEARCH METHODOLOGY

Interviews are a method of collecting data in which qualitative and/or quantitative questions can be asked (Doddy & Noonan, 2013:16). The range of interview formats includes structured, unstructured and semi-structured interviews (Doddy & Norman, 2013:25). One-on-one interviews were guided by a semi-structured interview schedule to explore the perceptions, beliefs and emotions of retail pharmacists with regard to their viability. This is a method used in qualitative research and is ideal for exploring the perceptions, beliefs and emotions of participants. Interviews generate contextual accounts of participants’ experiences and their interpretation thereof (Schultze & Avital, 2011).

2.3.1 Population

The Oxford Advanced Learner’s Dictionary (Ashby, 2000) defines a population as a well-defined collection of individuals known to have similar characteristics. A population can also be defined as an aggregation of cases that meet specified, pre-determined inclusion criteria in which the researcher is interested (Burns & Grove, 2005:40). For the purposes of this study, the population comprised independent retail pharmacists practising in Johannesburg, Gauteng.

2.3.2 Sampling method

Sampling entails selecting a portion of the population to represent the entire population and can also be defined as the use of a group of individuals from the stated population with whom to conduct the research (LoBiondo-Wood & Haber, 1998:250). One of the methods of sampling in qualitative studies is purposive sampling. This was the method chosen for this study and is a method of sampling used to achieve a specific purpose, such as obtaining information from the specified group regarding their profession and business (Maree, 2011:195). The researcher’s prior knowledge of the population was used to select individuals with specific characteristics (Botma et al, 2010:201).
The sample for this study was five practising retail pharmacists from the central, north, south, east and west of Johannesburg. Inclusion criteria were that the sample must include independent retail pharmacists who had practised for a minimum of five years in Johannesburg, Gauteng. Retail pharmacists with less than 5 years’ experience and those who were not involved in the entity’s business management were excluded from the study.

2.4 DATA COLLECTION

This is the process of gathering and processing information in relation to a topic of interest (Ashby, 2000:37), which in this study was exploring factors affecting the viability of independent pharmacies in Johannesburg, Gauteng Province. The method selected required direct interaction with the subjects (pharmacists) and involved the collection of data in a predetermined manner. The study utilised one-on-one, semi-structured interviews to explore the perceptions, beliefs and emotions of retail pharmacists regarding the viability of retail pharmacies. The duration of each interview was between 30 and 45 minutes. Interviewing continued until data saturation was achieved.

Interviewing is a method of collecting data in which qualitative and/or quantitative questions can be asked (Doddy, 2013:22). A range of interview formats exist that includes structured, unstructured and semi-structured interviews (Doddy, 2013:24). This study utilised one-on-one interviews guided by a semi-structured interview schedule to explore the said perceptions, beliefs and emotions of retail pharmacists. Interviews generate contextual accounts of participants’ experiences and their interpretation thereof (Schultze & Avital, 2011). Table 2.1 lists the advantages and disadvantages of interviews.
### Table 2.2: Possible advantages and disadvantages of interviews

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Semi-structured interviews are useful to gain insight and context.</td>
<td>• May be perceived as intrusive to the participant.</td>
</tr>
<tr>
<td>• Assist participants to describe what is important to them.</td>
<td>• Time-consuming, in conducting the interview and also in relation to arranging them, travelling to the venue, post-interview transcription and analysis of the data.</td>
</tr>
<tr>
<td>• Generation of quotes and stories.</td>
<td>• Susceptible to bias, which may include:</td>
</tr>
<tr>
<td>• Enable the researcher to develop a rapport.</td>
<td>− the participant's desire to please the researcher;</td>
</tr>
<tr>
<td>• The researcher is able to observe as well as listen.</td>
<td>− saying what they think/feel the researcher wishes to hear; such as giving an official point of view rather than their personal view;</td>
</tr>
<tr>
<td>• Complex questions can be asked.</td>
<td>− the desire to create a good impression may lead to participants not answering honestly;</td>
</tr>
<tr>
<td>• The researcher can explain the purpose of the research and answer any questions the participant may have about the study.</td>
<td>− there is a tendency to say something rather than nothing if the participant cannot answer a question or has nothing to say on a topic;</td>
</tr>
<tr>
<td>• The researcher can probe the participant's responses and seek further clarification.</td>
<td>− the researcher's views can influence the participant's responses by expressing surprise or disapproval.</td>
</tr>
<tr>
<td>• Participants can seek clarification of a question.</td>
<td></td>
</tr>
<tr>
<td>• They assist the participant to provide detailed responses.</td>
<td></td>
</tr>
<tr>
<td>• Can explore participants' reasons for acting in a certain way or their interpretations of events.</td>
<td></td>
</tr>
<tr>
<td>• Interviews can be a rewarding for participants as they stimulate self-exploration and discovery.</td>
<td></td>
</tr>
<tr>
<td>• Personal benefit: the telling of one's story.</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Doddy & Noonan, 2013

Semi-structured interviews presented an opportunity for independent pharmacists to reflect and narrate their experiences in managing a retail pharmacy. Participants were able to vocalise, in discussion, issues and experiences presented to them as independent pharmacists. The nature of the interviews allowed for narratives and
references to illustrate perspectives. The interviewer had flexibility to probe participants further in order to exhaust the topic during the discussion.

The necessity for interviews was challenging, beginning with securing appointments, distances travelled and unwillingness to engage with the topic, as no immediate and direct benefits would be realised. The interviewer’s experience and own perspectives were difficult to subdue.

Participants’ responses were recorded, with prior written consent (see consent form, Appendix II). Two voice recorders were utilised and the data was subsequently stored for safe keeping and for verification and continuity, particularly alignment with the research aim.

2.2.1 Research Questions

The diminishing number of independent retail pharmacies and the change in the pharmaceutical landscape formed the basis of the research.

The following questions were used as a guide for the interviews that were conducted.

1. How do you think running an independent retail pharmacy compares with running any other retail business?
   - Differentiation from other retail businesses

2. Could you describe any changes you have noticed over the past 5-10 years in retail pharmacy trends?
   - Degree of rivalry
   - Threat of entry
   - Threats of substitution
   - Supplier power
   - Buyer power

3. Has the provision of pharmaceutical care changed from a professional perspective over the past 5-10 years?
   - Impact of professional developments, particularly pertaining to the training and qualifications of all pharmacy personnel.
2.2.1.1 Field notes

Detailed field notes were written to record that which the researcher experienced and encountered whilst conducting the interviews. These reports incorporate a sequence of all that the researcher thinks, sees, feels and hears whilst conducting an interview. Field notes are particularly useful for data verification, as the researcher recalls the details of the interview (Botma et al., 2010:218). An observational protocol that comprised three sections was utilised (Creswell, 2009:181-182). These sections included descriptive notes (reconstruction of the dialogue and recollection of the individual, physical setting), reflective notes that record the researcher’s thoughts as well as demographic information that details the time, date and place of each interview and the demographics of the participants.

2.5 DATA ANALYSIS, TRANSCRIPTION AND CODING

This process entails the dissection and comprehension of the collected data by making use of thematic analysis and an independent coder (Ashby, 2000:36). Data is prepared (reconstructed) with preliminary coding to allow for ease of reference between interviews. The data analysis process is systematic, sequential, verifiable and continuous. Observation focuses on the integration of themes, (recurring ideologies often linking important findings), patterns and categories in the data that prompt further questions (Brink, 2006:55).

Source: Adapted from Cresswell 2009

Figure 1.3: Provincial distribution of corporate pharmacies (3,316)

For the purposes of this study, Cresswell’s method was applied to the data analysis.

Data analysis was undertaken after the interviews following the transcription of the voice recordings. Themes were determined with the assistance of an independent coder. Researcher bias that could compromise the rigour of the study was eliminated by the use of inter-observer comparisons. The presence of two observers per interview can also eliminate potential bias (Bowling, 2002:362).

2.6 PILOT STUDY

Pilot studies, also known as ‘feasibility’ studies, are mini versions of a full-scale study, as well as the specific pre-testing of a particular research instrument such as an interview schedule or questionnaire (Ashby, 2000:880). It is an important element of a study design and increases the likelihood of a successful study. Pilot studies fulfil a range of important functions, providing insight into an appropriate sample size and improving the study design and can provide valuable insights for other researchers (van Teijlingen & Hundley, 2001).
Pilot studies also detect possible shortcomings in the study design, identify unclear items in the questionnaire and provide feedback regarding the wording, information and structuring of the questionnaire (Welman & Kruger, 1999:146).

One interview served as the pilot study for the research that was to be undertaken. The interview was deemed to be successful. The results of the pilot study were therefore included in the final study. The pilot study, as a proactive approach, served as a means of validating the instrument that was chosen (semi-structured interviews) as a means to reduce error. The results were used to identify and correct any errors before they were built into the final research instrument (Morse, 2002).

2.7 VERIFICATION OF DATA

Guba’s (1981) model of trustworthiness, which describes four general criteria for the evaluation of research from both a quantitative and a qualitative perspective, was applied. The four general criteria are credibility (internal validity), transferability (external validity), dependability (reliability) and confirmability (objectivity) (Thomas & Kathy, 2011:151-155). Within these criteria are specific methodological strategies for demonstrating qualitative rigour, such as the audit trail, checks when coding, categorising, or confirming results with participants (pharmacists), peer debriefing, persistent observation, negative case analysis, structural corroboration and referential material adequacy (Thomas & Kathy, 2011:151-155).

2.8 ETHICAL CONSIDERATIONS

Research is subject to ethical standards that promote and ensure respect for all subjects (as well as the profession) and protect participants’ rights. Research must be conducted in a manner that minimises disruption to the practice of pharmacy.

The Declaration of Helsinki (2000) states that every precaution is to be taken to protect the privacy of research subjects and the confidentiality of their personal information. The pharmacists (subjects) had to be adequately informed of the aims, methods and sources of funding, any possible conflicts of interest and institutional affiliations of the researcher (Nelson Mandela University), the anticipated benefits and potential risks of the study and the discomfort it could entail, as well as any other relevant aspects of the study. The potential subjects were informed of their right to refuse to participate in
the study or to withdraw consent to participate at any time without reprisal. Subjects were given the option of being informed about the general outcome and results of the study as well as the dissemination thereof (World Medical Association, 2016).

In addition, in line with the Nuremberg Code (1947), volunteers were afforded the opportunity to participate in the research, to withdraw should they choose to and protection from harm during, or as a result of, the study. Justice was upheld at all times in the interest of the participants. All participants were informed of the purpose of the research, the role of the interview in the research, the time required as well as being assured of the confidentiality of the information discussed during the interview. (The informed consent form is attached as Appendix II).

The research intended to uphold all guidelines in accordance with all professional ethic codes, for example those in the National Health Research Ethics Council Guidelines and the Department of Health, as well as the Guidelines for Good Clinical Practice (GCP).

In accordance with professional ethical codes, semi-structured interviews were conducted within a population of suitable independent retail pharmacists in Johannesburg. Verification of the data was guided by Guba’s model of trustworthiness. The pilot study was instrumental in conducting subsequent interviews. Bias was minimised in the analysis, transcription and coding of the data by making use of an independent coder. The research design (qualitative, exploratory, descriptive and contextual) was thus implemented successfully.
CHAPTER 3
DISCUSSION OF INTERVIEW FINDINGS

3.1 INTRODUCTION

The study of the perceptions of retail pharmacists with regard to the viability of retail pharmacy in Johannesburg, Gauteng was conducted through 6 (5 + 1 pilot) semi-structured, one-on-one interviews with independent pharmacists practising in north, east, west, south and central Johannesburg. The research design was qualitative, exploratory, descriptive and contextual, a design used in qualitative research for exploring the perceptions, beliefs and emotions of participants. Interviews generate contextual accounts of participants' experiences and their interpretation thereof (Schultze & Avital, 2011:4).

All qualitative studies are contextual. Erlandson et al. (1993) hold that much is to be gained by looking, listening, feeling and smelling versus routine conversation, hence the need for people, locations and times to be verified by more than one source. Thus, the decision to sample from the five geographical points of Johannesburg was upheld.

This study was classified as basic research as application of the research was secondary to knowledge generation. It was a design suited for comprehensively understanding the phenomenon under investigation (the viability of independent retail pharmacists in Gauteng) (Botma et al., 2010:82). A preliminary interview served as a pilot study.

The aim of this study was to establish the perceptions of retail pharmacists and to identify factors influencing the viability of retail pharmacy practice and business. The research objectives were to:

- explore the experiences and resultant effects of practising retail pharmacy in Johannesburg for the past five years and
- make recommendations to independent retail pharmacies on overcoming the common challenges to best suit the market. Participants were qualified retail pharmacists who had practised in this capacity for a minimum of five years in the Johannesburg, Gauteng region of South Africa. Retail pharmacists with less
than five years’ experience and those who were not involved in the entity’s business management, were excluded from the study.

The interview at Johannesburg South was conducted with Participant One. He had been practising at the same address as an independent retail pharmacist for more than 10 years and had managerial experience. His tenure as a retail pharmacist thus provided feedback worth noting.

Johannesburg East interviews were conducted with two retail pharmacists, one having practised inside a shopping centre and the other not. Participant Two was registered with 34 years’ experience in managing a retail pharmacy. The second participant from this area was designated as Participant Three and had a career as an independent retail pharmacist spanning more than 25 years.

Johannesburg West was represented by Participant Four, a registered independent pharmacist with approximately 6 years’ experience at the same location and a further 9 years at various other locations.

The interview for Johannesburg Central was held with Participant Five, an independent retail pharmacist who had also attended short courses in business management.

Lastly, the interview in the north of Johannesburg was conducted with Participant Six who was not a pharmacy owner but was involved in various business aspects of the pharmacy. He was a registered retail pharmacist with more than 7 years’ experience.
Table 3.1: Summary of participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Location in Johannesburg</th>
<th>Qualification</th>
<th>Other learning activities</th>
<th>Years of relevant experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Johannesburg South</td>
<td>B.Pharm</td>
<td>none</td>
<td>≥ 10 Years</td>
</tr>
<tr>
<td>2</td>
<td>Johannesburg East</td>
<td>Dipl.Pharm</td>
<td>none</td>
<td>≥ 34 Years</td>
</tr>
<tr>
<td>3</td>
<td>Johannesburg East</td>
<td>Dipl Pharm</td>
<td>none</td>
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</tr>
<tr>
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<td>B.Pharm</td>
<td>none</td>
<td>≥ 9 Years</td>
</tr>
<tr>
<td>5</td>
<td>Johannesburg Central</td>
<td>B.Pharm</td>
<td>Short business courses</td>
<td>≥ 7 years</td>
</tr>
<tr>
<td>6</td>
<td>Johannesburg North</td>
<td>B.Pharm</td>
<td>none</td>
<td>≥ 7 Years</td>
</tr>
</tbody>
</table>

Registration details of the participants were provided but have not been included in the report in the interest of confidentiality.

3.2 THEMES AND SUB-THEMES IDENTIFIED

The following themes and sub-themes were identified.

1. **Legislative changes** impact negatively on the viability of independent pharmacies. Sub-themes for this theme were: (i) entry of corporate pharmacies into the retail pharmacy space; (ii) retail pharmacies’ ownership by pharmacy wholesalers; (iii) pharmaceutical industry that determines prices, with price fixing as a disadvantage to independent pharmacists and (iv) independent pharmacies lack support from government.

2. **Medical aids’ funding structures are a challenge.** The related sub-themes were: (i) designated service providers (DSPs) are a cause of a decreased customer base leading to unfair competition with no protection for independent pharmacies and (ii) doubts regarding the legality of DSPs and courier pharmacies.

3. **Pharmaceutical care highlighted as a prospective growth area.** This is because independent pharmacies are not financially viable with a low return on
investment. Sub-themes include: (i) approval and marketing of in-house brands; (ii) failure to increase dispensing fee; (iii) unfair advantage for corporate pharmacies in economies of scale and (iv) corporates increasing focus on the retail element versus professional service provision, thus creating a need to push volumes to be financially viable.

Table 3.2: Summary of themes and sub–themes identified

<table>
<thead>
<tr>
<th>CATEGORIES OF THEMES FOR DISCUSSION</th>
<th>SUB-THEMES</th>
</tr>
</thead>
</table>
| 1. Legislative changes               | (i) Entry of corporate pharmacies into the retail pharmacy space.  
                                         (ii) Retail pharmacies’ ownership by pharmacy wholesalers.  
                                         (iii) Pharmaceutical industry that determines prices, with price fixing that disadvantages independent pharmacists.  
                                         (iv) Independent pharmacies lack support from government |
| 2. Medical aid funding structure challenge | (i) Designated service providers (DSPs) are a cause of a decreased customer base leading to unfair competition with no protection for independent pharmacies.  
                                                   (ii) Doubts regarding the legality of DSPs and courier pharmacies. |
| 3. Pharmaceutical care as a prospective growth area | (i) Approval and marketing of house brands.  
                                                    (ii) Failure to increase dispensing fees.  
                                                    (iii) Unfair advantage for corporate pharmacies in economies of scale.  
                                                    (iv) Corporates’ increasing focus on retail element versus professional service provision, thus creating a need to push volumes to be financially viable. |

Each of these themes will now be discussed through their sub-themes.

3.3 DISCUSSION OF THEMES AND SUB-THEMES

3.3.1 Theme 1: Legislative Changes

According to the Pharmacy Act, as amended, retail pharmacies in South Africa are licensed entities in which compounding, counselling and dispensing of medicinal substances occurs under the supervision of a registered pharmacist.
On 25 April 2003 the Minister of Health, in consultation with the South African Pharmacy Council and in terms of Sections 22 and 22A of the Pharmacy Act, passed regulations relating to the ownership and licencing of pharmacies. Any person may, subject to the provisions of Regulation 7, own or have a beneficial interest in a community pharmacy in the Republic of South Africa. This decision heralded the entry of several new participants in the marketing space, most notable being the macro community pharmacies also referred to as corporate pharmacies (Gilbert, 1998). These macro pharmacies were characterised by their supersized front shops and discounted cash prices on retail products. As reflected in the interviews, a marked change was observed in the pharmacy landscape with respect to the practice of retail pharmacy. Four of the five participants alluded to this statement. Participants stated that the corporate pharmacies’ wholesale shopping experience was welcomed by consumers at the cost of compromising pharmaceutical care. These entities were viewed as responsible for commercialising the practice of pharmacy. Participant Four said: “The biggest mistake was allowing non-pharmacists to own pharmacies. Every tier has contributed, from government to Pharmacy Council.”

Figure 3.1 reflects the distribution of corporate pharmacies throughout the nine provinces of South Africa. Gauteng is reported to have the largest number of corporate pharmacies to date.

Source: SAPC 2016 Annual report

Figure 3.1: Distribution of Corporate Pharmacies by Province
Porter’s five forces framework, *(Competitive Strategy: Techniques for Analyzing Industries and Competitors, 1980)*, relates the average profitability of participants in an industry to five competitive forces, namely:

- degree of rivalry;
- threat of entry;
- the threat of substitutes;
- buyer power and
- supplier power.

Participants expressed the view that there were negative effects due to the resultant degree of rivalry between independent and corporate pharmacies. The corporate pharmacies’ buying power and supplier power, in comparison to the independent pharmacy, afforded these establishments the upper hand, as economies of scale determined the end cost, particularly with respect to non-professional products (front shop items). Participant Two stated “Well, you know how they are making it. Buying power and selling things that are not related to pharmacy. If you walk into a Dischem you will see a dispensary right at the back.”

The introduction of courier pharmacies, *(retail pharmacies whose business is sending prescription medicines to patients by post or courier)*, heralded a new era in pharmacy practice. Medicine users were offered an alternative option of filling their prescriptions. The prescriptions would be forwarded to a registered dispenser who in turn couriered the prescribed medicine to the patient. Thus, the patient did not require to step into a pharmacy. Concern arose with the limited patient-pharmacist interaction, as what little there was revolved around drug utilisation reviews conducted in line with the relevant funder’s payment rules and restrictions. Storage of drugs in transit, patient counselling and pharmacy practice were aspects of much contention within the industry, as expressed by the research participants.

Participant Two explained “My biggest problem with those is there is no counselling, no opportunity for the patient to be like this is what is happening to me? It seems I get a different medicine every month, it’s the same ingredient you know and when it’s out of stock they just give the next ingredient without explaining. They come in here all day long and they are like ‘What is this for, I haven’t taken it for a month because it’s
not the right thing’ and you are like it is the right thing but they say it doesn’t look the same”.

Dispensing medical doctors create the threat of substitutes that eliminates the need to use a retail pharmacy. The regulation in which doctors were permitted to dispense medication under specified conditions came into effect in 2003 (Medicines and Related Substances Act 101, 1965). Participant Four alluded to the effect of dispensing doctors.

A pricing committee set up by the minister of health was introduced in 2004 that introduced:

- a single exit price (SEP);
- tiered dispensing fees and
- amendments to logistics fees charged by pharmaceutical wholesalers/distributors.

The introduction of the SEP eliminated pricing incentives previously introduced with bulk purchases and other marketing drives. Tiered dispensing fees are based on the value of the product, the higher the value (usually innovator products) the less the dispensing fee and vice versa. This was proposed to encourage growth in the generic medicine market.

Participant Three argued: “There’s a big change! Let me tell you something, your profit margin that time was 50% you could make a good living, your profit margin now is about 12 to 14%. How could you survive on that percentage? You see these idiots that don’t understand the efficacy of running a business. They don’t understand. They say you work on this margin or that margin.”

Questions were raised about the appropriateness of remuneration models for these mandatory duties associated with dispensing that affected the long-term financial viability of relevant service providers. It has been suggested that remuneration models need to reflect an appreciation of pharmacists. Participants complained that there has not been an increase in years.
In a survey of 200 pharmacists (22% in public employment and 78% in private) conducted by Gerhard Joubert, Head of Group Marketing and Stakeholder Relations at PPS, 86% of the respondents felt threatened by the growing number of corporate retail pharmacies and 91% stated that they did not believe current legislation caters sufficiently for the needs of pharmacists (Joubert, 2015).

3.3.2 Theme 2: Medical Aids’ Funding Structure Is A Challenge.

A feature of the Medical Schemes Act is prescribed minimum benefits (PMB), which can be described as a set of defined benefits to ensure members have access to certain minimum health benefits (Council for Medical Schemes, 2018). Medical aids are obligated to cover the costs related to the diagnosis, treatment and care of these. The chronic disease list (CDL) specifies medication and treatment for 25 chronic conditions covered under the PMBs, (refer to Appendix VI for the complete list of conditions), as detailed under the Medical Schemes Act.

South Africa’s disease profile is described as a ‘quadruple burden of disease’, namely a high prevalence of HIV and AIDS, which is linked with tuberculosis, increased maternal and child morbidity and mortality, increased prevalence of non-communicable diseases, mostly driven by risk factors related to life-style and finally, violence, injuries and trauma (StatsSA, 2014).

Designated service providers are healthcare service providers (doctor, pharmacist, hospital and other healthcare service providers) that are a medical scheme’s first choice when its members require diagnosis, treatment or care for a PMB condition (Council of Medical Schemes, 2018). The cost of PMBs is reported to have increased by 13% from R556 in 2014 to R608 per beneficiary per month in 2015. The question posed by Participant Four concerned the link between the prevalence of the listed conditions with the actual disease profile of South Africa. The general consensus was that the list is misleading and does not reflect the true remunerable chronic base as it presents. Participant Five stated “The most common diseases we see are only a handful.”
Participants cited challenges in the way DSPs operate in the retail pharmacy sphere. The main issues highlighted were agreements entered into by medical aids with mainly corporate pharmacies, which served to lock in a:

- minimum percentage mark-up in favour of the medical aid and
- customer base in favour of the pharmacy.

Participant Two argued “In our case it’s unique technically we not trying to undercut, they are not undercutting us they are selling it at 26% and say we are prepared to selling at 26 why are they stopping us”.

The SEP introduced in 2004 is applicable to medicines sold in the private sector. This is the price at which a manufacturer must sell to all pharmacies, irrespective of volume sold. The SEP applies to medicines that can only be bought in a pharmacy (Pampel, 2013).

The legislated pricing schedule dictates that pharmacies apply a maximum product mark-up fee of 36% with no minimum expressed. The professional fee element of the
remuneration is affected through a tiered dispensing fee model that is based on the value of the product, as stated above (the higher the value the less the dispensing fee and vice versa). Participants expressed frustration at the low percentage mark-up offered by funders within a DSP arrangement and believed this is only possible for retail pharmacies whose core business is not dispensing medicine. Such arrangements were believed to favour the designated service provider by ensuring a consistent client base.

Participant Two stated “You get a customer saying sorry I can’t buy from here anymore. Now that means when he came and got his script and picked up whatever he wants, Syndols® or something with it, it’s all gone because they just don’t come here anymore so there’s no spin offs on whatever he bought when he went to the till if he wanted to buy a chocolate or something. We’ve lost all of that.”

Designated service providers/medical aid arrangements are exclusive to specific corporate retail pharmacies and often exclude independent pharmacies. Participants considered this an unfair practice, as all retail pharmacists should be afforded an opportunity to become a DSP despite the unacceptable low rates medical aids are willing to pay in these arrangements. An outcry to the government for failing to protect independent pharmacies was made by the participants who questioned the legality of these arrangements. Participant Three asked “Why are DSPs even legal?” Participant Two shared that his chronic patient script count had decreased by as much as 80% due to medical aid DSP arrangements.

The Independent Community Pharmacy Association (ICPA) has embarked on a campaign to challenge DSP arrangements as well as the calculation of penalty co-payments levied on services obtained from service providers that have no DSP arrangements with the funder. As part of the campaign, the ICPA has also called on the public to voice an opinion on the practice of closed DSPs.

Medical aid members opting to utilise the services of a non-DSP retail pharmacy are penalised (up to 20% of the cost of the prescription), which may act as a deterrent by having to pay a portion of the total cost of their prescription. This resulted in a diminished customer base for non-DSP retail pharmacies. The ICPA holds that its engagement with the Council of Medical Schemes has resulted in prioritisation of the
practice of DSP business arrangements (Independent Community Pharmacists’ Association (ICPA), 2017).

Designated service provider arrangements were accused of being responsible for the growth of courier pharmacies. Courier pharmacies dispatch medicine by post or other delivery means to customers according to medical aid specifications. This results in fewer customers collecting their prescriptions from retail pharmacies, thus reducing potential business. The appointment of designated service providers is contrary to public interest; it destroys the pharmaceutical healthcare footprint and undermines the delivery of primary healthcare (ICPA, 2017).

Participant Three said: “It cannot be accepted that the general public is twisted to specific service providers at the cost of their wellbeing. I mean, look at how disempowered these patients become.”

3.3.3 Theme 3: Pharmaceutical Care As A Prospective Growth Area

The World Health Organisation (WHO) introduced the concept of a seven-star pharmacist (see Figure 3.3), a multi-functional role encompassing caregiver, communicator, decision-maker, life-long teacher, leader and manager. Participants described these roles as the key differentiators between corporate pharmacies and independent pharmacies. Participant Four explained “Pharmacists practising pharmaceutical pharmacy offer more than retailers where customers are just a number”.
Pharmacy as a profession defines itself as a patient-focused profession as opposed to a general view of a product-for-profit profession (Williams, 2006:219). Pharmaceutical care was loosely identified as the vehicle to achieve a large number of the ideals mentioned above. Participants were of the opinion that a focus on the elements that truly define the profession may be the answer to an improved future for independent retail pharmacists. Concerns were raised over the minimal attention given to the roles of communicator, caregiver and teacher, as evident in the business models of corporate courier pharmacies.

Participant Three expressed his opinion by saying: “You see the reason they come to a community pharmacy, all the years;” “You speak to them, their kids were small, they growing up, they ask advice. A Dischem has got a Mr van Tonder there next day Mr van der Merwe following day Mrs Pampapoer following day this pharmacist. You can never correlate everyone together and get a relationship with somebody.”

Failure by the government to fairly increase pharmacist professional fees was confirmation of a poor recognition of pharmaceutical care provision. The participants felt that dispensing fees had been minimally increased since inception. A participant stated “...and also getting it back to money and business, we’ve had the same dispensing fee since.” Participant Two added: “This year we’ve had 1% in medicine
how can that possibly be allowed when we have an inflation rate of 6% and then they give us a 1% in medicine.”

Table 3.3: Gazetted dispensing fee amendments (National Health Plan Strategy, 2018)

<table>
<thead>
<tr>
<th>Dispensing fee 2017</th>
<th>New Dispensing fee 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ex VAT</td>
<td>ex VAT</td>
</tr>
<tr>
<td>&lt; R97.05</td>
<td>&lt; R107.15</td>
</tr>
<tr>
<td>R97.06 - R258.87</td>
<td>R22.50 + 33% of SEP</td>
</tr>
<tr>
<td>R258.88 - R906.09</td>
<td>R285.80 - R1000.32</td>
</tr>
<tr>
<td>&gt;R906.10</td>
<td>&gt;R1000.33</td>
</tr>
<tr>
<td></td>
<td>R160.00 + 5% of SEP</td>
</tr>
<tr>
<td></td>
<td>R172.00 + 5% of SEP</td>
</tr>
</tbody>
</table>

The figures depicted above were not welcomed and were viewed as the reason independent retail pharmacy had become a questionable investment. Participant Three declared his intentions not to renew the rental lease because of the poor remuneration schedule, whilst Participant One stated that he had strong reservations on future income streams through independent pharmacy. Participant One explained, “I was actually telling someone that as it stands I am trying to salvage whenever I can; I probably should jump. I don’t think I can renew the lease twice, probably I will sit for the last year and scramble what I can then take what I can and re-invest somewhere.”

The Pharmaceutical Society of South Africa states that a pharmacist’s main income should be derived from providing services rather than trading in medicine (Healthcare report, 2000). However, this was contrary to the experiences of the participants.

Participant Three said “There’s a big change! Let me tell you something your profit margin that time was 50% you could make a good living, your profit margin now is about 12 – 14%. How could you survive on that percentage? You see these idiots that don’t understand the efficacy of running a business. They don’t understand.” He added “They say you work on this margin or that margin.”

A growing trend by corporate pharmacies is the marketing of in-house brands. This practice skewed the playing field, as it could provide the corporate an additional revenue stream and endorsed the product-based pharmacy practice approach. The green list campaign initiated by one of the corporate pharmacies is aimed at promoting specific brands of products above others in line with agreements secured with related manufacturers. A call for a review of such conduct and of registration of ethical products by corporate pharmacies was made. Participant One questioned: “I mean how did they allow retail pharmacies to own wholesalers?”

3.4 RESEARCHER’S SUMMARY

The general tone of the interviews was largely despondent with a slight glimmer of hope. Participants concurred that the retail pharmacy landscape had undergone significant changes. Changes identified were neither in favour of independent retail pharmacists nor the profession of pharmacy in its entirety.

The identified themes continued throughout the interviews and suggested a fair representation of the views of the independent pharmacy community at large.
CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The study aimed to establish the perceptions of retail pharmacists in Johannesburg based on factors influencing the viability of pharmacy retail practice and business. A study of literature pertaining to retail pharmacy practice in South Africa within the context of professional pharmacy practice and that of business management was instrumental in guiding the fundamental elements of this research. Business studies undertaken on profitability, sustainability and business analysis provided objectivity in exploration of the aim. The Pharmacy Act outlined the legal framework within which the business of a retail pharmacy is conducted in South Africa.

Chapter 1 described the overview of the study and indicated the aims, objectives and rationale for the study. Chapter 2 provided an in-depth description of the research methodology followed by an exploration and discussion of the research findings in Chapter 3.

4.2 CONCLUSIONS

Factors identified in the study highlighted the influence of legislative amendments on pharmacy practice. The impact of changes in ownership of retail pharmacies resulted in the entry of corporate pharmacies, which have been perceived by retail pharmacists as disadvantaging factors. Pricing regulations minimised income potential, whilst medical aids’ funding structures further compromised the income of retail pharmacists by reducing the payable mark-up on medicinal products. Exclusive business arrangements between medical aids and selected retail pharmacies further challenged the retail pharmacy market.

The business model of a courier pharmacy was interpreted as negating pharmaceutical care, as it was perceived to discredit the practice of pharmacy. Diminishing pharmaceutical care increased the need for professional interpersonal interaction. Independent retail pharmacies, with adequate government support, are possibly in a position to fulfil that need. Retail pharmacists are likely to be the best
source of pharmaceutical care and are thus able to maximise public need with the hope of improving turnover.

4.3 LIMITATIONS OF THE STUDY

Minimal literature could be located on the exploration of the relationship between the legislative framework and the business elements and success. The business acumen and training of the retail pharmacists interviewed were not engaged as a variable in the research.

The study could have benefitted from exploring the views of other stakeholders in retail pharmacy, such as medical aids, courier and corporate pharmacists, as well as the general public on the viability of retail pharmacies. Additional input by the stakeholders could assist in obtaining a more informed perception of the viability of retail pharmacies in Johannesburg as well as perceptions throughout South Africa.

4.4 RECOMMENDATIONS


2. Recommendations for accredited pharmacy business management training. An addition to the final year curriculum of the Bachelor of Pharmacy qualification focusing on business analysis, managerial skills and financial management, reinforced by an internship programme in retail pharmacy would empower retail pharmacists to run more viable retail pharmacies.

3. Engage the portfolio of health committee in parliament to address the diminishing practice of pharmaceutical care.

4.5 CONCLUDING REMARKS

Retail pharmacists have a multi-faceted responsibility to be healthcare professional service providers, educators, gate-keepers of medicinal products and the additional responsibility to ensure the viability of the business entity. Hindrances encountered by retail pharmacists to balancing these responsibilities and to successfully marry them are a challenge for retail pharmacists. A middle ground, beneficial to all areas of their responsibilities is therefore an ideal to strive towards. The pharmaceutical retail
industry needs to recognise the issues and the lessons inherent in their service to improve future retail pharmacy prospects.
REFERENCES


Pharmaceutical statistics [online] https://www.who.int/pharmaceutical statistics [date accessed July 2018]

PMB’s and Chronic Disease List https://www.cms.co.za (accessed October 2018)

PPS pharmacists survey https://www.icpa.co.za (accessed September 2018)


APPENDIX I: RESEARCH METHODOLOGY

This study will utilise the one-on-one interviews guided by a semi-structured interview schedule to explore the said perceptions, beliefs and emotions of retail pharmacists on the viability of retail pharmacists

A method used in qualitative research ideal for exploring perceptions, beliefs and emotions of participants. This study will utilise the method to explore the said perceptions, beliefs and emotions on viability of retail pharmacies in one-on-one interviews guided by a semi-structured interview schedule.

Population

The Oxford Advanced Learner’s Dictionary (2000) defines a population as a well-defined collection of individuals known to have similar characteristics. For the purposes of this study the number of pharmacists in retail pharmacy practice in Gauteng is reported as 1096 (South African Pharmacy Council, April 2016)

Sampling method

Sampling entails selecting a portion of the population to represent the entire population and can also be defined as the use of a group of individuals, from the stated population, with whom to conduct the research (LoBiondo-Wood & Haber 1998:250). One of the methods of sampling in qualitative studies is purposive sampling which is the chosen method for this study.

The sample size for this study is 5 practising independent retail pharmacists in Johannesburg who meet the inclusion criteria. Inclusion criteria are that the pharmacists must have been working in retail pharmacy for a minimum period of 5 years, in the Johannesburg, Gauteng region.

Data collection

This is the process of gathering and processing information in relation to a topic of interest: Factors affecting the viability of Independent pharmacies in Johannesburg, Gauteng. The method selected, requires direct interaction with the subjects (pharmacists) and involves collecting of data in a pre-determined manner. The current study will utilise scheduled semi-structured interviews with 5 participants and may continue until data saturation is achieved.
Participants’ responses will be recorded, with prior written consent. Two voice recorders will be utilised and the data will be subsequently stored for safekeeping. It is expected that data will be expressed in words, emotions, ideas and actions that will be collected to allow for verification and continuity particularly in-line with the research aim.

**Research Questions**

The following will be used as a guide to the interview:

1. How would you compare running an independent retail pharmacy with running a different retail business?

2. Has there been a change in retail pharmacy business trends in the last 5 -10 years?

3. What changes have you noted in pharmaceutical care provision?
# APPENDIX II: INFORMATION AND INFORMED CONSENT FORM

## NELSON MANDELA METROPOLITAN UNIVERSITY

### INFORMATION AND INFORMED CONSENT FORM

<table>
<thead>
<tr>
<th>RESEARCHER'S DETAILS</th>
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</tr>
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<td><strong>Title of the research project</strong></td>
<td>Retail pharmacists’ perceptions of factors influencing the viability of their practice and business in Johannesburg, Gauteng province.</td>
</tr>
<tr>
<td><strong>Reference number</strong></td>
<td>H18-HEA-PHA-001</td>
</tr>
<tr>
<td><strong>Principal investigator</strong></td>
<td>Nondumiso Sybil Gazi</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>4A Millard Road, Bedfordview</td>
</tr>
<tr>
<td><strong>Postal Code</strong></td>
<td>2007</td>
</tr>
<tr>
<td><strong>Contact telephone number</strong> (private numbers not advisable)</td>
<td>+27 721558337</td>
</tr>
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### A. DECLARATION BY OR ON BEHALF OF PARTICIPANT

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td><strong>I, the participant and the undersigned</strong></td>
<td>(full names)</td>
</tr>
<tr>
<td><strong>ID number</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address (of participant)</strong></td>
<td></td>
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### A.1 HEREBY CONFIRM AS FOLLOWS:

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Nondumiso Gazi from Faculty of Health Sciences of the Nelson Mandela University.</td>
<td></td>
</tr>
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### The Following Aspects Have Been Explained to Me, the Participant:

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<tr>
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<th>Aim:</th>
<th>The aim of this study is to establish perceptions of retail pharmacists; in Johannesburg, Gauteng; on factors influencing the viability of pharmacy retail practice and business.</th>
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</thead>
<tbody>
<tr>
<td>2.2</td>
<td>Procedures:</td>
<td>I understand the procedures to be followed when participating in the study.</td>
</tr>
<tr>
<td>2.3</td>
<td>Risks:</td>
<td>No known risks, as an individual, retail pharmacist and or business owner are anticipated, to the participant.</td>
</tr>
<tr>
<td>2.4</td>
<td>Possible benefits:</td>
<td>As a result of my participation in this study, recommendations to improve the viability of independent retail pharmacies</td>
</tr>
<tr>
<td>2.5</td>
<td>Confidentiality:</td>
<td>My identity will not be revealed in any discussion, description or scientific publications by the investigators.</td>
</tr>
<tr>
<td>2.6</td>
<td>Access to findings:</td>
<td>Any new information or benefit that develops during the course of the study will be shared as follows:</td>
</tr>
</tbody>
</table>

#### Voluntary participation / refusal / discontinuation:

- My participation is voluntary: YES NO
- My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle: TRUE FALSE

### The Information Above Was Explained to Me/The Participant By:

Nondumiso Gazi

in English

and I am in command of this language, or it was satisfactorily translated to me by

(name of translator)

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.
5. Participation in this study will not result in any additional cost to myself.

<table>
<thead>
<tr>
<th>A.2</th>
<th>I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:</th>
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<td>Signed/confirmed at on 20</td>
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<tr>
<th>B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)</th>
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<tr>
<th>Signed/confirmed at on 20</th>
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</thead>
<tbody>
<tr>
<td>Signature of interviewer</td>
</tr>
<tr>
<td>Signature of witness:</td>
</tr>
<tr>
<td>Full name of witness:</td>
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</table>
## C. DECLARATION BY TRANSLATOR (WHEN APPLICABLE)

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<tr>
<td><strong>I,</strong></td>
<td>(full names)</td>
</tr>
<tr>
<td><strong>ID number</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Qualifications and/or current employment</strong></td>
<td></td>
</tr>
</tbody>
</table>

I confirm that I:

1. Translated the contents of this document from English into *(language)*

2. Also translated questions posed by *(name of participant)* as well as the answers given by the investigator/representative;

3. Conveyed a factually correct version of what was related to me.

Signed/confirmed at **on** 20

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential.

<table>
<thead>
<tr>
<th><strong>Signature of translator</strong></th>
<th><strong>Signature of witness:</strong></th>
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<td>Full name of witness:</td>
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**D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT**

Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
  - the following occur

(indicate any circumstances which should be reported to the investigator)

<table>
<thead>
<tr>
<th>Kindly contact</th>
<th>Nondumiso Gazi</th>
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at cellphone number and email address

+27 795256623; s215293908@nmmu.ac.za

XXX
APPENDIX III: INVITATION TO PARTICIPATE ON STUDY

Nelson Mandela University
Summerstrand Campus
Faculty of Health Sciences
Tel. +27 (0)41 504 3946
s215293908@nmmu.ac.za

Date January 2018
Ref: 215293908
Contact person: Nondumiso Gazi

Study Title

Retail pharmacists’ perceptions of factors influencing the viability of their practice and business in Johannesburg, Gauteng province

Dear Retail Pharmacist

My name is Nondumiso Gazi. I am a registered pharmacist and a student enrolled for a Master’s degree in Health and Welfare Management (Student number: 215293908) at the Nelson Mandela University. For the purposes of the degree I am conducting a study to establish how the pharmacy model is changing and how that change has been perceived by independent retail pharmacists in Johannesburg, Gauteng.

The objectives of the research are:

1. To explore experiences as well as resultant effects in practising retail pharmacy, in Johannesburg, for the last five years.
2. To make recommendations to independent retail pharmacies on overcoming the common challenges to best suit the market

Participation in the research involves submitting to an interview, the results of which will form a collective representation of the perceptions of retail pharmacists on the changing pharmacy model. Results will be made available to you and will be
disseminated within the university and other academic structures including peer reviewed journals.

The study will be undertaken under the supervision of two members of Nelson Mandela University staff and with the approval of the University’s Ethical Committee (H18-HEA-PHA-001).

I invite you to participate in this study. Your identity will not be revealed and withdrawal shall not result in any known consequence/s.

Yours sincerely

Ms N Gazi

Contact details in the event of enquiries:

Ms N Gazi (s215293908@nmmu.ac.za; 0721558337)

Ms AG Klopper (supervisor) Dr BC Knoesen (co-supervisor)
aileenk@absamail.co.za; Brent.Knoesen@mandela.ac.za
Telephone: 061 9695364 Telephone: 074 3209463
APPENDIX IV: THIRD INTERVIEW

Retail pharmacists' perceptions of factors influencing the viability of practice and business in Johannesburg, Gauteng province

Date: 30 May 2018

Time: 13.32

Introduction: As per the paperwork/letter handed to the subject

The following were used as a guide to the interview:

1. How would you compare running an independent retail pharmacy with running a different retail business?

2. Has there been a change in retail pharmacy business trends in the last 5-10 years?

3. What changes have you noted in pharmaceutical care provision?

INTERVIEWER: How does running an independent retail pharmacy currently compare with running other retail businesses?

SUBJECT: Yes it is. Very much different. Sorry (customer interrupts)

INTERVIEWER: We were comparing running a retail pharmacy to running any other business

SUBJECT: No.1 you got to be aware of the drugs and the drug interactions

INTERVIEWER: The technical aspects

SUBJECT: The technical aspects, the chemical aspects. For example if you go to Pick n Pay you don't have to say, are you allergic to fish, are you allergic to chicken

INTERVIEWER: I've got that
SUBJECT: Or even clothes, it's the chemical and technical aspects of running of a pharmacy. And the ability to explain to the various customers the various conditions and how one would alleviate these certain conditions by means of taking certain drugs and the c/l of the

INTERVIEWER: In that technical space it would be different. On a business outlook? Would you leave a pharmacy to run a KFC franchise

SUBJECT: It's a different thing, there's registration there's all this crap you got to do. If you opened a clothing shop or a fast food shop, u don’t need to get licences and there’s got to be so many sq meters and all this sh..t! You just open and get a trading licence. There's a difference

INTERVIEWER: And you continue to trade. But wholistically, as with other independently owned businesses competing in the same space as macro entities

SUBJECT: I would say, I give community pharmacy 10 years in which they close down

INTERVIEWER: You think so? That’s grim!

SUBJECT: No, no I will give them 10 years. No1, the challenge of community pharmacy in regards to Dischem, and Pick n Pay and all that sh…t. There’s a big difference. As you can see I had a lot of fancy goods and cosmetics which has been thrown out. No.1 Dischem, their brand lines, as well their shampoos, their vitamins are exceptionally much cheaper than the individual pharmacies and you as a pharmacist you wouldn’t buy Berocca from me if you can get Berocca if R30 or R40 cheaper at a Dischem

INTERVIEWER: Yeah

SUBJECT: I would say, I give community pharmacies 10 years before they close down. That's the one aspect.

INTERVIEWER: For sure

SUBJECT: I mean when I qualified 1965, there wasn’t this sh….t You dispensed, your dispensing fee and that’s it. And there was an ethical law which stated, what was the
law saying. It said, you cannot say to a customer go this pharmacy its cheaper than that pharmacy. and the medical aids could not direct.

INTERVIEWER: Oh, is it? Where they go

SUBJECT: Could not direct a pharmacy and say listen Glendower doesn’t do fedhealth go to medicare that’s the difference

SUBJECT:

INTERVIEWER: You see it then speaks to the changes in the trends in the last 5 years

SUBJECT: There’s a big change! Let me tell you something your profit margin that time was 50% you could make a good living, your profit margin now is about 12 – 14%. How could you survive on that on that percentage. You see these idiots that don’t understand the efficacy of running a business. They don’t understand. They say you work on this margin or that margin.

I wanna ask you a question, do you know how many pharmacists and I’m sure you well aware of this: You have a good customer, very good customer and they come and say listen give an antibiotic for my son, give me some amoxyl®, give me some moxypen®. What do you say, f..k off. They gonna go down there

INTERVIEWER: No, and they get it! That’s true

SUBJECT: You say sure come in and they get it. This f…ken Pharmacy Council u cant even give a pill without a f…ken prescription. I mean u cant give injections have you heard of it a pharmacist cannot give injections of vit bco. They are mad! They have f…d up the pharmacy completely.

INTERVIEWER: Whom? You mean the pharmacy council?

SUBJECT: They are not for the pharmacists!

INTERVIEWER: No, They do say their mandate is for the public and not for us the pharmacists even though we pay the fees.

Customer interrupts
SUBJECT: Can I just help the lady there?

INTERVIEWER: Yes sure

SUBJECT: They say age before beauty!

Laughter

INTERVIEWER: We were discussing the trends in the last 5 years. We spoke about the medical aids are forcing people to go to certain pharmacists, the pharmacy council

SUBJECT: That’s wrong! They should not do that. They should say right equal providers. You can go to Dischem, you can go this one but the price is the same. And that’s what hit a lot of pharmacies. I don’t know if you remember when this bl…dy b…tch, this alcoholic, the minister OF HEALTH, what’s her name? That bloody drunk addict. Nkambala? The one they did a transplant, and started drinking again, the one did their

INTERVIEWER: Ehm

SUBJECT: But I’m saying, She started this, why didn’t she go for the dentists why didn’t she go for the doctors. Do you know how many pharmacies closed their doors when she started this your mark up must be this or that? 490 PHARMACIES

INTERVIEWER: Do you think the bigger culprit is the medical aids, pharmacy council or doh?

SUBJECT: The whole 3 together.no 1 the medical councils said go this person and to that person, the doh underlines the medical councils so they feel the efficacy and the probability of the poorer class of whatever it is that they don’t have to outlay a levy or whatever, is a better proposition. all 3 together, the pharmacy council as well, the whole lot

INTERVIEWER: So there’s definite trends and changes of the last few years

SUBJECT: There’s a lot of changes! i mean years ago, years ago, you could have gone if there was a problem. I will tell you what happens years ago. i was smoking right in the back, you know away from this, by the office
SUBJECT: The one guy gave 10, the other guy 15, the other guy gave 20, the other
guy gave 25 and the other 30, you know what I mean. But we were forced to do this
because this minister of health, she f…d everything

INTERVIEWER: You mean they gave what do you mean they gave..

SUBJECT: Discounts

INTERVIEWER: Oh you mean discounts

SUBJECT: I mean when I qualified, it was one price. You could go from here to Durban
to Cape Town and it was one dispensing price. And that was levelled, that was good.
There wasn’t reduction in price, reduction. Alright we used to sell, we would give a
10% discount whatever you want shampoos, conditioners all that sh…t. At the moment
I don’t see a future for community pharmacies. This is my opinion.

INTERVIEWER: I had hoped there would be some promise in pharmacists doing more
pharmaceutical care stuff. That makes which makes you different from a an ordinary
retail shop, that which makes you different from a herbal shop - The advice to the
patient, the care in terms of professional care. Is that still an avenue pharmacists can
pursue?

SUBJECT: Very much so. If you go, let’s say you go Dischem theres Mr A one side ,
Mr B

Customer interruption

You see the reason they come to a community pharmacy, all the years. You speak to
them, their kids were small, they growing up, they ask advice. A Dischem has got a
Mr van Tonder there next day Mr van der Merwe following day Mrs Pampapoer
following day this pharmacist. You can never correlate everyone together and get a
relationship with somebody.

INTERVIEWER: So the, the independent pharmacies are still bigger on
pharmaceutical care, they provide pharmaceutical care
SUBJECT: Very much so, very very much so

INTERVIEWER: I hope and wonder how pharmacists can grow that p/care to make it viable. Because that’s what distinguishes you from a herbal shop.

SUBJECT: I tell you what they can do, get hold of the m/aid and say listen let the customers go to whichever pharmacy they want. No levies to be charged throughout of South Africa. Not one price there and one price there, one price there, it doesn’t work like that.

INTERVIEWER: So those DSP’s, the arrangements with the medical aids are a problem.

SUBJECT: Of course it is.

INTERVIEWER: One pharmacist questioned whether the DSP’s are even legal.

SUBJECT: No its not legal. I remember like I’m saying, now I remember one of the pharmacy laws was’ you will not taut for prescriptions. But now the medical aids are now indirectly touting for prescriptions. They are saying take your prescription and go this pharmacy. Go to Medirite, go to Pick n Pay, go to Dischem -we have a contract with Dischem. That is touting for prescriptions. That’s one of the ethical rules maybe they have done away with it now, I don’t know. You must check on that.

INTERVIEWER: I must check on the act, the pharmacy act or the medicines and related substances act.

SUBJECT: Like I said one of the main components is you shall not tout for prescriptions. You cannot say, a dr there... he cannot say dr Marais, listen don’t go to Rodney his prices are high go to Dischem you’ll get a better deal. You cannot do that.

INTERVIEWER: Yes that’s wrong. The medical aids in essence have gained much power

SUBJECT: Of course they have gained much power. I mean I have very good friends, I’m talking friends, they will not come here because they are good friends of mine. They say Ronnie why must I pay a levy of R140 when I can go to Medi rite and I don’t pay nothing. You would do the same if you and I were good friends, and you lived
around the corner and came for dinner and whatever it is. You understand im saying, you cant blame them. And that's where the problem, there's got to be a complete turnaround of pharmacy in regards the community in regards to the big DSP, there's got to be a change. And they not prepared to give it to you. And that's the problem. I mean these guys on the pharmacy council, they know nothing, what do they know, they know extremely fuckall. They should get a pharmacist who goes.. like , like who can .. can go around and say look what is going on in pharmacy.. this is wrong.

**INTERVIEWER:** One who has owned because if u worked for someone its diff to when u have owned the entity.

**SUBJECTS:** Let me tell you something, I have owned this place for 34 years, I told you. I have sold and I made a loss but I couldn't handle it. Its not that. The cars break down, the accounts this this and I worked from. This, this, and I worked from 8 am in the morning till 11 pm at night, 7 / 11. Couldn't do that anymore. Now I finish at 6pm, I go home have dinner with the family and whatever it is.

**INTERVIEWER:** All the other stress belongs to somebody else.
APPENDIX V: FIFTH INTERVIEW

Retail pharmacists’ perceptions of factors influencing the viability of practice and business in Johannesburg, Gauteng province

Date: 22 June 2018

Time: 15h45

Introduction: As per the paperwork/letter handed to the subject

The following were used as a guide to the interview:

1. How would you compare running an independent retail pharmacy with running a different retail business?

2. Has there been a change in retail pharmacy business trends in the last 5 -10 years?

3. What changes have you noted in pharmaceutical care provision?

INTERVIEWER: How does running an independent retail pharmacy currently compare with running other retail businesses?

SUBJECT: Like a clothing shop

INTERVIEWER: A clothing shop, a KFC or any other

SUBJECT: In terms of the business side of it, its very much the same, you are still running a business and are looking at profits and you looking at the technical aspects. But when it comes to pharmacy we are not dealing with commodities, we are dealing with people who are really looking for assistance and that’s what makes it different to running another retail store. Like, its not like someone buying a t-shirt or a jersey where you just look at size and whether you like it whereas here we really have to start using our knowledge to be able to assist patients and to be able to make a difference. So I think its very much different in that terms, at the end of the day its still running a business. We still looking at the numbers, you still must make a profit, you still must pay the bills, you still have to pay rent so the technical things are still the same
INTERVIEWER: You must still make a profit

SUBJECT: But I think it's more fulfilling because you actually helping people in a different way you meeting someone's needs and I think that’s critical

INTERVIEWER: That’s very true because now you look at its just the product they are buying, what more are they looking for

SUBJECT: So we are adding value to a product. So if someone comes in with a script, they coming with a piece of paper with words on them which they don’t even know what they mean. And I think at least what I see in my own practice is that doctors don’t – they just script and they give to the patient “go to the pharmacy they will give you” so they sometimes don’t even know what the doctor has given them.

INTERVIEWER: Yes they don’t know most times

SUBJECT: Either they are too scared to ask the doctor because they could be in a position where they are very stressed and they forget to ask and then we become the point where we become the conversation for the patient.

INTERVIEWER: Yes, the person to talk to.

SUBJECT: Exactly. We end giving up a lot of value over and above what we are trying to sell. And then we do add ons, so we say ok – this will help you in a different way- we provide lifestyle modification advice and. You know there some things, simple things we know we should do but you need someone to tell you to do them, to reinforce what you already know. So, we do add value in that sense

INTERVIEWER: And I think they do feel different to when they leave the doctor’s rooms its different to when they leave a pharmacy

SUBJECT: Ya, that’s why I moved to a bigger store and I wanted it to be airy and bright coz when people come, when they walk into your door, they usually stressed

INTERVIEWER: Yes

SUBJECT: You want them, when they walk out of door, you want them to feel a bit happier
INTERVIEWER: A bit calmer

SUBJECT: It's the environment that the different pharmacies create. You know when you walk in. Like when you have a happy picture instead of a grey sitting room, any doctor's rooms is scary coz you always apprehensive

INTERVIEWER: A clinic effect, the white collar/ jacket effect

SUBJECT: The white jacket effect. So it makes a difference in the pharmacy, in independent pharmacy - coz we all have our own looks, we all have our own styles we take than on into our businesses.

INTERVIEWER: You actually portray that in the way you run your business.

SUBJECT: So, with every independent pharmacy. The Clicks’ all have the same style, the Dischems all have their own styles

SUBJECT: Or have the franchise style. Now as independents pharmacists we are fortunate in that we can add our own little personality to it. We don’t have anon-pharmacist telling us what to do.

INTERVIEWER: I loved that. That one thing I loved, trying out what I would like to try.

SUBJECT: That’s what for me Is fulfilling. This is me, the walls and things is designed by me. Its not someone telling you taking up too much space and I mean come pray at my temple sometimes (referring to a Hindu temple/altar in his office), where would you find that at a Clicks or a Dischem.

INTERVIEWER: No you don’t.

SUBJECT: Because that’s how independents run.

INTERVIEWER: Also you know Ndumi, you know John etc.

ISUBJECT: We phone them on their phones its quick quick, its different.

INTERVIEWER: What changes in retail pharmacy business trends have you noticed in the last 5 -10 years?
**SUBJECT:** There’s a lot of change. Firstly the medical aids right. The medical aids is a big thing, there’s been huge changes in the medical aids part where they’ve changed their regulations wrt DSP’s. Five years ago I would service say 100 HIV patients and then the medical aid came up with the rule that they cant get it at an independent pharmacy, it has to be couriered to them or a corporate pharmacy. So that was huge for me because we lost all our patients we were taking care of because they would pay an additional 20 % out of their pocket.

**INTERVIEWER:** They moved, most cant afford that

**SUBJECT:** Most cant afford that. You really think that one pays such a high amount for their medical aid, you would expect them to cover that

**INTERVIEWER:** To cover anything for your chronic condition

**SUBJECT:** Exactly. The thing is that, that has changed. The biggest thing is the way this DSP thing works. Its an unfair practice to independents, because we can provide the same service as corporates provide, probably even a better service. I think a way better service than the courier pharmacy who doesn’t even speak to the patient.

**INTERVIEWER** This is what most pharmacists have told me. I spoke to a guy who has both Dischem and Clicks in the same centre. He asked a very interesting question that are these DSP’s even legal, if are they not a contravention of some law,

**SUBJECT:** It is a contravention I think, you know they say they don’t want perverse incentives, this is a peverse incentive to a different party.

**INTERVIEWER:** True, its indirect tauting

**SUBJECT:** I have patients that get their meds couriered to them, so the box goes straight to the home or to the workplace. Sometimes they come in here, they open the box in front of me and ask “Deevesh what is this, it looks different to me, I’m too scared to take it” coz sometimes they are not even told what they are getting or they are told but cannot visualise coz they don’t have that one on one with a pharmacist.

**INTERVIEWER:** If they are told, they are not sometimes.
SUBJECT: For me it’s a saddening part because we lost those patients so you loose a part of your business right. As a pharmacist you loose their care coz sometimes they come with an acute script and you forget that they are on another script and you like ‘Oh no, now what” and some of them don’t even tell you sometimes. Because they getting theirs couriered by a different pharmacy.

INTERVIEWER: They are on warfarin

SUBJECT: So we give them a brufen® because that’s best for their muscle pain

INTERVIEWER: So they are getting treated at different points, why should we do that to patients. For me that’s very unfair.

SUBJECT:

INTERVIEWER: I think it also infringes, this is my personal view, on a person’s right to choose where they get service provision.

SUBJECT: Exactly

INTERVIEWER: That is the biggest thing, changes in the medical aids and then the uprise of all these corporate pharmacies in every nook and corner. I mean in town we used to be – independent pharmacies used to rum the cbd, Braamfontein and we used to add our value. If you look at it now there’s a Dischem and there’s Clicks coming up soon. So the corporates are just invading all space, every nook and crook they wanna get into. But that’s business, and business is not always nice. Their core business is not pharmacy that’s where I have an issue.

SUBJECT: Yes

SUBJECT: They are business people selling 2 for 1 deals of cosmetics, which is great. I go shopping at Dischem.

INTERVIEWER: I do too

SUBJECT: Because I get cheap stuff. But I don’t go there to get help when im sick. I rather go to a pharmacy or a doctor you know coz that’s their core speciality.
INTERVIEWER: And that’s why I call shopping at the corporates a wholesale experience and going at an independent pharmacy, a boutique experience.

SUBJECT: Exactly. So that’s a big trend over the last few years. I mean Dischem only came last year and I heard there’s a Clicks coming up and today i heard that a Pick n Pay is opening around the corner.

INTERVIEWER: I believe their markets are different, I really truly believe your market is different to the Dischem, to the Clicks client. It seems intimidating initially but when you really think about it you will see they have different markets

SUBJECT: Its how you sell yourself to your client

INTERVIEWER: Yes, to your prospective client

SUBJECT: Because look, my front shop is small. I don’t keep Pantene® and Organics® its not my core, its not where I want to focus on but what I wanna focus on – you can see my dispensary is bigger than my front shop, almost!

INTERVIEWER: Its sizeable even compared to some Clicks dispensaries

SUBJECT: Exactly, because this is where my core business is providing medication. You know there is so many changes. And then with the corporates coming in, they competing with price

INTERVIEWER: Economies of scale come into play

SUBJECT: Economies of scale come into play, that’s a big thing for independent pharmacies. And we don’t have the support corporates have. They have buying power, their own wholesalers.

INTERVIEWER: That’s already cutting down on logistics fees which gives them at least 10 % leverage. So those are big things affecting independents, I think

SUBJECT: Clinics have become big now, that’s trending now in most pharmacies no where most pharmacies are keeping clinics. That’s the direction that we will find ourselves in eventually
INTERVIEWER: Yes, That’s leading me to the next one, is that now how we should be considering pharmaceutical care as being the centre of retail or community pharmacy practice. What changes have you noted in pharmaceutical care. You just said to me that there is more clinics opening up which means there is bigger recognition for pharmaceutical care and more primary healthcare versus commodity trading

SUBJECT: I think eventually there’s going to need to be a balance between the two because commodity trading will always be there, will be the at the core part of the pharmacy but a big add on will have to be a focus on primary healthcare. So, screening will be a big thing, screening will be important and also being able to assist in some of the key standard issues that everybody is exposed to. The common things like maybe STD’s, contraception EHHMM

INTERVIEWER: Those are still issues, people think they are not. They still issues

SUBJECT: They are issues, exactly. i think sometimes we can add value there. People’s lives have become too busy.

INTERVIEWER: And also the trend in the disease profile of the country is pointing towards lifestyle diseases and those need education, healthcare interventions and participation a lot more than wha was infectious disease where we gave you a course of antibiotics and we new that would sort you out. But now we have your gouts, diabetes

SUBJECTS: There’s too many multiple things happening together and that’s a big issue. Clinics, I think is what’s going to change the face of pharmacy at some point or its going to be an important add on to a pharmacy.

INTERVIEWER: It’s going to grow it bigger. But how pharmacists use that is key. For instance if you have clinic runs and you have outsourced it and want nothing to do with it. But it doesn’t talk to each other, its got to be incorporated somehow.

SUBJECT: It’s got to be incorporated. For me, I’m still thinking about the clinic, I have 3 ways I’m thinking about how to do it.

INTERVIEWER: So the clinics, more pharmaceutical care is our hope for the future
SUBJECT: More holistic care. The biggest mistake was allowing non-pharmacists to own pharmacies. Every tier has contributed, from government to Pharmacy Council.

INTERVIEWER: They all contributed to the demise, would you call it a demise?

SUBJECT: I wouldn't call it a demise, it's a change.

INTERVIEWER: Thank you so much for your time and input. Its truly appreciated.
APPENDIX VI: LIST OF CHRONIC CONDITIONS ON PRESCRIBED MINIMUM BENEFITS

i. Addison’s disease
ii. Asthma
iii. Bronchiectasis
iv. Cardiac failure
v. Cardiomyopathy
vi. Chronic Obstructive Pulmonary Disorder
vii. Chronic renal disease
viii. Coronary artery disease
ix. Crohn’s disease
x. Diabetes Insipidus
xi. Diabetes mellitus types 1 & 2
xii. Dysrhythmias
xiii. Epilepsy
xiv. Glaucoma
xv. Haemophilia
xvi. Hyperlipidaemia
xvii. Hypertension
xviii. Hypothyroidism
xix. Multiple sclerosis
xx. Parkinson’s disease
xxi. Rheumatoid arthritis
xxii. Schizophrenia
xxiii. Systemic lupus erythematosus
xxiv. Ulcerative colitis
xxv. Bipolar Mood Disorder
xxvi. HIV/AIDS
One Stop Solution
24 Firenze Gardens
Warbler Road
Cotswold Ext
Port Elizabeth
6045
www.onestopsolution.co.za

TO WHOM IT MAY CONCERN

I, Michele van Niekerk, declare that I have done the language editing for the thesis of:

NONDUMISO SYBIL GAZI (215293908)

entitled:

RETAIL PHARMACISTS’ PERCEPTIONS OF FACTORS INFLUENCING THE VIABILITY OF PRACTICE AND BUSINESS IN JOHANNESBURG, GAUTENG PROVINCE

Submitted in partial fulfilment of the requirements for the degree of Master of Arts in Health and Welfare Management at the Nelson Mandela University.

I cannot guarantee that the changes that I have suggested have been implemented nor do I take responsibility for any other changes or additions that may have been made subsequently.

Any other queries related to the language and technical editing of this treatise may be directed to me at 076 481 8341.

Signed at Port Elizabeth on 20 March 2019

Mrs M van Niekerk