

PHARMACISTS' PERCEPTIONS OF OCCUPATIONAL SPECIFIC
DISPENSATION (OSD): EXPLORATORY STUDY OF CAREER AND
HUMAN RESOURCE PERSPECTIVES

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KEY WORDS

Occupational specific dispensation (OSD)

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Public sector employment image

Attraction and retention

Career pathing

Career advancement

Organisation commitment

Pay satisfaction

Health human resource



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ABSTRACT

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Prior to 2007, South Africa's government became concerned about the loss and inability to retain certain professionals in its employment. Health human resources were distributed in favour of the private sector and urban areas while rural areas survived on a meagre portion of health employees. In 2007, the government introduced a re-designed remuneration structure for individual skilled professions namely, Occupation Specific Dispensation (OSD), with the goal to attract and retain professionals. This study qualitatively explores the perceptions of public sector employment (PSE) by pharmacists to extract how OSD-policy may or may not be succeeding. It also investigates the opinions of pharmacists on the promotional structure of OSD and opportunity for career advancement (CA) as a possible indication of organisational commitment.

Participants were recruited from four career streams in OSD's structure, all employed in the Department of Health, Provincial Government of the Western Cape. In the first stage of data collection, one-on-one interviews were conducted with key-informants which consisted of policy specialists (n=2) and management (n=2). In the second stage, focus group interviews were conducted comprising of production and supervisory pharmacists (n=27). Sampling strategies encompassed purposive, snowball and stratified sampling to ensure saturation of data and provide comparisons between groups and sub-groups. Thematic analysis of interview transcripts was performed using inductive coding in the first stage and *apriori* coding in the second stage. Themes and sub-themes were "reflexed" onto

Human Resource and Work Motivation Theory by engaging a three question reflexive framework to ensure consistency in the interpretation of results.

Eleven major themes emerged: overlapping of salary grades; variety of positions; being a manager of professionals; envisioning promotion; pay versus responsibility; pay equity and expectancy; OSD and attraction; OSD and retention; over-time and after-hours remuneration; interpreting OSD; and using unions to negotiate policy for professionals. 41 sub-themes that emerged were positively, negatively or neutrally connected to perceptions of PSE or CA. Positive sub-themes of PSE is that OSD has “ensured that entry level positions are extremely attractive” and OSD is “attracting more junior pharmacists to management positions”. Negative sub-themes of PSE include that a “retention strategy for experienced pharmacists tends to be neglected” and “some work related factors may nullify retention strategies”. Negative or stagnant perceptions of PSE produce an image that fails to care for individual employee needs and tarnishes the image of public sector employment. Positive sub-themes of CA are that OSD now “permits individual freedom of career path choice” and OSD “has created a variety positions through a broadened post structure”. Negative sub-themes of CA are that “experienced pharmacists stagnate in their career” and “supervisors have a lot more responsibilities but get paid the same as production pharmacists”. Since the perception of career mobility is related to organisational commitment and retention, negative perceptions of career advancement may result in apprehension to develop via promotion or career path change. This can lead to employee boredom, complacency or frustration of career ambitions and eventual loss of staff.

Some aspects of OSD, such as overlapping of salary grades, should be addressed by policy-developers to ensure the successful accomplishment of policy goals.

May 2015

DECLARATION

I declare that *Pharmacists' perceptions of occupational specific dispensation (OSD): exploratory study of career and human resource perspectives* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Michelle Theunissen

May 2015

Signed
UNIVERSITY of the
WESTERN CAPE



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This thesis is dedicated to my husband, Stuart and my family. Thanks to Stuart for the multiple cups of coffee and love and to my mother who has been a huge support at home. Also to my brother who has always encouraged me to excel and my friends who have been patiently waiting and prayerful throughout this process.

Psalm 36 v 5

Your steadfast love, O Lord, extends to the heavens, your faithfulness to the clouds. Your righteousness is like the mountains of God; your judgments are like the great deep.

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LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral
BBBEE	Broad based black economic empowerment
CA	Career advancement
CHC	Community health centre
CNP	Clinical nurse practitioner
CSP	Community service pharmacist
DOH	Department of Health
DPSA	Department of Public Service Administration
GR	Group
HEARD	Health Economic and HIV&AIDS Research Division
HIV	Human immunodeficiency virus
HRH	Human resources for health
HRM	Human resource management
JD	Job description
KI	Key-informant
KPA	Key performance area
MDG	Millennium development goals
n.d.	No date
NHI	National health insurance
NIC	Newly industrialised country
NSP	National strategic plan
OSD	Occupational Specific Dispensation

PGWC	Provincial government of the Western Cape
PHC	Primary health care
PN	Professional nurse
PPTC	Provincial pharmacy and therapeutics committee
PSC	Public service commission
PSE	Public sector employment
RDP	Reconstruction and development programme
RWOPS	Remunerated Work Outside of the Public Service
SA	South Africa
SAPC	South African Pharmacy Council
SPMS	Staff Performance Management Systems
STI	Sexually transmitted infection
TCTE	Total cost-to-employer
WHO	World Health Organization

TERMS AND DEFINITIONS

Occupational Specific Dispensation (conceptual definition, Section 3.3.1)

OSD can be described, in terms of human resource theory, as a reward and retention strategy. Its development is based on human resource strategies and organisational goals of the public sector. It is structured according to remuneration and decision-making levels and can be used as a human resource tool to recruit, pay, reward and promote professionals. Career and pay progression depends on experience, competencies and performance determined by regular performance evaluation or SPMS.

Production pharmacist (Section 3.3.2)

Production pharmacists report to pharmacist supervisors. Production pharmacists act in the scope of a standard pharmacist and perform the duties assigned for the particular facility in which they are employed. They assist the supervisory pharmacist to fulfill their functions in maintaining duties, reporting discrepancies and assisting other staff to provide a pharmaceutical service to the public. Some production pharmacists may undertake management tasks at the request of the supervisory pharmacist.

Supervisory pharmacist (Section 3.3.2)

Pharmacist supervisors report to either a pharmacist in charge or the CEO of the facility in which they operate. Pharmacist supervisors thus act as managers in that they manage the pharmacy or a department of the pharmacy with respect to the staff, budget, equipment, stock and operations, together with the pharmacy manager. The supervisor thus ensures the delivery of pharmaceutical services to the public. In some cases the supervisor may be the responsible pharmacist depending on the level or type of pharmacy that they oversee.

Perceptions (Section 4.3)

In the context of this research, perceptions are seen as the opinions or persuasions of the participants on the subject matter, viz. how the research participants

understand the particulars of OSD. Perceptions can never truly be opinions since perceptions are interpreted by the mind (to form conceptions). Perception in this context is therefore assumed to be opinion by the negotiation of conversation.

Perspectives (Section 4.3)

In the context of this research a perspective will be considered as an interpreted “bigger picture” of the perceptions of the groups of participants in the study, that is, the interpreted opinion of the policy specialists, production and supervisory pharmacists.

Academic hospital (Section 4.5.3)

Academic hospitals are also known as tertiary or level 3 hospitals. A level 3 hospital provides specialist and sub-specialist care such as neonatology, endocrinology and neurosurgery. Tertiary hospitals are normally centers for training medical staff in specialist fields. They are also classed as provincial tertiary, national referral or central referral hospitals. (Cullinan, 2006)

District Hospital (Section 4.5.3)

District hospitals are also known as secondary hospitals and can be classed as level 1 or 2 hospitals. Level 1 hospitals are situated in each defined health district for local admission of patients. These hospitals offer a range of general out-patient and in-patient services, are operational 24-hours a day, provide emergency services and house a surgery theatre but do not contain an intensive care unit. Level 2 hospitals (also known as regional hospitals) provide some specialist services but are not as comprehensive as academic hospitals. (Cullinan, 2006)

Community health Centre (Section 4.5.3)

A community health centre (CHC) may be more like a clinic which is open 8 hours a day and provides the public with basic primary health care (PHC) services. Some community health centers offer 24 hour maternity and emergency services, contain a surgical procedures room and a ward with approximately 30 beds for overnight observations. CHCs are managed by nurses that refer patients

to secondary level hospitals if patients require more specialised services. (Cullinan, 2006)

***Apriori* codes (Section 4.7.2.4)**

Apriori can be defined “known before” or “deductive”. (Apriori, n.d). Codes that are developed before data collection (based on theory and existing literature) are called *apriori* codes. Codes derived from the data during data analysis are called *inductive* codes (Nieuwenhuis, 2010).

5/8ths and 6/8ths pharmacists (Section 6.2.3.2)

5/8ths pharmacists work 5 hours of an 8 hour standard work day. 6/8ths pharmacists work 6 hours of an 8 hour standard work day. The pharmacists have traditionally been termed “half-day” pharmacists.



CHAPTER 1

INTRODUCTION

Since the commencement of a democratic government in 1994, South Africa has planned and worked to meet the demands of a nation in need. These needs include, among others, living, employment, education and health needs, all of equal importance for survival of the nation (The presidency, 2014).

South Africa (SA) is uniquely neither a developing nor developed country, but classed as a newly industrialized country (NIC) or emerging economy (International Monetary Fund, 2011). Although NICs may become the future economic power-houses of the world, South Africa has one of the highest Gini coefficients¹ (The World Bank Group, 2015) which remains a hindrance to SA's economic growth. A sensible aim of the government is, therefore, to close the income gap of the extremely wealthy and the extremely poor, a feat that will require the investment of time and money (ANC, 2011). As a means to address the major socio-economic problems, government introduced the Reconstruction and Development Programme (RDP) in 1994 (ANC, 2011).

The RDP affected a White Paper for the transformation of the health sector in South Africa in 1997. The goals of the Department of Health focused on transforming the public health care system into one, unified structure by defragmenting health services. Primary Health Care (PHC) would also be re-engineered to form the core of the system along with the development of human resources for health. This would ensure accessibility and availability of a range of community health care services. The White Paper also sought to rectify maldistribution of health care workers between rural and urban areas in South Africa (DOH, 1997).

Re-engineering public healthcare in South Africa has revealed the Human Resources for Health Crisis which was compounded by the need to address the

¹Statistical measure of inequality of income or wealth in a country (Corrado Gini)

burden of the HIV/AIDS epidemic that faces the nation (George, Quinian, & Reardon, 2009). Between 1994 and 2007, it became an apparent necessity to correct the imbalances of health care staff employed in public and private sector and urban and rural areas in order to achieve healthcare goals (George, Quinian, & Reardon, 2009).

The Department of Higher Education and Training has classed many health professionals in the top 100 scarce skills occupations. It has become rare to find qualified and experienced medical staff such as nurses, doctors and pharmacists (DHET, 2014). Being in demand may have bred a sense of superiority as employers from different sectors have had to compete for human resources.

As a means to attract and retain professionals with scarce skills, the government re-designed salary structures to suit individual professions, which led to the conception of Occupational Specific Dispensation (OSD). Employees in public service were previously remunerated by a single structure which was inadequate to deal with the diverse needs of different professions (Matshekga, 2014). The ultimate goal of re-engineering healthcare is to reach the nation with essential health services, a basic human right. With effect, reaching more people requires more healthcare workers.

Although many developing countries have made changes to public service remuneration, OSD is exclusive to South Africa. Countries in Sub-Saharan Africa have implemented an assortment of pay models since the 1960's, some after gaining colonial independence. Pay models based on "crisis-response", political changes and recently, rational models, have been tried but none with absolute success. Benin, Ghana, Zambia, Burkina Faso, Tanzania and Uganda have not been consistent with their choices while Botswana is the most stable and eligible to implement a competitive skills-market or performance-based model with possible success (Kiragu & Mukandala, 2003). OSD encompasses the pinnacle features of an ideal pay model but success is only possible with consistent

financial support and post-implementation monitoring. These features will be discussed in detail in the literature review (Chapter 2).

In 2008, Ireland decided to continue with a single, central, pay structure for public service employees and decided not to incorporate performance-based pay, but to motivate and encourage organisational commitment by other means (O’Riordan, 2008).

Since the implementation of OSD, two studies have been conducted in South Africa. Motsosi and Rispel (2012) found that OSD had managed to attract and retain nurses with specialised qualifications at two hospitals in Gauteng. George and Rhodes (2012) found that OSD had certainly aligned the salaries of most healthcare professionals with the international market.

The key aim of this study was to explore the perceptions’ of pharmacists concerning OSD. This was not only to investigate if OSD is achieving its goals but discover how it may be succeeding or failing in achieving its goals. The style of the research was built on allowing stakeholders the freedom to express their opinions on OSD and related topics. Perceptions are built by researcher-participant collaboration.

The literature review (Chapter 2), explores the reasons why OSD was necessary and how it has been structured. The chapter then shifts focus to connected Human Resource Theory and major popular theories of industrial psychology to build a foundation for reflexive interpretation (discussed in Chapter 4 and 5).

Chapter 3 (Theoretical framework) is a rationale for the source of the research questions, aims and objectives based on the literature review. Methodology of the qualitative paradigm and the chosen methods are elucidated in Chapter 4 (Methodology). In Chapter 5 (Data analysis and results), the application of an interpretive question framework and thematic analysis of data is documented to ensure transparency and transferability of the study.

The results in the form of major themes and sub-themes (perceptions) are presented in Chapter 6 (Research findings) with evidence from raw data quotations of interview transcripts. Chapter 7 discusses these findings in detail in a descriptive and interpretive style (reflexed onto foundational theories).

In the final conclusive chapter (Chapter 8), the research questions are answered by assessing pharmacists' positive and negative perceptions of OSD with recommendations to policy developers and suggestions for future research.



CHAPTER 2

LITERATURE REVIEW

2.1 SECTION 1: CURRENT LITERATURE ON HUMAN RESOURCES FOR HEALTH

2.1.1 Introduction

As the custodians of medicines, pharmacists are committed to fulfill the health needs of the populace of South Africa within their scope of practice. This registered group of professionals is required to have sound knowledge of medicines and the legislation governing them. Their role is to discharge medicines to the public and ensure the correct, rational and safe use of prescribed medicines (SAPC, 2010).

Dispensing of medicine and the correct and successful use thereof is the last stage in patient care, thus the job of pharmacists comes with great responsibility. With the current socio-economic climate in South Africa, health care needs of the disadvantaged are taxing on public services. This, among other factors such as low numbers of graduating pharmacists (SAPC, 2011) and job stress (Rothmann & Malan, 2011), has led to sector choice snobbery and increased competition between sectors to attract qualified pharmacists. These sectors include retail and community pharmacy, academia, hospital and institutional pharmacy and the pharmaceutical industry.

This section of the literature review is a result of the examination of reports regarding the current state of human resources for health care professionals and pharmacists in South Africa.

2.1.2 Human Resources for Health crisis: Global

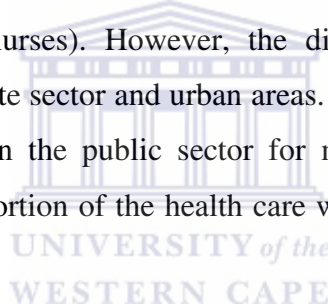
In 2006, the World Health Organisation (WHO) reported that there were 59 million health workers in the world with the emphasis on inadequate distribution between countries and within countries. The greater percentage of health workers

was found to be in wealthier countries. The WHO estimated that 4.3 million health workers were still required to meet the global health needs (WHO, 2006).

The World Health Organisation (WHO) also estimated that the scale-up of services and antiretroviral supply in Africa would require 20% to 50% of the existing health force in African countries as opposed to 10% in other countries due the distribution of HIV/AIDS burden of disease (WHO, 2006).

2.1.3 Human Resources for Health crisis: South Africa

Although the number of medical practitioners and nurses to general population is favourable in South Africa, the figures are deceptive. The recommended ratio by the WHO for medical practitioner density per 100 000 population is 20:100 000 and 120:100 000 for nurses. In 2003, the total ratio was 485:100 000 (77 medical practitioners and 408 nurses). However, the distribution of health staff was concentrated in the private sector and urban areas. This leaves a greater portion of the population reliant on the public sector for medical care which employs a comparatively smaller portion of the health care work force (George, Quinian, & Reardon, 2009).



2.1.4 Critical shortage of pharmacists globally

In a systematic review of literature regarding the global pharmacy workforce, Hawthorne and Anderson (2009) attempted to discover the reasons for global shortages of pharmacists. They found following possible reasons:

- Feminisation (and subsequent decrease in hours of service) of the career
- Uneven distribution of pharmacists between public/private sector and rural/urban areas
- Graduates performing internships close to undergraduate institutions
- An increase in the numbers of registered technicians (Hawthorne & Anderson, 2009).

Hawthorne and Anderson (2009) found fewer pharmacists to be employed in rural areas and the public sector which was disproportionate to the population needs. This echoes the overall medical staffing trends globally.

2.1.5 Human resource trends of pharmacists in South Africa

Unlike medical practitioners and nurses, the number of pharmacists per population in South Africa is below the WHO recommendation of 1: 2300. In 2011, the South African Pharmacy Council reported that there were 3849 of the population being served by one pharmacist (SAPC, 2011).

Of the 12813 registered pharmacists in 2010, 29% were employed in the public sector. Public service medically supports approximately 80% of the population (SAPC, 2011). The figure of 80% has been disputed by David Harrison (Harrison, 2009) since a portion of the uninsured public may prefer to pay cash to see medical practitioners in the private sector or may use private hospitals.

2.1.6 Impact of Human Resource for Health crisis on near future events: Urgent health care needs in South Africa

At the United Nation's Millennium summit (2000), South Africa embraced the international community's eight Millennium Development Goals (MDGs) for the period 2000 to 2015. Three of those goals were aimed at improving health care and health services in South Africa:

- MDG 4 – To reduce child mortality
- MDG 5 – To improve maternal health
- MDG 6 – To combat HIV/ AIDS, Malaria and other diseases (UNDPSA, 2010).

These MDGs were translated into Medium Term Strategic Framework elements (MTSFs) for national policy and then to Strategic Priorities (2004 – 2009) for the NHS (National Health System). The most important strategy arose from the NHS Strategic Priorities, namely the HIV and AIDS and STI strategic plan for South Africa (NSP), 2000 – 2005 being the first edition. The NSP 2007 – 2011 (p.7) stated the following:

“HIV and AIDS is one of the main challenges facing South Africa today. It is estimated that of the 39.5 million people living with HIV worldwide in 2006, more than 63% are from sub-Saharan Africa. About 5.54 million people are estimated to be living with HIV in South Africa in 2005,...”(DOH, 2007).

The two main goals of the NSP 2007 – 2011 were to decrease the incidence rate of HIV by 50% and to expand access to appropriate treatment, care and support to 80% of all people diagnosed with HIV (DOH,2007).A human resources for health analysis report constructed by HEARD² in 2009 stated the following:

“The HRH (Human Resources for Health) crisis will have a devastating impact on the delivery of primary health care (PHC) services and ART (Anti-retroviral Treatment) scale up within South Africa, preventing South Africa from achieving the HIV prevention goals of the NSP 2007-2011.” (George, Quinian, & Reardon, 2009).

2.1.7 Government’s solution for Human Resource for Health crisis:

National Human Resources Plan 2006

In 2006, the national human resources plan focused on training and developing health staff in order to improve the health staffing crisis in South Africa. Other policies that were implemented, according to Lehmann (2008), around this period of time were:

- The introduction of community service for a number of professionals that previously may not have required service time, post-registration
- The introduction of rural and scarce skills allowances to attract professionals into employment in rural areas
- The introduction of Occupational Specific Dispensation, a new wage structure for professionals (Lehmann, 2008).

The National Department of Health (DOH) published a strategy to modernise tertiary hospital services. HEARD’s¹ report (George, Quinian, & Reardon,

²Health Economic and HIV & AIDS Research Division

2009) listed the following suggestions made in this strategy to attract and retain professionals: upgrading salaries; non-financial benefits; financial incentives for rural employment; creation of new posts; creation of mid-career posts for doctors; compulsory community service; RWOPS (Remunerated Work Outside the Public Service) policy review; effortless registration of foreign qualified professionals and advertisements of South African posts overseas to recruit migrated professionals.

2.1.8 Occupational Specific Dispensation (OSD)

2.1.8.1 What is Occupational Specific Dispensation (OSD)?

In a statement published on-line in June 2007, The Department of Public Service and Administration (DPSA) in South Africa announced the implementation of a new salary structure for some categories of public employees namely Occupational Specific Dispensation (DPSA, 2007).

2.1.8.2 The Department of Public Service and Administration (DPSA)

DPSA, formerly The Commission of Administration, was born out of the Public Service Commission (PSC) in 1996. The task of the DPSA is to support the Minister in executing policy based on constitutional mandate that will improve Public Service (DPSA, 2011).

2.1.8.3 The structure of OSD for pharmacists

OSD is based on career “grades” and salary “notches”. Pay progression or pay increases occur within a Specific salary scale or grade by climbing notches annually or accelerating that progression based on performance. Salary/career grade progression normally occurs when applying for a new position or receiving a promotion based on proven experience. This improves the salary scale on which pay progression is based (DPSA , 2010a).

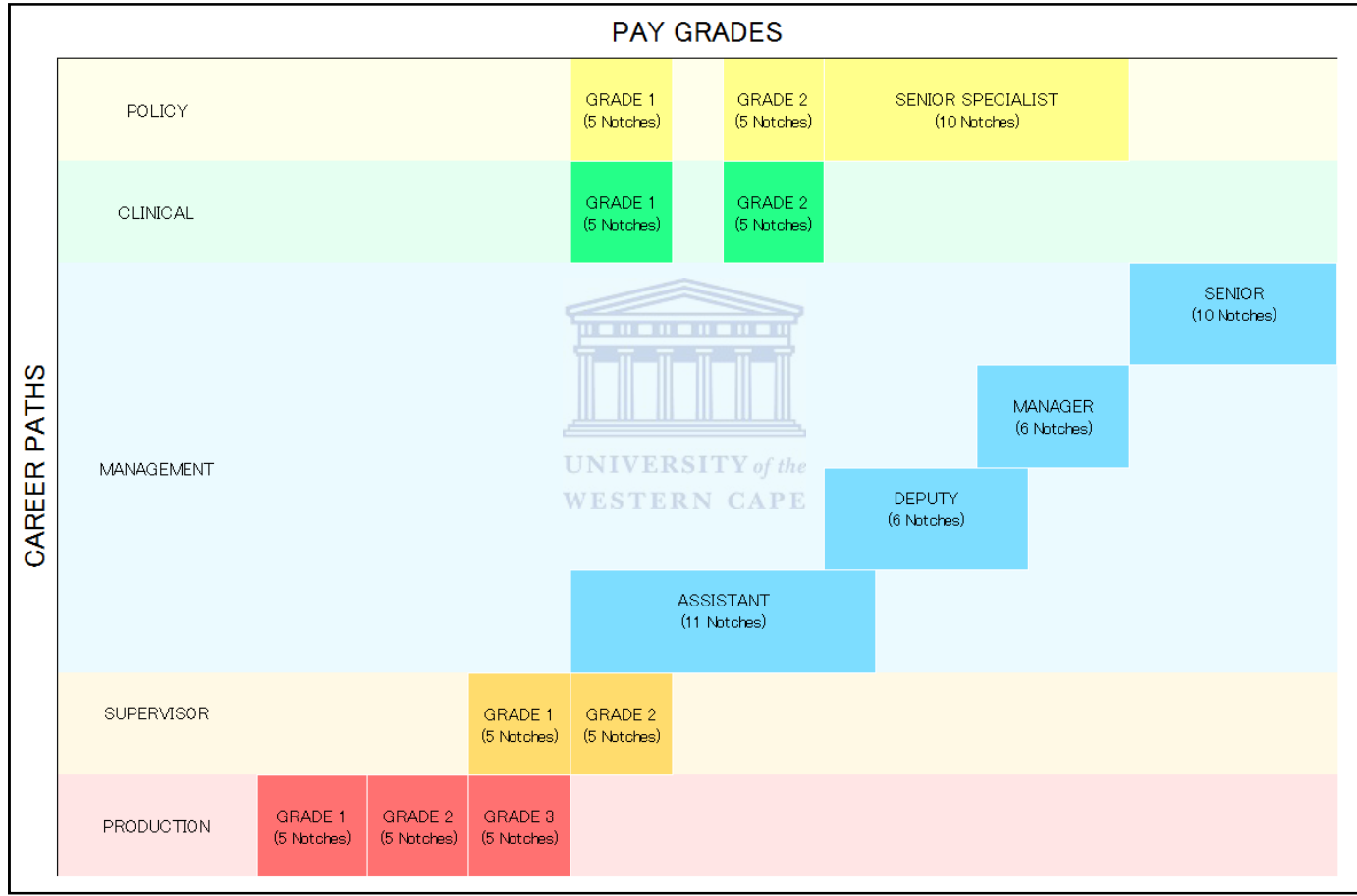


Figure 1: Pay grades within career paths/streams developed for pharmacists in the public sector

In circular 4 of 2009, an internal government circular issued by the DPSA, two occupations are created for pharmacy in government (point 8.2.1) namely Pharmacists and Pharmacist Assistants. Two career streams for Pharmacists have emerged: The production/supervisory stream (which includes management) and clinical pharmacists/policy developers (DPSA, 2009). The career streams, pay grades with salary notches and overlapping of grades are represented in Figure 1, a construction based on annexure A2 of Resolution 1 of 2010 (DPSA,2010b).

2.1.8.4 The provisions of OSD

OSD ensured:

- Remuneration was specific to each profession
- Career pathing opportunities were unique to each profession based on experience and performance
- Pay progression in each grade was based on performance
- Grade progression was based on performance
- Performance or experience was recognised when progressing within grades or between grades
- The scarce skills allowance was incorporated into the new salary packages
- An improvement in career paths by offering a variety of career paths
- The salary structure was based on the “total cost-to-employer (TCTE)” and was similar to those previously held by middle management and senior management services (DPSA, 2010a).

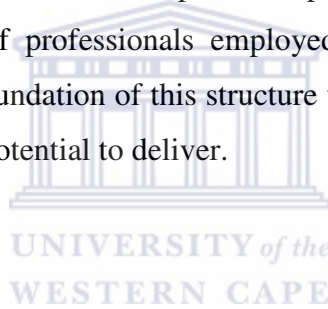
DPSA also proposed that each grade have long salary bands or ‘notches’ and extensive overlapping of salary bands between grades to allow professionals to remain in production roles without being forced to move into supervisory or managerial positions. OSD would also allow for dual career paths meaning that professionals can specialise in their field or progress to supervisory or management positions while earning an equivalent salary (DPSA, 2007).

2.1.8.5 The goals of OSD

Government had expressed their concerns about losing professionals and wanted to “attract and retain skilled employees”. At that stage (2007), all state employees had been graded and paid according to one single salary structure or hierarchy. This structure did not suit the needs of individual professions and the salary increases per notch were poor. OSD promised tailored salary grading per profession and substantial salary increases that rewarded performance (DPSA, 2007).

2.1.9 Conclusion

This section of the review has looked at the human resource health staff crisis in South Africa and the proposed solutions to staffing in the public sector. One of the major strategies was to introduce Occupational Specific Dispensation (OSD) as an answer to low levels of professionals employed in the Public Sector. In the following section, the foundation of this structure will be investigated to elucidate an understanding of its potential to deliver.



2.2 SECTION 2: HUMAN RESOURCE THEORY

2.2.1 Introduction

This section contains a brief synopsis of human resource theories as a foundation for the introduction of human resource tools such as Occupational Specific Dispensation (OSD) to attract professionals to the public sector.

2.2.2 The underlying Human Resource Theory in OSD policy development

Occupational Specific Dispensation (OSD) is a career remuneration structure that involves other South African employment policies and conditions in its development (e.g. Employment Equity, Skills Development and Broad Based Black Economic Empowerment Acts [BBBEE]).

Although pay is the basis for OSD, the ultimate goal of the structure is to classify positions in each specific career. It defines the “role, status, duties, functions, responsibilities and accountabilities” (section 195, The Constitution) of each job in public organisation in the form of performance requirements. The individual’s performance can be measured against performance requirements to fulfill operational requirements and determine if organisational goals are met (Hoffman & Groeneveldt, 2009).

Three academics, Peter Drucker, Henry Mintzberg and Thomas Paterson, have influenced human resource and organisational development in South Africa. However, Thomas Paterson has had the greatest influence on the structure of OSD (Hoffman & Groeneveldt, 2009).

2.2.2.1 Paterson’s decision bands method

Paterson stated that a job cannot be remunerated according to skills or effort made but rather according to the decision-making content (Bussin, 2010). Other factors that influence job evaluation can be subjectively added, thus evaluation criteria must be standardised. Paterson defined six decision bands based on the kind of decisions made by employees (policy-making decisions at the top of the hierarchy and primary decisions at the base of the hierarchy). These bands can then be

divided into grades and sub-grades. Grades sort the band into higher and lower importance categories and sub-grades are given values based on job factors.

The advantages of this method are:

- Ease of implementation
- Eliminates the need for pay plans
- Helps to locate positions that are remunerated incorrectly.

The disadvantages are:

- Ignores the skills required for the job
- Organisation, problem solving and planning are also important aspects of jobs at higher levels and may not be considered (Bussin, 2010).

2.2.2.2 Job evaluation

OSD is based on Paterson's decision bands in combination with formal job evaluation (Hoffman & Groeneveldt, 2009). The EQUATE® job evaluation system (by KPMG) was used in the case of health care professions. The Department of Health was asked to draft its own policies by consulting senior employed professionals and professional statutory bodies (DPSA, 1999). Salaries and amendments to grades and sub-grades were negotiated via collective bargaining councils (Gray & Van der Merwe, 2009).

2.2.3 OSD's ability to attract professional staff

Pay is the key instrument used to entice managers and professionals into an organization (Coetzee, 2010). It has been suggested that the remuneration offered does not need to be excessive, but must be noticeably fair or competitive.

One of the goals of OSD was to initially align salaries with the market value and then to provide substantial salary increases between notches. However, OSD's implementation did not guarantee an immediate salary increase but focused on a career plan for the future (DPSA, 2007).

Among a number of motives for the development of OSD, the Human Resource Development Strategy for the Public Service (2002-2006) stated the following:

“The combination of a negative perception of working conditions in the Public Service, a high demand for qualified professional staff in the private sector and growing international opportunities for skilled South Africans has seriously influenced the ability of the Public Service to attract and retain skilled and competent staff.”(Hoffman & Groeneveldt, 2009).

OSD is a type of reward and remuneration strategy. If a reward strategy is developed well, it positively influences the “employer brand” and enhances the organisation’s status as the preferential employer among employee. (Bussin, 2010).

2.2.4 OSD’s ability to retain and motivate professional staff

2.2.4.1 Retention strategies: Human resource definition

According to South African studies and as previously mentioned, retention of highly skilled employees depends on compensation, job characteristics, training and development opportunities, supervisor support, career opportunities and work/life policies offered by the organisation. Retention strategies are affected by these known retention factors and are implemented to improve job satisfaction, organisational commitment and work engagement which influences “stay/go” decisions of employees(Coetzee, 2010).

The most important of the retention strategies mentioned are as follows: assessment and evaluation of employees, job redesign, leadership, training and development, career development and mobility, managing work/home inter-role conflict and reward and remuneration (Coetzee, 2010). Pay is, however, not the key element of retention and motivation of professional employees but other means of compensation such as bonuses, profit shares and time off influence organisational commitment. If the process of compensation is transparent, achievable and competitive, other intangible rewards become important to the employee (Coetzee, 2010).

Ramlall (2004) postulates that all well known retention strategies implemented in organisations today are rooted in employee work motivation theories. By understanding work motivation theories, employers tweak retention strategies in their organisations to ensure “critical” employees are retained.

2.2.5 The role of Human Resource Management (HRM)

In order for an organisation to accomplish its goals it needs to:

- Hire the most suitable people for positions
- Train them properly
- Motivate them to work their best
- Encourage them to stay with the company.

Human resource management involves all the measures an organisation takes to attract, develop and retain suitable employees (Collins, 2009).

The processes of human resource management are composite and there is plenty of information on the topic. In short, attracting employees involves recruiting qualified applicants and selecting those that “fit” the organisation. Development focuses on training current employees and orientating new staff. Employee retention concerns motivating employees to excel, appraising their performance and compensating them appropriately (Collins, 2009).

2.2.5.1 Recruitment

Recruitment of employees not only involves attracting and selecting the appropriate employee but also getting the candidate to accept the offer made. There are several strategies that can be used to accomplish this but the most popular is presenting a sober picture of the job (the positive and negative qualities), ensuring that the salary offer is competitive with the rest of the market and offering rewards (benefits or incentives) that are both financial and non-financial (Spector, 2000).

2.2.5.2 Retention and development

Retention strategies partially rely on development of the employee. Hughes & Half (2015) in Coetzee (2010) mention the primary reasons people stay in their jobs: they feel that their managers understand and motivate them; they feel involved in challenging and meaningful work; there are prospects of career advancement; they perceive that their manager is visible and fair and the company shows interest in their employees (Coetzee, 2010). It is important to note that these are non-financial factors.

In South African surveys Döckelet *al* (2003) and Lesabe and Nkosi (2007) found that retention of highly skilled and professional workers depended on:

- Compensation
- Job characteristics (skill variety and job autonomy)
- Training and development opportunities
- Supervisor support
- Career opportunities
- Work/life policies (Coetzee, 2010).



Retention is also affected by recruitment. Recruiting the wrong candidate can lead to loss of an employee. Loss of an employee is an expensive process (see Fig. 2). It requires fresh financial investment in recruiting, selecting and training a replacement. It also leads to lower productivity which indirectly affects the organisations' finances (Holdford, 2012).

THE COST OF LOSING A PHARMACIST(Holdford, 2012).

There are negative consequences to losing a pharmacist:

- Waiting time increases leading to patient frustration
- Patients acquire medicine services elsewhere
- Remaining pharmacists have to cover the tasks of the former employee leading to increased employee stress and overtime costs
- The organisation must spend money to recruit a replacement
- Training of the new pharmacist requires time from other employees/pharmacists
- It may take about one year for the new pharmacist to become 100% productive while he/she learns about the details specific to the position.

Figure 2: The consequences of losing a pharmacist, a "critical" employee

2.2.6 Reward and remuneration

The term reward refers to all types of rewards that employees receive in exchange for their efforts made for the employer. Such as:

- Direct financial payments (salaries, wages, commissions, bonuses, incentives)
- Indirect financial payments (medical-aid and pension fund contributions)
- Non-financial rewards (intrinsic motivation such as challenging work tasks, development opportunities, recognition, supervisor support and fair treatment).

Remuneration is another term for compensation or pay. It refers to the tangible payment and benefits the employee receives in exchange for work. A reward strategy (or structure) consists of all the types of rewards (financial and non-financial) but is based on a remuneration structure (Coetzee, 2010).

Gilman (2009) and Torrington *et al* (2009) both state that an organisation's goals can be achieved by using reward and remuneration to recruit and retain highly skilled employees, to improve their performance, to ensure fairness and to motivate staff (Coetzee, 2010).

2.2.7 Reward strategy

A reward strategy guides the organisation on how rewards will be managed. Both the organisations' goals and the employees' needs are considered when developing this strategy. The reward strategy normally operates together with the organisational strategy and the human resources strategy to form the total reward framework (see Figure 3).

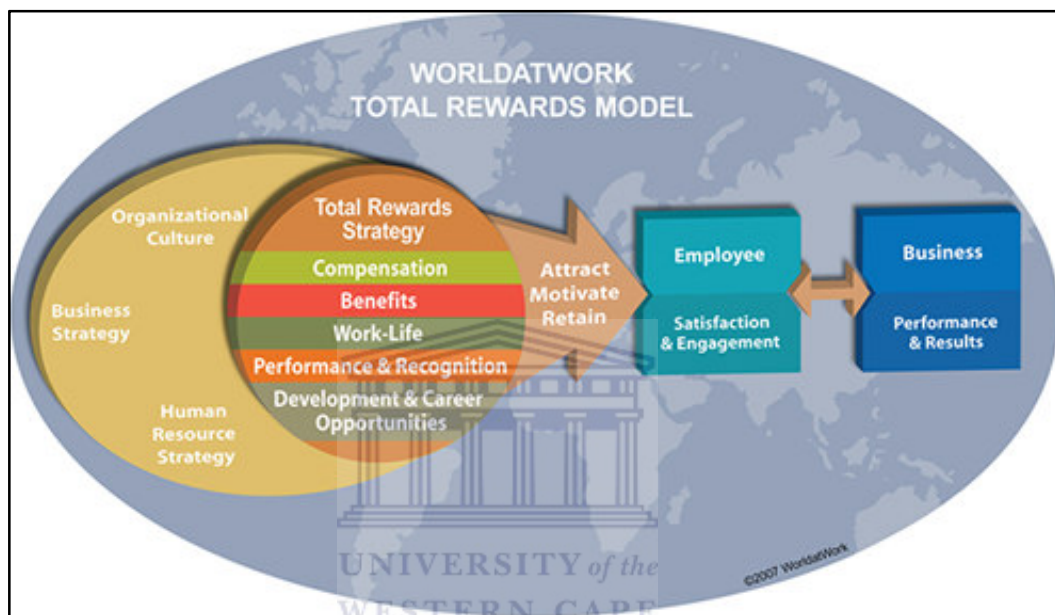


Figure 3: The total reward framework/model presenting the total reward strategy (WorldatWork, 2007)

The organisational strategy describes the process by which its goals must be achieved. The reward strategy needs to be developed to “drive” the employees to meet those goals. In other words, *“the right total reward strategy can deliver the right amount to the right people at the right time, for the right reasons.”* (Gross & Friedman, 2007 in Bussin, 2010).

2.2.7.1 Employee reward needs

When developing a total reward strategy, the employee's value of financial and non-financial rewards must be assessed and considered. The total reward system must be carefully designed. This will ensure that the employer gains a positive reputation with current and potential employees. As stated previously, one of the

purposes of total reward systems is to motivate employees. Since needs and values of employees cannot always be directly assessed, human resource management relies heavily on theories of work motivation(Bussin, 2010).

2.2.8 Work motivation

The general definition of motivation is “*an internal state that induces a person to engage in particular behaviour*” (Spector, 2000). There are two perspectives to motivation:

- Considering the direction, intensity and persistence of behaviour over time
- Concerning the desire to achieve some goal(Spector, 2000).

Franco *et al* (2002) define worker motivation as how willing an individual is to uphold a certain effort to attain organisational goals (Franco, Bennett, & Kanfer, 2002).

2.2.9 Work motivation theories

Motivation theories are built to explain why work performance varies between individuals. These theories can be used to forecast the choices employees will make concerning tasks, the amount of effort that will be spent and if the employee will persist in effort. (Spector, 2000).

While the ability of the worker and the availability of resources are essential to perform work tasks, they are not enough to ensure the type of performance an employer may need. Work performance depends on the motivation of the worker (Franco, Bennett, & Kanfer, 2002).

2.2.10 “Need” theories of work motivation

Need theories classify human needs in categories and assume that people are motivated to fulfill these needs, for example, food or recognition(Spector, 2000). They focus on “what” motivates people.

2.2.10.1 Hierarchy of needs: A.H. Maslow

According to Alfred Maslow, humans are motivated fundamentally by “needs” and these can be arranged in a hierarchy of pre-potencies (or levels of power or importance, see Figure 4). The more pre-potent needs must be fulfilled before the next level of needs may be considered (Maslow, 1943).

The starting point is normally physiological needs. These needs are those that allow humans to survive or live (listed in Figure 4’s lowest level of the hierarchical pyramid constructed as an illustration by Finckelstein). The physiological needs are the most dominant of all the needs and if all needs are unfulfilled, these needs will dominate human motivation and all other needs will be diminished in importance. Once the basic physiological needs are satisfied, the other needs on higher levels of the pyramid will start to surface, each need arising as the lower pre-potent needs is satisfied (Maslow, 1943).

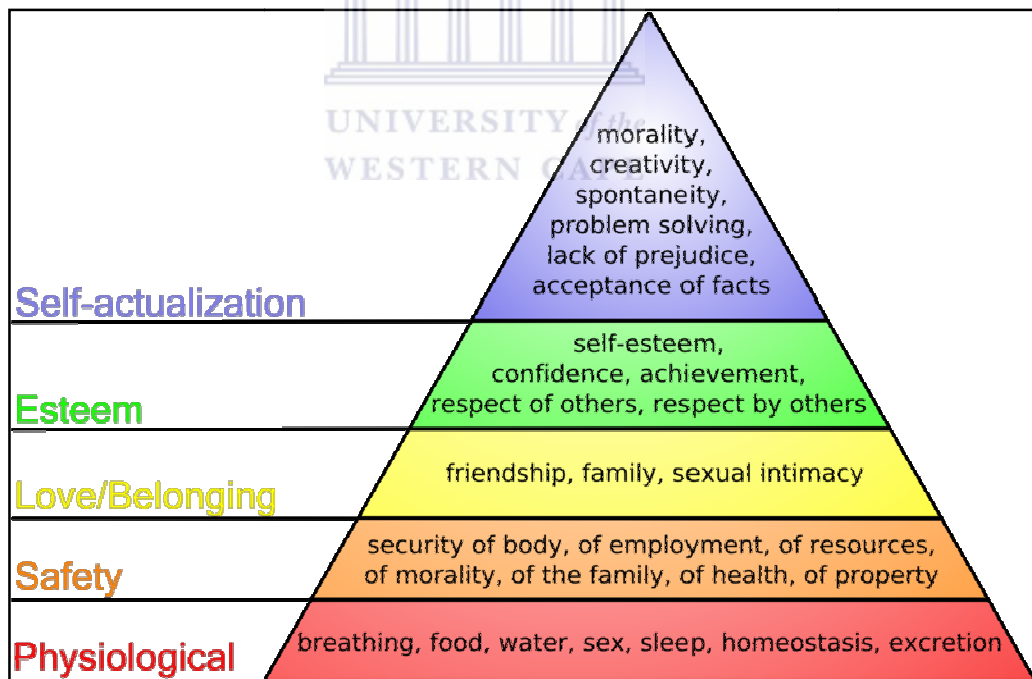


Figure 4: Maslow's Hierarchy of Needs (Finckelstein, 2008)

The second most important needs are those of “safety” on the second level of the hierarchy. These are not only bodily safety and well being, but also refer to

security in terms of environmental security in resources and family, as listed in Figure 4. These needs are often considered the driver for seeking philosophical security such as existential meaning of life and the universe, i.e. in religion and science (Maslow, 1943).

Once the physiological and safety needs are fulfilled, man is motivated to love or belong. The “love needs” can be fulfilled in an affectionate relationship such as belonging to a group in society, through friends, family or a partner (Maslow, 1943).

The need for esteem follows that of belonging. Esteem refers both to self-respect and recognition by others. Humans need to sense achievement to advance in motivation. As Maslow said, *“The satisfaction of the self-esteem need leads to feelings of self-confidence, worth, strength, capability and adequacy of being useful and necessary in the world.”* (Maslow, 1943).

When all pre-potent needs on the lower levels of the hierarchy are fulfilled, the need of self-actualisation arises. According to Maslow, Kurt Goldstein first coined this term, and Maslow explains it as being “self-fulfillment”, “reaching ones full potential”, or “becoming everything that you are able to become”. *“What a man can be, he must be...”* (Maslow, 1943).

According to Campbell and Pritchard (1983), Maslow’s theory has no empirical foundation but is rather based on experience. Self-actualisation is defined individually since it will be different for each person (i.e. one woman may desire to be the best mother she can be, whereas another would apply her creative talent to paint a master piece), thus self-actualisation is the *“most existential in nature and the most difficult to define...”* (Campbell & Pritchard, 1983).

Maslow explains that the order of needs is not always fixed. In some cases an individual may value one need more than another, despite the damage it may cause them. Some humans have an inability to be needy on some levels due to

prolonged deprivation or self will. It is also impossible for any need to be wholly fulfilled and so needs on the next level may arise partially due to a relative fulfillment of the pre-potent need (Maslow, 1943). Campbell and Pritchard (1983) explain it as follows: two levels of needs may be operating simultaneously, yet the lower level need will dominate (Campbell & Pritchard, 1983).

2.2.10.2 The Two-Factor Theory: F. Herzberg

Frederick Herzberg's theory is also known as the dual-structure theory or the motivator-hygiene theory (see Figure 5). He postulated, from reviewing early literature on job attitudes and conducting a study from interviews with accountants and engineers, that two sets of work motivators exist, viz. extrinsic and intrinsic factors (Campbell & Pritchard, 1983).

Herzberg's dual-structure of hygiene and motivator factors	
Extrinsic Factors/Hygiene Factors <i>Sources of need satisfaction that arise from organisational context (physiological needs)</i>	Intrinsic Factors/Motivator Factors <i>Factors derived from individual's relation to the job itself (psychological growth needs)</i>
Pay and Benefits Supervision Relationship with co-workers Company policy and administration Job security	Achievement Recognition Responsibility Advancement/Promotion Growth The work itself

Figure 5: List of intrinsic and extrinsic factors according to Herzberg's Two-Factor Theory (Campbell & Pritchard, 1983)

According to Herzberg, motivating employees requires enough motivators or intrinsic factors. Hygiene (extrinsic factors) will not lead to motivation (Spector, 2000).

Herzberg concluded that the factors that lead to job satisfaction were distinct from those that lead to job dissatisfaction. According to this the opposite of job satisfaction is not job dissatisfaction but rather no job satisfaction. Similarly the opposite of job dissatisfaction is not job satisfaction but rather no job dissatisfaction. *“...we normally think of satisfaction and dissatisfaction as opposites, i.e. what is not satisfying must be dissatisfying, and vice versa. But when it comes to understanding the behaviour of people in their jobs, more than a play on words is involved.”* (Herzberg, 2003). Thus motivators or intrinsic factors lead mainly to job satisfaction, while hygiene or extrinsic factors were the main cause of discontent in ones job(Herzberg, 2003).

There was one major failing in Herzberg’s research, viz. that he relied on descriptions of events that were dissatisfying and satisfying. Employees tended to describe things they do themselves as satisfying and events that involve others as dissatisfying. This would cause separation in the factors (Spector, 2000).

Although Herzberg’s initial research was flawed, he added another important dimension to his research in that he suggested that work be enriched to bring about full utilisation of personnel. Job enrichment allows for the opportunity of psychological growth by manipulating motivator factors(Gruneberg, 1979).

The “thrust” of Herzberg’s argument is that factors like pay and working conditions are job contextual factors and do not ultimately lead to job satisfaction but will be dissatisfying if they are not present, whereas factors that have to do with the job itself and the individual lead to psychological growth if enriched and thus job satisfaction if fulfilled, but do not necessarily lead to dissatisfaction if not present (Gruneberg, 1979).

2.2.11 Cognitive theories of work motivation

Men and women think about what has happened in the past and wonder what may happen in the future. They have expectations about future outcomes from making certain decisions. Motivation theories that recognise the human thinking element

of work are called cognitive theories or process theories (Campbell & Pritchard, 1983). These focus on “how” people are motivated.

2.2.11.1 Expectancy Theory: V. Vroom and E. Lawler III

Victor Vroom’s process theory has become the foundation of most tests in work performance and motivation called the Expectancy Theory (see Figure 6). He later modified it to the Expectancy-Valence Theory (Campbell & Pritchard, 1983). It has been tailored on several occasions by other experts in organisational psychology.

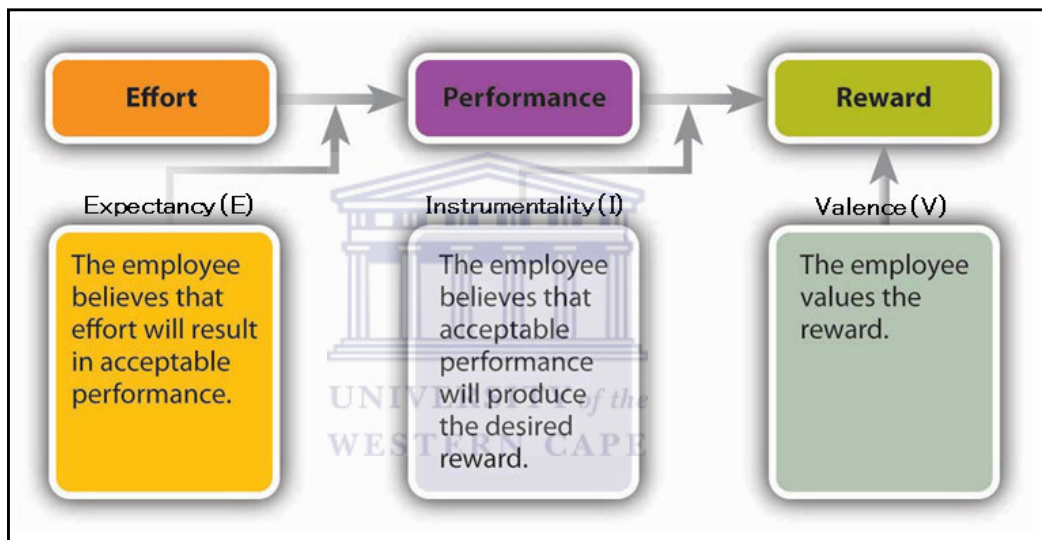


Figure 6: A simplified depiction of Vroom's Expectancy Theory modified by the author(Collins, 2009)

The basics of Vroom’s theory with minor adaptations made by Edward Lawler III are as follows:

Expectancy (E) is the perceived likelihood that effort will lead to performance, Instrumentality (I) is the perceived likelihood that performance will lead to the reward and Valence (V) is the value of that reward to the individual. Thus the motivational force (MF) applied to a task is a function of all three variables (Lawler III & Suttle, 1973):

Motivation Force = Expectancy x Instrumentality x Valence

or

$$MF = E \times I \times V$$

Some logical predictions that can be made about human motivation according to the equation are:

- The higher any one of the three given variables is, the higher the motivation force or effort will be
- If one of the variables is high but the other two are substantially low, the motivation force will be low
- If any of the variables is zero (Expectancy, Instrumentality or Valence), the effort will be zero (Spector, 2000).



2.2.11.2 Equity Theory: J. S. Adams

The Equity Theory is based on individuals' perceptions of social comparisons. Many researchers have presented similar theories, but Adams' version is the most comprehensive. The concept revolves around an exchange between the individual and the organisation (Campbell & Pritchard, 1983).

Definitions of the terms related to this theory are:

Inputs: Factors perceived as investments into the organisation that will produce a return (e.g. skill, education, effort, ability, age, beauty)

Outcomes: Returns from the organisation based on the individual's investments

Value ratio: Ratio of inputs to outcomes

Person: The individual that is comparing his/herself

Other: The reference that the individual is reflecting his/her comparison on

If the "person" compares their "value ratio" to that of the "other" and finds that they do not differ, he/she perceives equity. Perceived inequity occurs when the comparison of "value ratios differ" (Campbell & Pritchard, 1983).

Collins lists the characteristics of the potential "other" as:

- Someone who has a similar position
- Someone in the same organisation but who has a different position
- Someone who is in the same occupation
- Someone who has similar demographics
- Oneself at a different age (Collins, 2009).

2.2.12 OSD's connection to motivating professionals

According to Willis-Shattuck *et al* (2009), in a systematic review of research on retention and motivation of health care workers in developing countries, the following factors motivated employees:

- Financial (salaries and allowances)

- Career development (opportunity for specialisation or promotion)
- Continuing education (training and development)
- Hospital infrastructure (work environment)
- Resource availability (to perform work)
- Hospital management (positive working relationship)
- Personal recognition or appreciation (Willis-Shattuck *et al*, 2009).

Since OSD features most the essential elements, in terms of financial reward and career opportunities, of a reward strategy (see Figure 7), it has potential to induce work motivation. Although most research emphasis has been on financial incentive, Willis-Shattuck *et al* (2009) mention that financial reward was always suggested in combination with other types of incentives.

Reward and remuneration affect both retention and motivation of employees. Although well-remunerated employees are less likely to look for employment elsewhere, pay must be used with caution as a tool to motivate employees. Incentives such as pay, benefits and praise improve short-term employee motivation but non-financial rewards, such as challenging and interesting work, seem to improve long-term motivation (Bussin, 2010).

OSD as a reward strategy (Based on PHSDSBC Res 3, 2009, annexure A2 PHSDSBC Res 1, 2010 & Circular 4 of 2009).

OSD offers the following motivating elements:

- A flexible remuneration package
- A total “cost to employer” remuneration package with built-in benefits including:
 - Medical Aid contribution
 - 13th cheque
 - Pension fund contribution
 - Annual paid leave
 - Paid maternity leave
 - Scarce skills
 - A pensionable portion and a cash, non-pensionable portion
- A competitive salary
- Annual increases
- Accelerated salary increases (notches) based on performance (evaluated by Staff Performance Management Systems [SPMS])
- Clear career paths and more choices of career paths
- Dual career paths
- Promotion of grades depending on years’ experience and performance
- Promotion to more senior positions subject to post availability and based on qualifications, years experience and skills.

Figure 7: Occupational Specific Dispensation (OSD) for pharmacists acts as a reward strategy

Based on the Expectancy Theory, employers thus need to show employees that effort made to achieve organisational goals will be rewarded. This ensures employee motivation(Coetzee, 2010).

2.2.13 Conclusion

Pay is a key instrument to entice professionals to join an organisation but will not necessarily ensure that those employees are retained and motivated. Other factors influence organisation commitment such as bonuses, profit shares and “time-off” from work.

OSD is considered a remuneration structure but can also be seen as a reward strategy, discussed further in Chapter 2. Reward strategies are developed to motivate employees to achieve organisational goals by satisfying employee needs. Work motivation theories can guide organisations to satisfy needs via the reward strategy. Retention, which is connected to motivation, is therefore also ensured via a well-developed reward strategy.

Retention strategies based solely on pay will inevitably fail, but pay can be used when employees are professionals that see rewards as long term goals. However, “*the career path needs to be known*” (Hoffman & Groeneveldt, 2009). Pay must therefore be linked to an independent career development process and a recognition policy, as is the case with OSD.

CHAPTER 3 THEORETICAL FRAMEWORK

3.1 INTRODUCTION

This section highlights the major points embedded in the literature review. Research problems and questions were elucidated via systematic identification of the gaps of knowledge regarding pharmacist's employment in the public sector and their relation to Occupational Specific Dispensation (OSD).

3.2 CONSTRUCTING THE FIRST RESEARCH QUESTION

3.2.1 Major findings in the literature review leading to the first question

Figure 8 aligns the major concepts and the research problem of this section.

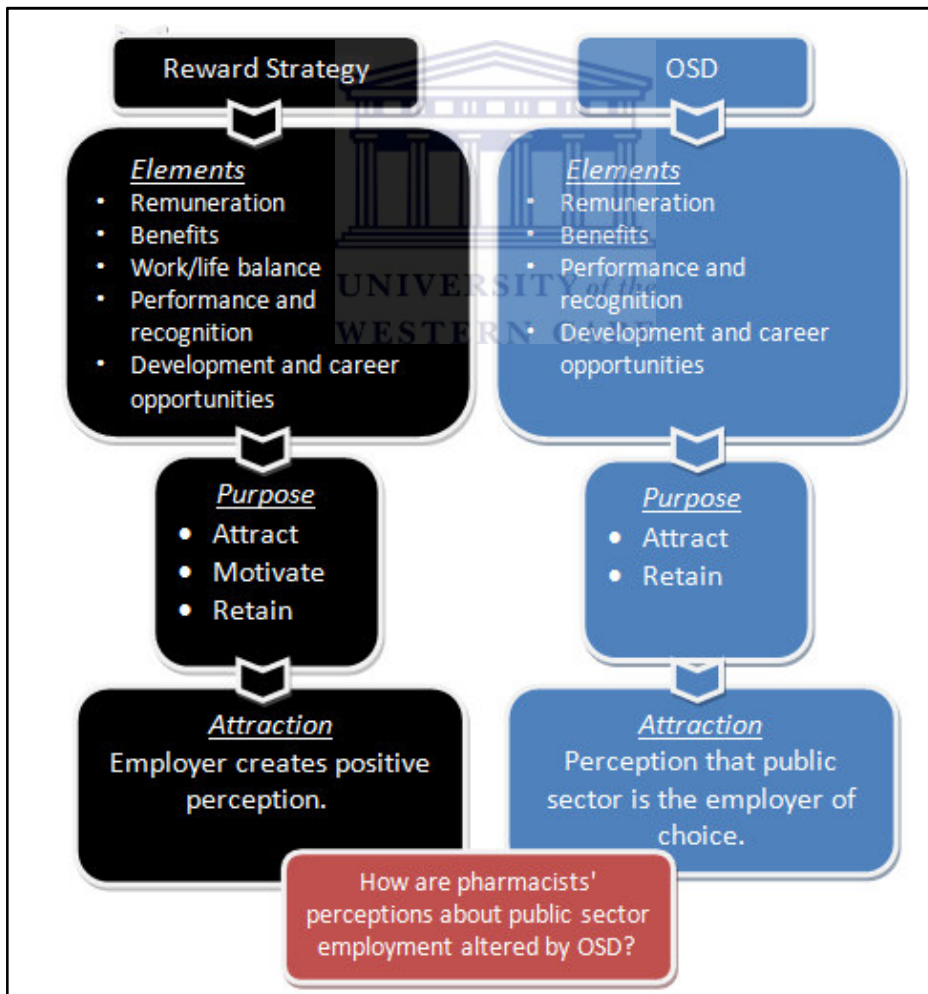


Figure 8: Connection between reward strategies and OSD's ability to attract pharmacists to public sector employment

In Figure 8, the elements, purpose and method of attraction of OSD corresponds to that of a well developed reward strategy according to human resource theory and literature.

The major findings in the literature review are:

- There is a serious shortage of pharmacists in the public sector in South Africa (SAPC, 2011)
- It is critical that more pharmacists be employed in the public sector in South Africa in order to achieve strategic goals to improve the health of the nation and specifically to meet the national goals of HIV and AIDS treatment escalation (DOH, 2007)
- Government's solution to attract and retain pharmacists was to implement OSD (DPSA, 2007)
- One of the main reasons for implementation of OSD was to improve the perception of public sector employment among pharmacists (DPSA, 2002)
- Human resource theory states that well developed reward strategies may lead to an organisation being perceived as the employer of choice (Bussin, 2010).

Based on the concepts of reward strategies and findings, a definition of OSD can be constructed as seen in Figure 9 below.

Defining OSD

There is no official and single definition for OSD. Based on literature about OSD and human resource theory and for the purposes of this study, OSD can be conceptualised as follows:

OSD can be described, in terms of human resource theory, as a reward strategy (Bussin, 2010). Its development is based on human resource strategies and organisational goals of the public sector (Hoffman & Groeneveldt, 2009). It is structured according to remuneration (Hoffman & Groeneveldt, 2009) and decision making levels (Bussin, 2010) and can be used as a human resource tool

to recruit, pay, reward and promote professionals. Career and pay progression depends on experience, competencies and performance (DPSA, 2010a) determined by regular performance evaluation or SPMS (Staff Performance Management Systems).

Figure 9: Building a conceptual definition of Occupation Specific Dispensation (OSD)

3.2.2 Research problem and first question

There is no current research to investigate whether the perceptions of pharmacists regarding public sector employment have been altered, and if so, how have they been altered. It is important to find out why pharmacists are currently employed in the public sector. Have they moved to the public sector fairly recently due to OSD or other factors? The question that follows is based on OSD's purpose to attract pharmacists.

Question 1: How do pharmacists perceive public sector employment? Have their perceptions shifted and if so, are they influenced by OSD?

3.3 CONSTRUCTING THE SECOND RESEARCH QUESTION

3.3.1 Major findings in the literature review leading to the second question

Figure 10 aligns the major findings below with the research problem in this section.

The major findings are:

- OSD in its independency is merely a reward and remuneration structure(DPSA, 2007)
- OSD provides a visual plot of tangible and intangible earnings of pharmacists such as remuneration, benefits, leave, pay increases and incentives based on performance (DPSA, 2010a& Coetzee, 2010)
- OSD provides a career structure for pharmacists with a choice of career paths, provides clear requirements for pay progression and grade progression and provides opportunity for promotion (DPSA, 2010b)
- OSD thus addresses a number of important retention factors in the South African context (Coetzee, 2010) such as compensation, career mobility, career opportunities and work-life policies (via leave benefits)
- OSD can also be defined as a type of retention strategy (DPSA, 2007) since it embraces elements of well-known retention strategies such as assessment and evaluation of employees, career development and mobility and reward and remuneration (Coetzee, 2010).

In Figure10 below, retention strategies are based on retention factors and work motivation theory. Retention strategies are implemented via personnel processes. The outcomes will either be positive or negative.

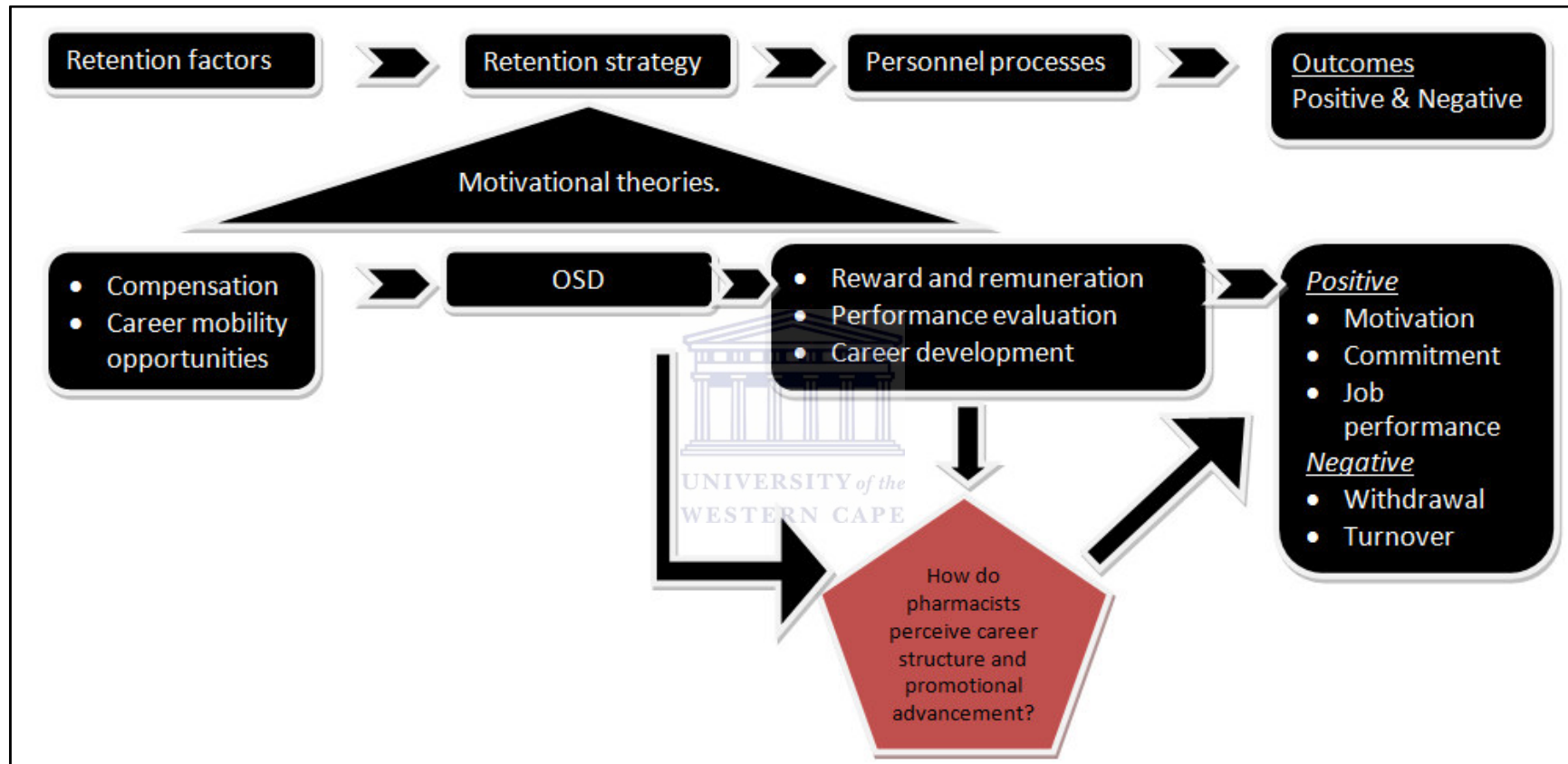


Figure 10: The relationship between the perception of OSD as a career structure and employee retention.

Updated conceptual definition of OSD

OSD can be described, in terms of human resource theory, as a **reward and retention strategy**. Its development is based on human resource strategies and organisational goals of the public sector. It is structured according to remuneration and decision-making levels and can be used as a human resource tool to recruit, pay, reward and promote professionals. Career and pay progression depends on experience, competencies and performance determined by regular performance evaluation or SPMS.

Figure 11: The final conceptual definition of OSD

- Retention strategies are based on motivation theories (Ramlall, 2004). Motivation and retention are intertwined (Coetzee, 2010). Well implemented retention strategies lead to motivation, thus motivation theories are the basis for retention strategies
- OSD is merely a structure but personnel processes give “life” to the structure. It is important to note that people impact the outcomes of retention strategies (Coetzee, 2010)
- Some of these personnel processes include: human resource planning, employee selection, reward and remuneration, performance evaluation, training and development and career development (Coetzee, 2010)
- Career mobility (career development, training and promotion) is positively related to commitment (Lesabe & Nkosi, 2007). Thus, pharmacists’ perceptions of career advancement provided by OSD may be an indication of successful retention (See Figure 10).

3.3.2 Research problem and second question

There has been no investigation to determine how the career streams, and positions created within OSD's paths, are envisaged by production and supervisory pharmacists in the public sector.

Definitions of “production” and “supervisor” pharmacists

The following definitions are based on inspection of Western Cape Department of Health Staff Performance Management Systems (SPMS) documents with regards to job descriptions, job purpose, key results areas and organograms.

What is a production pharmacist?

Production pharmacists report to pharmacist supervisors. Production pharmacists act in the scope of a standard pharmacist and perform the duties assigned for the particular facility in which they are employed. They assist the supervisory pharmacist to fulfill their functions in maintaining duties, reporting discrepancies and assisting other staff to provide a pharmaceutical service to the public. Some production pharmacists may undertake management tasks at the request of the supervisory pharmacist.

What is a supervisory pharmacist?

Pharmacist supervisors report to either a pharmacist in charge or the CEO of the facility in which they operate. Pharmacist supervisors thus act as managers in that they manage the pharmacy or a department of the pharmacy with respect to the staff, budget, equipment, stock and operations, together with the pharmacy manager. The supervisor thus ensures the delivery of pharmaceutical services to the public. In some cases the supervisor may be the responsible pharmacist depending on the level or type of pharmacy that they oversee.

Are pharmacists motivated to climb the “ladder” in the OSD structure? Do pharmacists know how to climb the “ladder” in the public sector? Are the positions available adequate and appropriate to offer promotion to primary levels of pharmacists. Answering the question that follows may be an indication of the retention potential of OSD.

Question 2: How do production and supervisory pharmacists perceive career advancement and the promotional structure of OSD?

3.4 RESEARCH AIMS

The following aims were developed to answer the two research questions elucidated in the previous section:

1. To explore the perceptions of pharmacists regarding public sector employment
2. To establish a connection between the perceptions of pharmacists and OSD's potential to alter the image of employment in this sector
3. To explore how pharmacists perceive the career and promotional structure of OSD
4. To establish the connection between pharmacists' perceptions of public sector career structure and OSD's ability to retain pharmacists.

3.5 RESEARCH OBJECTIVES

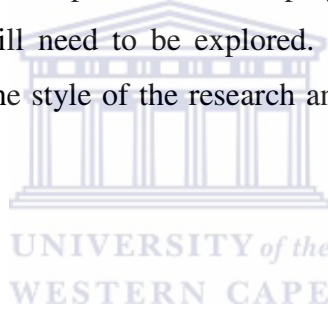
The following objectives are based on the four broad research aims in the previous section.

1. Explore the opinions of pharmacists concerning remuneration, work benefits, work-life balance, recognition and career development elements of OSD as a remuneration and reward strategy
2. Explore the positive and negative aspects of the above listed elements of OSD
3. Determine how the positive or negative opinions of pharmacists will affect the public sector employment based on Human Resource and Work Motivation Theory
4. Use Human Resource and Work Motivation Theory to assist with recommendations or alterations if necessary
5. Explore the perceptions that pharmacists have of personnel processes i.e. administration of remuneration and benefits, performance evaluation, career progression, career pathing and the career structure of OSD

6. Establish the negative and positive aspects of the above mentioned personnel processes
7. Determine how these positive and negative perceptions on career structure and pathing will affect career ambitions based on Human Resource and Work Motivation Theory
8. Use Human Resource and Work Motivation Theory to assist with recommendations or alterations if necessary.

3.6 CONCLUSION

Two simple research questions have been constructed based on major findings in the research literature review. The questions and consequent objectives are exploratory in nature and focus on perceptions of pharmacists who are employed in the public sector. Since the public sector employs pharmacists in varying roles, different perspectives will need to be explored. The methods will therefore be chosen to complement the style of the research and are justified in the following chapter.



CHAPTER 4

METHODOLOGY

4.1 INTRODUCTION

In light of the research problems, questions and aims presented in the theoretical framework (Chapter 3), Chapter 4 gives details on the methodology chosen to explore and ascertain the best answers within resource limits.

This chapter includes a short introduction to qualitative research, conceptualisation of relevant terms, the research design and framework, sampling strategy, data collection methods, data analysis techniques, ethical considerations and the validity and reliability of the study.

4.2 QUALITATIVE RESEARCH

4.2.1 Introduction

Whether or not the researcher is aware of it, certain assumptions about “the world” and reality, affects the way “*we formulate our problem and research question and how we seek information to answer the questions*” (Creswell, 2013). Philosophy inevitably influences research design and methodology. Mouton (2001) describes the process of research as a progression between three worlds:

- World 1: Everyday life
- World 2: Science
- World 3: Meta-science.

The influences of meta-science have split research into research traditions or research paradigms. Most research experts agree that the major paradigms are positivism, interpretivism and critical theory (Merriam, 2009).

Interpretive research leads to qualitative methodologies (Mouton, 2001). Interpretive ontology and epistemology assumes that reality is multiple and that the nature of knowledge is subjective (Creswell, 2013). Merriam (2009) explains it as follows: “*there is not a single observable reality. Rather multiple realities, or*

interpretations, of a single event. Researchers do not find knowledge. They construct it”(Merriam, 2009). Thus the term constructivism is often used interchangeably with interpretivism.

4.2.2 Characteristics of qualitative research

The definition of qualitative research is broad and progressive. Merriam (2009) states that “*qualitative researchers are interested in understanding the meaning people have constructed (or) how people make sense of their world and the experiences they have in the world*”(Merriam, 2009). “*Human behaviour, unlike that of physical objects, cannot be understood without reference to the meanings and purposes attached by human actors to their activities. Qualitative data, it is asserted, can provide rich insight into human behaviour.*”(Guba & Lincoln, 1994). The chief issue of the researcher is to understand the experience from the participants’ point of view by gaining an insider’s perspective.

The four major characteristics of qualitative research according to Merriam (2009) are:

- The research focuses on process, understanding and meaning
- The researcher is the primary instrument of data collection and analysis
- The process is inductive
- The product is richly descriptive.

4.3 THE CONCEPTS OF “PERCEPTIONS” AND “PERSPECTIVES”

The type of questions developed in the theoretical framework focus on the unearthing of perceptions of pharmacists and different perspectives of Occupational Specific Dispensation (OSD). It becomes necessary to define the concepts of “perceptions” and “perspectives” in the context of this research.

Conceptualisation of “perceptions”

A perception is the act of perceiving (Perception, n.d.). To perceive is to “come to comprehend or to grasp” (Perceive [Def. 1], n.d.). A synonym is “to understand” (Perceive [Def. 2], n.d.).

An opinion can be defined as “a belief or conclusion held with confidence but not substantiated by positive knowledge or proof” (Opinion [Def. 1], n.d.). It is also “a personal view, attitude or appraisal” (Opinion [Def. 2], n.d.). Other synonyms are a “feeling, an idea, a notion, a theory or a conviction” (Opinion [Def. 3], n.d.).

Conception is the result of conceiving (Conception, n.d.). To conceive is to “hold an opinion or belief” (Conceive, n.d.).

In the context of this research, perceptions are seen as the opinions or persuasions (as defined above) of the participants on the subject matter, viz. how the research participants understand the particulars of OSD. Perceptions can never truly be opinions since perceptions are interpreted by the mind (to form conceptions). Perception in this context is therefore assumed to be opinion by the negotiation of conversation.

Conceptualisation of “perspectives”

A perspective may be defined as “a mental view or outlook” (Perspective [Def. 1], n.d.). It is also seen as an “attitude, context, angle or frame of reference” (Perspective [Def. 2], n.d.).

In the context of this research a perspective will be considered as an interpreted “bigger picture” of the perceptions of the groups of participants in the study, that is, the interpreted opinion of the policy specialists, production and supervisory pharmacists.

4.4 RESEARCH DESIGN

4.4.1 Why I choose qualitative research

The research theoretical framework and question style has leant itself to the features mentioned by Merriam (2009) and Schwandt (1994) of qualitative, interpretivist human inquiry in the following ways:

- The research was focused on exploring pharmacists' perceptions concerning public sector employment and career progression in relation to Occupational Specific Dispensation (OSD) and thus understanding the phenomenon from the participants' perspective (Merriam, 2009)
- Data was in the form of conversation between researcher and participants and amongst participants. Participants and the researcher were thereby "constructing meanings" to their experiences in the form of words (Creswell, 2007). The researcher is therefore the primary instrument of data collection and analysis. The researcher can begin interpretation at the point of data collection. This includes clarification of non-verbal data and unexplained actions and responses by research participants. The disadvantage is that the researcher must guard against bias. This can be rectified by involving the participants in the interpretation and being transparent on thought process and influence during interpretation (Merriam, 2009)
- An inductive and deductive or "hybrid" (Fereday & Muir-Cochrane, 2006) process of analysis was used whereby the researcher allowed the data (interview transcripts) to dictate the emerging categories and themes (Merriam, 2009) and confirmation of those themes was established by researcher reflexivity in view of the theoretical underpinnings and participant-researcher collaboration.

4.4.2 Research framework

The research design is based on **phenomenology**. Phenomenology is the study of "*people conscious experience of their life-world*" (Merriam, 2009) or is the study of "phenomena", or the things people experience and how they experience them.

Experience is not easily observable and may be subjective, thus requiring research-participant negotiation (Newman and Benz, 1998).

In Figure 12, overlapping circles illustrate how a research philosophy is the foundation for research methodology and research methodology is the foundation for chosen methods of data collection and analysis. Choosing a research philosophy is also linked to why and how the research question is asked and answered. The research problem and question presents an **exploratory** style study into how pharmacists have responded to Occupational Specific Dispensation (OSD) and the “*deeper thoughts and behaviors that govern those responses*”(Creswell, 2007).

Methods based on exploratory methodology included data collection by conducting interviews with **keyinformants** and **focusgroups** with pharmacists. To ensure sound validity, a **reflexive** framework (Srivastava & Hopwood, 2009) for interpretation was combined with **thematicanalysis** of data in the form of transcribed verbatim interviews.

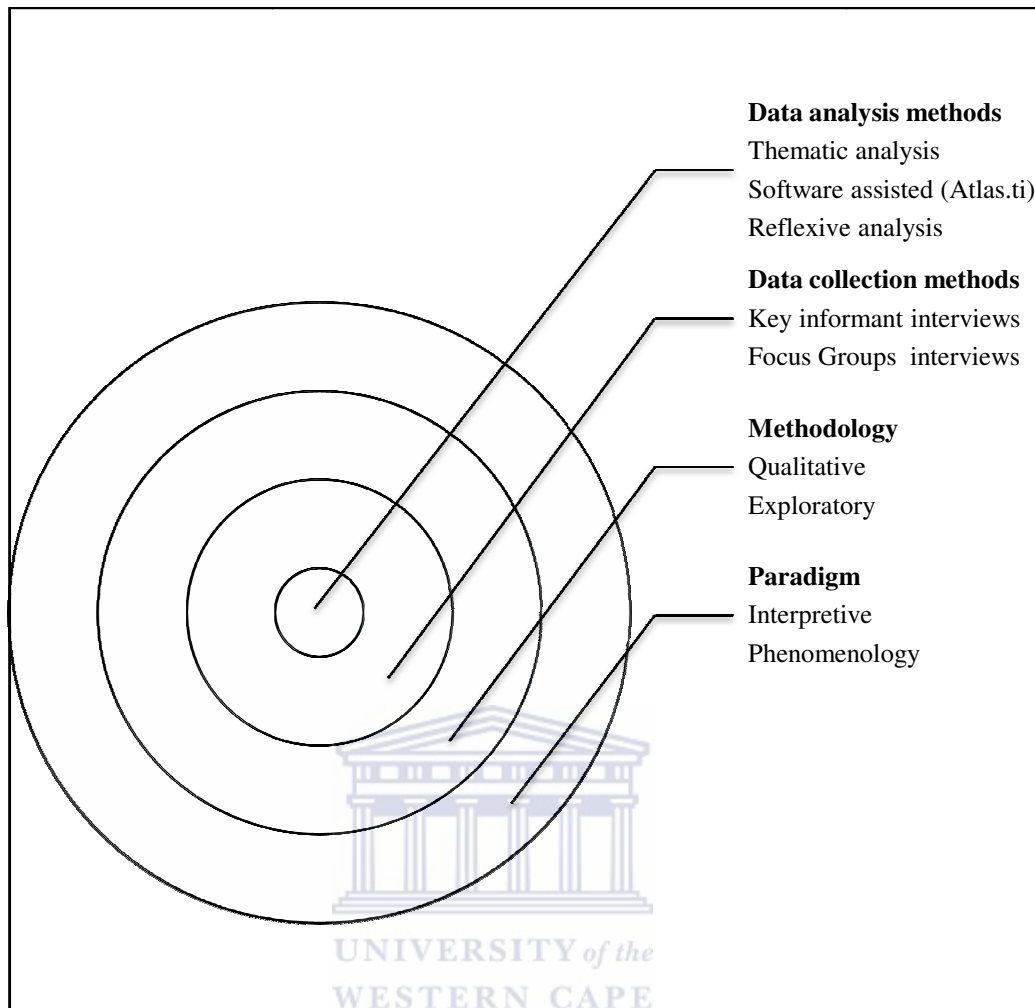


Figure 12: The research framework

4.5 RESEARCH SAMPLING STRATEGY

4.5.1 Theory of sampling

Non-random sampling (Strydom & Delpont, 2005) or non-probability sampling is regularly used in qualitative research. This type of sampling does not represent the general population, but is used to collect in-depth information to present a rich understanding of the topic from a small number of participants (Merriam, 2009).

Purposive sampling (sometimes called purposeful sampling), is chosen for this study and is commonly used in qualitative research. Purposive sampling assumes that the researcher wants to explore and understand something about a specific

phenomenon and chooses the sample that is mostly likely to yield that learning insight based on the sample's experience and expertise (Merriam, 2009).

4.5.2 Proposed sample structure

Many types of purposive sampling are listed in research literature. Creswell (2007) lists fourteen types of which the most appropriate for the purposes of this study is stratified purposeful sampling, which illustrates sub-groups and facilitates comparisons. I have chosen pharmacists in the employment of the Provincial Government of the Western Cape (PGWC) as my sample for convenience (Creswell, 2007).

In Figure 13 the proposed final sample of participants based on information supplied by the office of Head of Health, Western Cape (dated 15 August 2012) (n=43) would ideally have consisted of an equal number of production pharmacists (n=20) and supervisory pharmacists (n=20), to ensure comparison between different grades, and an estimate of 3 key-informants (n=3) depending on the quality of data supplied by these participants. Production and supervisory grades were also the most likely to yield an interesting perspective on career mobility since they are most junior in the promotional ranks. The production pharmacists should have had equal representation from central services (academic hospitals, n=10) and district services (district hospitals and community health centers, n=10), since the work of these pharmacists may vary. In the same way, supervisory pharmacists should have had equal representation from the two institutional levels (n=10). Groups constituting district pharmacists were a suggested mixture of those in community health centers (n=5) and district hospitals (n=5) for the following reasons:

- The number of production pharmacists employed per district is not sufficient to conduct a focus group per facility type
- This is also the case with supervisory pharmacists
- Inter-district focus group meetings would require participants to travel long distances which was not viable for many thus combined participant meetings per district ensured enough invited participants would attend.

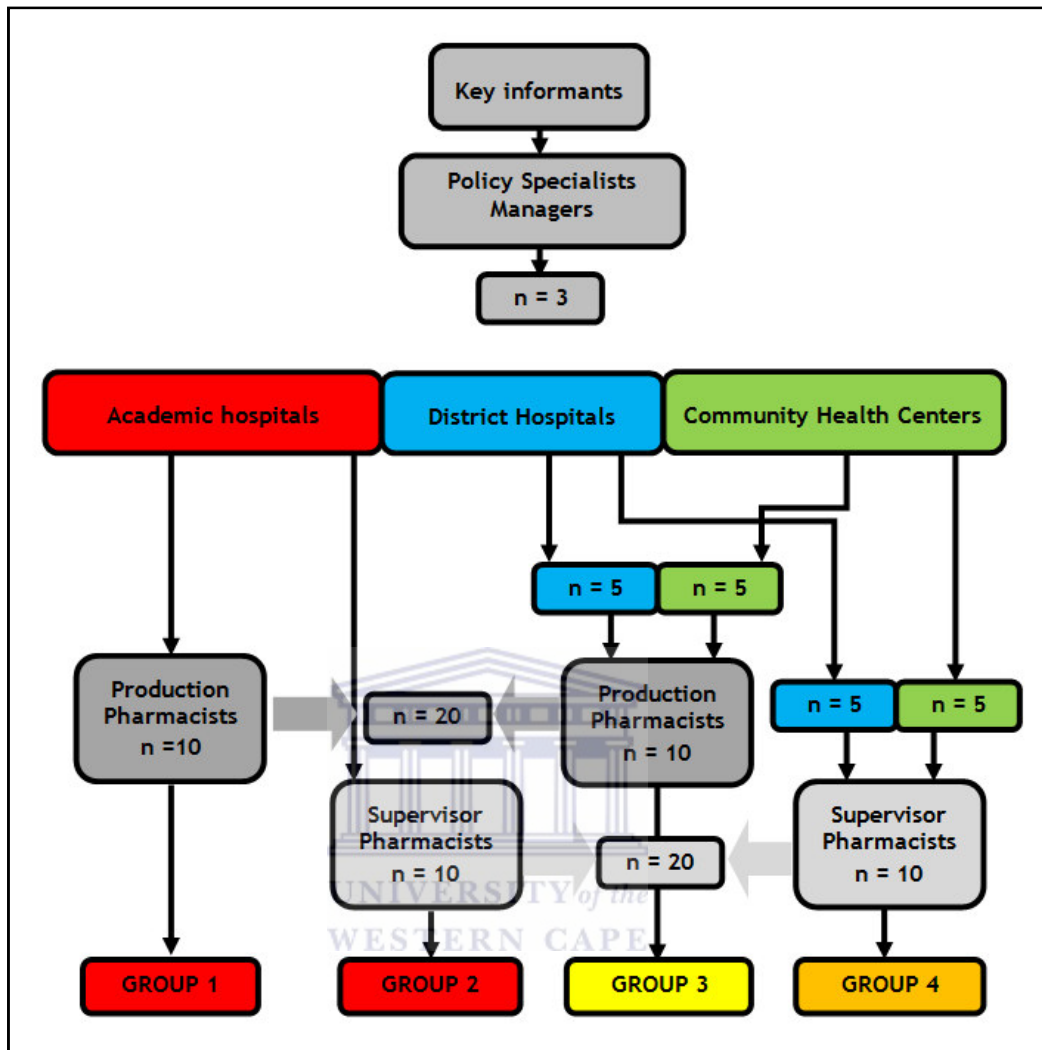


Figure 13: Proposed sample structure

Policy specialists and management from pharmaceutical services were also part of the proposed sample to provide supplementary information via key-informant interviews and to ensure dual perspectives and multiple sources of data (Creswell, 2007). These key-informants were involved in the blueprint and implementation of OSD for pharmacists and could therefore provide insight into the human resource aspects of the policy. Snowball type sampling (Merriam, 2009) was used to decide which policy specialists to interview in order to ensure all relevant information and data was collected. Each key informant was asked for a recommendation of the next, most knowledgeable key informant on unanswered issues.

In qualitative investigations, sample size is not as important as saturation of information (Merriam, 2009) and thus the proposed sample was open to manipulation and expansion in order to achieve the point of redundancy of the exploration (Merriam, 2009).

4.5.3 Access to sample

Access was gained to pharmacy staff in academic hospitals by communication with hospital superintendents. Letters of access approval have been attached (see Appendix C and D). Permission was gained to access pharmacy staff in district hospitals and community health centres in the Eastern/Khayelitsha sub-district from the director of Health Impact Assessment (Dr N.T. Naledi) from the office of Strategy and Health Support (see Appendix B).

Definition of an “academic hospital” in the public sector in South Africa

Academic hospitals are also known as tertiary or level 3 hospitals. A level 3 hospital provides specialist and sub-specialist care such as neonatology, endocrinology and neurosurgery. Tertiary hospitals are normally centers for training medical staff in specialist fields. They are also classed as provincial tertiary, national referral or central referral hospitals (Cullinan, 2006).

Definition of a “district hospital” in the public sector in South Africa

District hospitals are also known as secondary hospitals and can be classed as level 1 or 2 hospitals. Level 1 hospitals are situated in each defined health district for local admission of patients. These hospitals offer a range of general out-patient and in-patient services, are operational 24-hours a day, provide emergency services and house a surgery theatre but do not contain an intensive care unit. Level 2 hospitals (also known as regional hospitals) provide some specialist services but are not as comprehensive as academic hospitals (Cullinan, 2006).

Definition of a “community health centre” in the public sector in South Africa

A community health centre (CHC) may be more like a clinic which is open 8 hours a day and provides the public with basic primary health care (PHC) services. Some community health centers offer 24 hour maternity and emergency services, contain a surgical procedures room and a ward with approximately 30 beds for overnight observations. CHCs are managed by nurses that refer patients to secondary level hospitals if patients require more specialised services (Cullinan, 2006).

Permission was gained to access policy specialists from Helen Hayes (Manager of Pharmacy Service; Directorate: Pharmacy Services, Western Cape Government)³. A summary of the sites that were made available for access are listed in Table 1.

Permission granted for access to the pharmacy staff at sites in Cape Town and the Eastern/Khayelitsha sub-district	
Institution type	Sites
Academic hospitals	Groote Schuur Hospital, Tygerberg Hospital
District hospitals	Karl Bremmer Hospital, Westfleur Hospital, GF Jooste Hospital, False Bay Hospital, Helderberg Hospital, Eerste Rivier Hospital, Khayelitsha Hospital
Community health centers	Kleinvelei, Gustouw, Macassar, Strand, Nolungile, Michael Mapongwana, Mfuleni

Table 1: Permission granted to access staff at sites in the PGWC

4.5.4 Actual sample

The final sample consisted of 31 research participants (n=31). Four participants (n=4) were key informants chosen from amongst the policy specialists and managers, while the balance of the participants (n=27) were a mix of production

³Personal communication on 8 December 2013, Helen.Hayes@westerncape.gov.za

and supervisory pharmacists from academic hospitals, district hospitals and community health centers. The final number of participants that attended each focus group interview is represented in Figure 14.

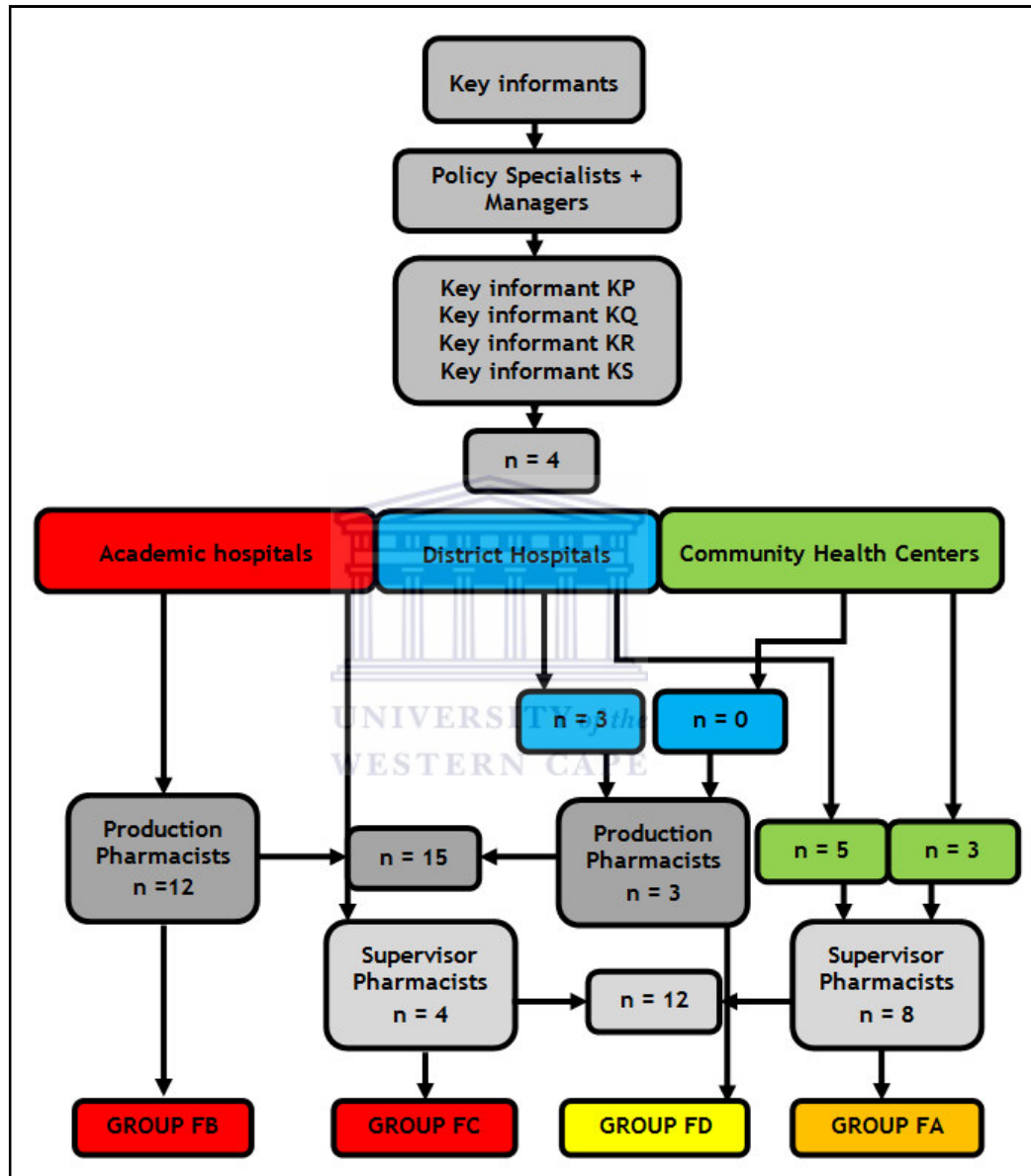


Figure 14: Actual sample structure

Participant numbers differ in the proposed and actual samples for the following reasons:

- Not all pharmacists could attend focus group interviews after work hours

- Not all pharmacists could attend focus group interviews within working hours
- Staff shortages and heavy workloads did not allow pharmacists to be available for focus group interviews at the same time
- Some pharmacists were not interested in participating
- Some pharmacists had to cancel on short notice after agreeing to attend
- There were no financial incentives offered to attract potential participants
- Some pharmacists could not be accessed due to managerial obstruction
- Some pharmacy and facility managers did not respond to my attempted communications
- Some pharmacists were the only pharmacist employed per facility.

In all cases, I would contact pharmacy management telephonically and via email to obtain their permission to visit the site. At the initial site visit I would present a short summary of the research and explain what would be required if a pharmacist would agree to be a participant of the research. I would obtain contact details of potential participants and then I would personally liaise with each contact via email and telecommunication to finalise a focus group interview. In some cases, pharmacists in management would assist me with the arrangements at their own discretion.

4.6 DATA COLLECTION METHODS

4.6.1 Introduction and theory of data collection

Creswell (2007) defines data collection as a “circle of interrelated” activities which illustrates that the process is more than just data collection itself but “goes beyond” to ensure good collection of information that will answer the research questions and objectives (Creswell, 2007). According to Creswell (2007), the most important steps in data collection are site identification, gaining access to the site and building relationships, sampling, collecting data, recording information, resolving field issues and storing data.

Merriam (2009) states:

“Data is nothing more than ordinary bits and pieces of information found in the environment. They can be concrete and measurable, as in class attendance, or invisible and difficult to measure, as in feelings.”

4.6.2 Process of data collection

There are a number of types of data collection which Creswell (2007) has divided into four main categories, namely observations, interviews, documents and audiovisual materials. For the purposes of this study, focus group interviews and one-on-one interviews were chosen for data collection.

An interview is defined as a conversation between researcher and participant based on questions that help focus the conversation on the research topic (Merriam, 2009). All types of interviews (including focus group interviews) are merely conversations with a purpose. Merriam (2009) quotes Patton (2002), *“...an interview is there to find out about things we can't see or read such as a person's thoughts, feelings, plans, and how others make sense of events that happen in their lives”*. The data derived from these interviews was therefore the direct words from participants about their thoughts, opinions, feelings, history, knowledge and experience of Occupational Specific Dispensation (OSD) and its relationships to their careers (Merriam, 2009).

Three categories of interviews are commonly used for research purposes namely structured, semi-structured and unstructured interviews. Semi-structured styled interviewing was chosen for this research to allow participants to *“define the world in unique ways”*(Merriam, 2009) and to allow flexibility while providing a guideline to the researcher in order to prevent respondents straying too far from the topic in conversation. Open-ended questions were used in the interview guides for both types of interviews.

4.6.3 Key informant interviews

Interviews were conducted one-on-one with Policy Specialists and managers due to their foundational knowledge and expertise of OSD.

All interviews were sound recorded and transcribed verbatim to preserve data for analysis. The interview guides used for one-on-one interviews can be found as Appendix I. Interview guides were remodeled after each interview due to reflexive interpretation and interim analysis.

4.6.4 Focus Group interviews

A focus group is merely a group interview on a topic in which the participants have knowledge on the topic. Since the data from these discussions are socially constructed during conversational interaction, focus group interviews reinforce constructivist philosophy (Merriam, 2009).

Merriam (2009) recalls Patton (2002) describing the difference between focus group interviews and one-on-one interviews in that they allow participants to respond to the thoughts of others. The data thus reflects points of view in social context thus adding an extra dimension to the data.

Some groups of pharmacists employed in academic hospitals and district services (district hospitals and community health centers) were placed in mixed groups to ensure freedom of expression which otherwise may be suppressed in the presence of close colleagues. Production and supervisory pharmacists were interviewed in separate groups to ensure freedom from potential “superior-subordinate” pressure (Greeff, 2005).

The interview question guide was modified after one-on-one interviews to suit focus group interviews and is attached as Appendix J and K. All focus group conversations were sound recorded and transcribed verbatim for analytical purposes.

4.7 DATA ANALYSIS TECHNIQUES

The two types of analysis that were applied in this research are discussed in this section:

1. Reflexive analysis
2. Thematic analysis

4.7.1 Reflexive analysis

4.7.1.1 What is reflexive analysis?

Reflexive analysis is the result of reflexive methodology. Unlike Grounded Theory (Glaser & Strauss, 1967), philosophers of reflexive research believe that it is impossible to conduct research that is purely inductive (that is, data driven). The researcher's interpretation ultimately drives the research.

“Nothing means anything on its own. Meaning comes not from seeing or even observation alone, for there is no “alone” of this sort. Neither is meaning lying around in nature waiting to be scooped up by the senses; rather it is constructed.”

“Constructed” in this context, means produced in acts of interpretations (Steedman, 1991 in Alvesson & Skoldberg, 2000).

Reflexive research is repetitive in that the data, research process and findings are frequently reflected on to refine meaning and research focus.

4.7.1.2 Who has recommended reflexive methodology?

Patton developed a three question framework of reflexivity as a basis for reflexive research. The questions were based on self-reflexivity, reflexivity about the subjects being studied and reflexivity of the audience's understanding of the study (Patton, 2002).

Srivastava (2009) developed a three question framework to ensure engagement with the data analysis process. This framework will be applied at stages of interpretation in this research.

4.7.1.3 Reflexive questions

Srivastava (2009) lists the three questions to ask when engaging with the data:

1. What is the data telling me?
2. What is it I want to know?
3. What is the dialectical relationship between what the data is telling me and what I want to know?

The first question ensures that the data is explored in the light of all theoretical, subjective and philosophical foundations of the researcher. The following question focuses on the research question and objectives. The final question leads to logical connection between what is known and if that knowledge answers the research aims and questions.

4.7.1.4 Application of reflexive questions

The reflexive question framework was applied when any subjective interpretation was required during the research process. Reflexive questions were therefore applied when developing both the one-on-one interview guides and focus group interview guides and during the development of major themes and sub-themes. This ensured that interpretation and development of the study was based on the theoretical underpinnings of the study. Reflexive questions were also used to develop the final discussion, arguments based on the foundational human resource theory and develop recommendations in the conclusion of the study.

4.7.2 Thematic analysis

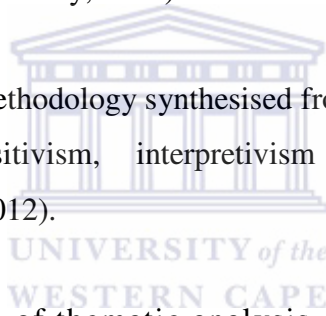
4.7.2.1 What is thematic analysis?

The Encyclopedia of Case Study Research defines thematic analysis as "...a systematic approach to the analysis of qualitative data that involves identifying themes or patterns of cultural meaning, coding and classifying data (usually textual) according to themes and interpreting the resulting thematic structures by seeking commonalities, relationships, overarching patterns, theoretical constructs or explanatory principals." (Lapadat, 2010, p. 926).

Thematic analysis is not restrictive but has been used by many researchers in different fields. It appears to be used both in quantitative and qualitative paradigms but is most suitable for qualitative analysis. Thematic analysis allows for reduction of qualitative data by segmentation, categorisation and summation and subsequent reconstruction to represent the most important concepts embedded in the data. Thematic analysis is conducive to description of the data and pattern-finding within the data without losing the context(Ayres, 2008).

Thematic analysis involves analysis of two types of data: both manifest and latent data. Manifest data is directly observable in the data, whereas latent data is indirectly observable with an underlying meaning attached. This makes thematic analysis an appropriate analysis tool of qualitative data since it involves human interpretation(Marks & Yardley, 2004).

Thematic analysis is a methodology synthesised from other methodologies such as grounded theory, positivism, interpretivism and phenomenology(Guest, MacQueen, & Namey, 2012).



4.7.2.2 Criticism of thematic analysis

Most qualitative research focuses on inductive methods that are purely data-driven. However, qualitative research is directed by the researcher. The researcher's knowledge or background drives the type of questions that will be asked and answered by the researcher. The researcher is therefore not "reinventing the wheel". This is important since evidence that contradicts the assumptions of the researcher is often purposefully decentralised. Counter-evidence must therefore be properly tested by the presented model (Marks & Yardley, 2004). How all emergent counter-arguments were incorporated is presented in the chapter on research analysis (Chapter 5).

4.7.2.3 Why did I choose thematic analysis?

Thematic analysis is a suitable method for exploratory studies that present large amounts of data where rigorous and systematic analysis is required. Large amounts of data require careful reduction to represent the "big ideas" from the research data.

According to Boyatzis (1998), there are five reasons why thematic analysis should be used as a sense-making approach. It is a means of:

- Seeing
- Finding relationships
- Analysing
- Systematically observing a case
- Quantifying qualitative data.

The Encyclopedia of Case Study Research describes thematic analysis as a means to reduce large volumes of data without losing the context. It allows the researcher and analyser to get "close to" or immerse oneself in the data. It also ensures that the interpretation is focused (Lapadat, 2010).

Thematic analysis was used to analyse interview transcripts of both one-on-one interviews and focus group interviews.

4.7.2.4 Coding

There are two ways of approaching coding in thematic analysis; by deductive or inductive means. Deductive coding is established before analysis of the data as an *a priori* framework. Inductive codes are derived from the data or are data-driven. They emerge from the data itself. The Sage Encyclopedia of Qualitative Research mentions that codes may be derived from the foundation conceptual model of the research, the literature review and professional experience (Ayres, 2008).

The Encyclopedia of Case Study Research suggests that researchers use their research questions, interview questions or theory derived categories as

apriori theme codes. This facilitates cross case comparisons. An inductive approach can also be followed where themes and codes that are grounded in the data are allowed to emerge from the data, to ensure that analysis is not prematurely closed. This allows for saturation of the codes and themes (Lapadat, 2010).

Definition of an “*apriori*” code framework for this research

Apriori can be defined “known before” or “deductive”(Apriori, n.d). Codes that are developed before data collection (based on theory and existing literature) are called *apriori* codes. Codes derived from the data during data analysis are called *inductive* codes (Nieuwenhuis, 2010). In this case codes were allowed to emerge inductively from data derived from one-on-one interviews with key-informants. These codes “established beforehand” were then reapplied as an *apriori* code framework for the focus group interview data. This framework was remodeled by allowing extra codes to emerge inductively from the group interview data and allow saturation of codes and subsequent themes.

4.8 ETHICAL CONSIDERATIONS

4.8.1 Introduction

Ethics can be defined as a "set of principles of right conduct" (Ethics [Def.1], n.d.) or a "social religious or civil code of behaviour considered correct especially that of a particular group, profession or individual" (Ethics [Def. 2], n.d.). In research, ethics is directly connected to the integrity of the researcher. In each stage of the research process ethical strategies were developed to ensure the protection of the participant. (Creswell, 2003).

Ethics approval was granted by the Ethics Research Committee of the University of the Western Cape. The research ethics committee approval letter is attached as Appendix A. Approval was granted to access the research participants at different sites by their gatekeepers namely Groote Schuur Hospital and Tygerberg Hospital and various district hospitals and community health centers in the Eastern District

(Appendix B).

Creswell (2003) gives a guideline to all the points to consider during development of the research project (Creswell, 2003). I have based my model of ethical considerations on his suggestions.

4.8.2 Implementation of ethical strategies

In the light of Creswell's (2003) suggestions, the following steps were taken in the research process to ensure the protection of the participants.

4.8.3 Strategies of Autonomy

The rights of the participants in this study were recognised. Participants were considered independent and had the right to make their own choices according to their own free-will. They were informed of the objectives and processes of the research. They were allowed to freely participate (volunteer). They were allowed to withdraw at anytime without consequences. They were informed that they had the right to request any withdrawal of statements or information supplied to the researcher at any stage.

The researcher tried, as far as possible to schedule interviews at convenient times or places based on the participants' needs.

The research was conducted in a language that was understood by the participants. This included the research information sheet, consent form and interview questions. In this case, however, all participants studied Pharmacy in South Africa and foreign pharmacists took the entrance exam in order to practice as pharmacists and were therefore competent in the English language. All communications were therefore conducted in English. Participants were informed that in the unlikely event of any questions arising regarding clarification of concepts or terms in another language, the researcher would search for an answer in two other official and popular languages in the Western Cape (Afrikaans and isiXhosa) before proceeding with the interview. I ensured that two consultants

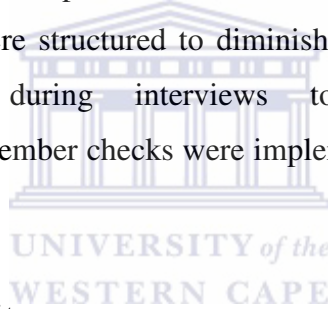
with home languages in Afrikaans and isiXhosa were on call and could be contacted telephonically during the interview.

4.8.3.1 Informed consent

An information sheet was presented to all participants stating particulars of the study and informing them of their rights. They voluntarily signed a consent form after being informed of the above (see Appendix E, F, G and H).

4.8.4 Strategies of Beneficence

The welfare of the research participants was considered as ultimately important at all stages of the research. Research strategies and data collection methods were constructed with the mental and physical health of the participants in mind. The voice of the research participants was considered as most important. For this reason, focus groups were structured to diminish peer and managerial pressure, probes were used during interviews to eliminate communication misinterpretations and member checks were implemented to ensure the validity of extracted themes.



4.8.4.1 Anonymity

The identity of the participants in the research were protected by using pseudonyms in transcriptions of data and storing electronic data with password protection during analysis. After analysis was completed, all electronic data became the property of the University of Western Cape and is securely stored at the University. Transcription copies kept after the research period are only kept by the University and the researcher and are securely stored. These transcription copies will be destroyed by the researcher after ten years.

Participants were allowed full access to data transcriptions where they had been involved and to summaries or findings of the research. Participants were informed of any verbatim quotations used in the thesis discussion. Only quotations that were non-identifying were used in order to ensure anonymity.

4.8.4.2 Confidentiality

All participants and the researcher understood and verbally agreed to confidentiality before participating in focus group interviews.

4.8.4.3 Confirmability and credibility

As discussed under research validity and reliability, transparency and documentation is important to ensure integrity of findings. The researcher kept an audit trail which is detailed in the analysis chapter (Chapter 5), iterative decisions by answering reflexive questions and a code book for thematic analysis.

4.8.5 Strategies of Justice

The purpose of this research was not to abuse or exploit participants. According to the Collins dictionary (2003), those that are vulnerable are “*capable of being physically or emotionally wounded or hurt*” (Vulnerable, n.d.). According to this definition, the participants, being other pharmacists on the same level as the researcher (colleagues), are not considered vulnerable.

4.9 RESEARCH VALIDITY AND RELIABILITY

4.9.1 Defining validity in the qualitative paradigm

In order for qualitative research involving the “science of people” to have any meaning or effect on current literature, the research must be rigorously performed (Merriam, 2009). The qualitative researcher must convince the reader that the conclusions made are sensible using detailed descriptions (Merriam, 2009). Since qualitative research leads to acquisition of understanding, what makes it valid will be different to that of quantitative research. Qualitative research authors often use the terminology “trustworthiness” (Nieuwenhuis, 2010) or “credibility” (Creswell, 2007). Since the view of reality differs vastly between the philosophical basis of qualitative and quantitative research, trustworthiness cannot be measured in terms of reality itself. In fact, “peoples’ constructions of reality and how they understand the world” is being investigated (Merriam, 2009). The qualitative researcher desires to reveal the perspectives of the participants in contexts of the situation being investigated.

4.9.2 Strategies employed to ensure validity

A number of strategies were used to improve trustworthiness in this study, i.e. triangulation, adequate engagement with data, researcher's position and member checking.

4.9.2.1 Triangulation

Triangulation means the application of multiple methods, multiples sources of data, multiple investigators or multiple theories to the research to confirm major findings (Merriam, 2009). In this study, two types of interview styles occurred, namely focus group and one-on-one interviews that allowed for opportunity to compare emergent themes from dual perspectives. The sample consisted of a mix of participants from different settings (tertiary hospitals, district hospitals and community health centers) and different employment grades (production, supervisory and policy specialists).

4.9.2.2 Adequate engagement with data

Analysis was rigorous and emergent findings reached the point of redundancy or saturation (Merriam, 2009). This was ensured by rigorous thematic analysis and coding narrowing and theme saturation.

4.9.2.3 Researcher's position

Merriam (2009) speaks of researcher's position as being reflexive which drives a critical reflection of oneself as the researcher. A reflexive question method was used during interpretation of the data and findings.

4.9.2.4 Member checks

All emergent themes and theories were presented to research participants at interim analysis stages to allow participants to critically review my interpretations (Creswell, 2013). Constructions of meaning are based on participant-researcher collaboration.

4.9.3 Strategies employed to ensure reliability

Reliability is defined as the level of reproducibility of the study (Merriam, 2009). Since human behaviour cannot be definite, qualitative researchers used the term “dependability” (Lincoln & Guba, 1985 in Creswell, 2007), or “consistency” (Merriam, 2009) instead of reliability. The question of “whether results are consistent with data collected” (Lincoln & Guba, 1985 in Merriam, 2009) must be answered. Thus an audit trail has been included in Chapter 5.

4.9.3.1 Audit trail

Since the dynamics of qualitative research can never be perfectly repeated (due to investigation of natural situations), the process by which a researcher arrives at an interpretation must be recorded in detail in order to demonstrate transparency (Merriam, 2009). Thus a detailed account of how the study was conducted with changes and reasons will be included in the analysis chapter (Chapter 5) of the thesis.

4.10 CONCLUSION

I have attempted to demonstrate the rationale for approaching this research from a qualitative paradigm, to link the theoretical framework with the research design and illustrate the connections between different parts of the research process with a focus on validity and reliability.

CHAPTER 5

DATA ANALYSIS AND RESULTS

5.1 INTRODUCTION

The purpose of this chapter is to outline the process of data analysis and how it is linked to researcher interpretation and validity and reliability of the research. In the findings and discussion chapters (Chapter 6 and 7), I will use quotations from the “raw data” transcripts to further validate the findings and interpretation thereof.

This chapter contains the following sections:

- An overview and account of the data collection and analysis process
- The analysis of key-informant interviews which includes steps of coding and analysis, an example of coding decisions, developing an *a priori* code list through an inductive approach (including theme saturation), the influence of member checks and the application of reflexive questions
- The analysis of focus group interviews which includes the use of an *a priori* code list (including the emergence of new inductive codes), the influence of member checks and the application of reflexive questions
- A summary of the strategies employed to ensure validity and reliability of the research
- The conclusion of the analysis process.

5.2 OVERVIEW OF THE RESEARCH ANALYSIS PROCESS

The end point of data saturation and subsequent data collection can never be known at the onset of qualitative style studies. For this reason the process is iterative, although one can learn from the experience and suggestions of previous research ventures.

Although Srivastava’s (2009) reflexive question framework was applied on set occasions (see section 4.7.1.4: Application of reflexive questions); the

thoughtprocess of moving between emergent themes and codes with reference to the grounding literature is reflexive and constant.

The data collection and analysis was conducted in 2 phases.

- Phase I: Key-informant interviews and thematic analysis
- Phase II: Focus group interviews and thematic analysis

5.2.1 Phase I: Key-informant interviews and thematic analysis

The data collection commenced with snowball sampling of key-informants. Only four key-informants were interviewed one-on-one. These were selected firstly by suggestion and secondly based on their degree of knowledge of the research topic and their connection to the area population. To narrow the field of research, key-informants from areas that were considered non-metropolitan or rural were not included as participants.

Each recorded interview was subsequently transcribed, verbatim, and thematically analysed with the assistance of qualitative analysis software, Atlas.ti®.

A code list framework was added to after each interview and interview guides were formatted to elicit relevant data. Themes and sub-themes (perceptions) were elicited.

5.2.2 Phase II: Focus group interviews and thematic analysis

After conducting the key-informant interviews, I found it useful to design a conversational tool in the form of “sayings” to be used in the focus group interviews to stimulate thoughts between guideline questions. This was based on perceptions of key-informants and can be seen as appendices L and M.

Pharmacists were arranged to discuss issues connected to the research topics. In Chapter 4 (Methodology), the composition of those groups can be seen in Figure 14 (Section 4.5.4). Groups did not consist of matching numbers of participants due to availability of participants.

The focus group interview recordings were transcribed verbatim and analysed in a similar fashion to the one-on-one interviews of key-informants. The code framework developed in phase I was applied to focus group interviews as an *a priori* code framework.

New codes were allowed to emerge and were added to the existing framework after each interview was conducted. Themes and sub-themes were also compared between the phases I and II. The interview guide was altered after each interview to extract pertinent information and to ensure the questions were applicable to the group dynamics.

5.3 ANALYSIS OF KEY-INFORMANT INTERVIEWS

5.3.1 Introduction

Analysis of transcripts from interviews with key informants was performed in subsequent order. Emergent themes were reported and presented to each participant after each interview and the participant was asked to comment. Comments were used to modify sub-themes in relation to themes. Each report was developed using reflexive questions and used to focus subsequent interviews on extracting information not elucidated in previous interviews.

5.3.2 Steps of coding and analysis

5.3.2.1 STEP 1: Transcript accuracy and familiarity

Each interview was transcribed verbatim and read through a number of times to ensure accuracy and obtain sensitivity to aspects of the interview. Points of interest were noted on the transcript.

5.3.2.2 STEP 2: Initial coding in Atlas.ti®

The transcript was then loaded into Atlas.ti® qualitative analysis software. With points of interest in mind, sections of the interview text (quotes) were selected and tagged with code references. These codes were in the format of short phrases summarising the content/context of the text or my interpreted meaning of the text.

Each code was also given a description of what type of text/conversation allows for its application. Some sections were tagged with multiple codes. Codes were extracted inductively but in some cases were named according to background literature if that connection was clearly seen.

5.3.2.3 STEP 3: Refining codes

Codes were refined by re-reading the transcript and quotes and modifying codes in the form of rephrasing or altering quote-code connections.

5.3.2.4 STEP 4: Grouping and interpreting codes to establish themes.

Codes were then grouped by connecting associated codes to a new node which was phrased as a sub-theme (perception). Some of these perceptions were grouped even further to represent an overarching idea or broad theme.

5.3.2.5 STEP 5: Ensuring saturation and an *a priori* code framework.

Codes from each interview were grouped in families to establish whether the number of codes emerging was decreasing with each new interview. This code list was used as an *a priori* framework for subsequent focus group interviews.

5.3.2.6 STEP 6: Participant reports and network diagrams

A report (themes and sub-themes and associated raw quotes) was then constructed for each key-informant based on interpretation of foundational themes with the assistance of network diagrams.

5.3.2.7 STEP 7: Participant feedback and key-informant themes

Key-informants' comments were used to modify the reports to ensure that interpretation was a participant-researcher collaboration. These reports were then used to establish the key-informant themes and sub-themes. Theme and sub-theme development was also used as a measure of data saturation.

5.3.3 An example of coding to demonstrate coding decisions

A single quotation of transcribed text can be tagged with multiple codes to ensure extensive interpretation. The connections between these quotes and codes are termed “co-occurring” which may assist with logical arguments.

In Table 2 below, an example to illustrate the interpretive process of progressing from raw data to major theme has been included. The example is based on a single quotation taken from key-informant KP’s transcript.

An example of transition from raw data to code, theme and sub-theme using thematic analysis and to demonstrate style of coding decisions.	
Transcript quotation	<i>KP: “...there's quite a bit of overlap, if you look at pharmacists’ Grade one, two and three, and then we've got pharmacy supervisors. A supervisor takes a lot of responsibility in an area and so do the assistant managers but there's quite a small difference between a pharmacist Grade 3 and supervisor. So really why do you want to be a supervisor? There's no financial benefit, but you get all the added responsibilities.”</i>
First code developed and applied	Responsibility and pay unmatched (salary too low): This code will be used whenever there is mentioned that pay is considered too low for the amount of responsibility.
Second code developed and applied	Promotion without increase in pay: This code will be used whenever there is mention of no benefits with promotion into a MORE responsible position.
Report statement	In some cases, pay and responsibility are not matched. Higher level production pharmacists are unlikely to enter supervisory pharmacist positions since there is no increase of pay and there is a lot more responsibility in the new position.
Theme	Pay versus responsibility
Sub-theme/perception	Supervisors have a lot more responsibilities but get paid the same as production pharmacists.
Research question link	Perceptions about career advancement (discourages advancement).

Table 2: Progression from raw data to themes

The theme and connected sub-theme is virtually the report statement paraphrased which was based on inductive codes. The report statement was then altered according to the participant's response during member checks (see under the "use of member checks and reflexive questions", section 5.3.5). These altered report statements modify the theme or sub-theme by degrees and are represented as modified key-informant themes and sub-themes. These and then linked to a research question in the findings section of this dissertation (Chapter 6).

5.3.4 Developing an *apriori* code framework

The total *apriori* code framework consisted of 113 codes. 79 of these codes were used as core codes, 18 were super-codes (which group themes and sub-theme codes into general categories associated with the background literature) and 16 codes were used as peripheral codes (connected to historical information supplied). The definition for *apriori* stated in Chapter 4 is reiterated below.

Definition of an "*apriori*" code framework for this research

Apriori can be defined "known before" or "deductive"(Apriori, n.d). Codes that are developed before data collection (based on theory and existing literature) are called *apriori* codes. Codes derived from the data during data analysis are called *inductive* codes (Nieuwenhuis, 2010). In this case codes were allowed to emerge inductively from data derived from one-on-one interviews with key-informants. These codes "established beforehand" were then reapplied as an *apriori* code framework for the focus group interview data. This framework was remodeled by allowing extra codes to emerge inductively from the group interview data and allow saturation of codes and subsequent themes.

A list of super and core codes is attached as Appendix O and P, where super-codes are marked by asterisks and core codes are coloured according to coding type. Peripheral codes are illustrated in Appendix N. Saldaña (2009) recommends a code list of between 80 and 100 codes. This would produce between 15 to 30 categories (the sub-themes of this research are linked directly to categories) and

approximately 5 to 7 major themes. However, there is no set number and a code list relies on the type and extent of the project.

Contribution of core code, themes and sub-themes per key-informant participant					
Key Informant	New core codes	Total core codes	New major themes	New subthemes	Total subthemes
KP	48	48	9	13	13
KQ	13	61	2	7	20
KR	13	74	0	7	27
KS	5	79	0	4	31

Table 3: Contribution of core codes per participant to the apriori framework

The contribution to core codes decreased considerably after the first interview (see Table 3) and no major themes arose after the second interview. However, sub-themes (or perceptions) kept arising within some themes. These sub-themes were often expansions or counter arguments of already existing themes and sub-themes, which will be presented in more detail to follow. The themes and sub-themes have been listed in Table 4 below.

List of the 11 major themes and 31 sub-themes after key-informant interviews	
Themes	Sub-themes
Overlapping of production and supervisor salary grades	<ul style="list-style-type: none"> • Experienced pharmacists stagnate in their career • Inexperienced pharmacists are promoted to management • Does not encourage pharmacists to progress • Permits individual freedom of career path choice
OSD and the variety of positions for pharmacists	<ul style="list-style-type: none"> • OSD has not created a variety of positions because there are few funded posts and there is no option yet for pharmacists that want to be clinical pharmacists • OSD has created a variety of positions since the post structure has been broadened
Being a manager of professionals	<ul style="list-style-type: none"> • OSD does not encourage managers to have extensive clinical experience as a foundation • Years experience does not necessarily equate to good management material (management does not necessarily need extensive clinical experience but rather appropriate management experience) • OSD encourages immature pharmacists to enter management positions • Production pharmacists (with promotional potential) are not exposed to management functions)
Envisioning promotion	<ul style="list-style-type: none"> • Not all pharmacists will be promoted • There is no incentive for those who will not/prefer not to be promoted

List of the 11 major themes and 31 sub-themes after key-informant interviews continued	
Themes	Sub-themes
Pay versus responsibility	<ul style="list-style-type: none"> • Supervisors have a lot more responsibilities but get paid the same as production pharmacists (discouraging advancement) • Responsibility is recognised through an improved post structure and pay will inevitably improve
Pay equity and expectancy	<ul style="list-style-type: none"> • Supervisors at different facilities have different responsibilities but get paid the same salary • Staff at Community Health Centers are uniquely overburdened (perceived inequity) • Experience not recognised can lead to inequalities in pay between pharmacists in the same position (perceived as unfair)
OSD and attraction	<ul style="list-style-type: none"> • OSD offers a competitive (market-related) remuneration package • OSD is attracting a better caliber of professional • OSD ensures that the entry level posts are extremely attractive • OSD is attracting more junior pharmacists due to management opportunities • The post structure has been enlarged by OSD and therefore more posts are available for employment • OSD has encouraged pharmacists to apply for rural positions

List of the 11 major themes and 31 sub-themes after key-informant interviews continued	
Themes	Sub-themes
OSD and retention	<ul style="list-style-type: none"> • Many pharmacists make a choice to be employed in the public sector for other reasons despite the remuneration offered • Retention strategy for experienced pharmacists tends to be neglected • Some work related factors nullify retention strategies
Overtime and after-hours remuneration	<ul style="list-style-type: none"> • The negotiated rate is poor (capped at level 8, below standard production pharmacist level 1) and problematic (causes discontentment) • Flexi-time/extended-hours policy with improved overtime rate may improve pay satisfaction, but is not universal
Interpreting OSD	<ul style="list-style-type: none"> • Some positions have not been recognised correctly after translation to OSD • There may be inter-provincial discrepancies between posts due to different interpretations of OSD
Using unions to negotiate policy for professionals	<ul style="list-style-type: none"> • We require unions' experience with technical proficiency and labour negotiations to assist us. Professionals are not comfortable with negotiation via a third party

Table 4: Themes and sub-themes that arose from key-informant interviews

5.3.5 The use of member checks and the application of reflexive questions

Srivastava's (2009) three question framework, which was used as a guide throughout the research process, is restated below:

1. What is the data telling me?
2. What is it I want to know?
3. What is the dialectical relationship between what the data is telling me and what I want to know?

Question 3 is presented as a separate paragraph in the discussion of each major theme in Chapter 5.

Participants conducted member checks for the purposes of validity/credibility. Each participant was mailed a report with the overarching themes and perceptions (or sub-themes) that arose from their interview. These themes included connected verbatim quotes from the interview transcript. Each participant was given a period of time to respond with objections or additional comments. Responses were also electronically entered into Atlas.ti® and the themes and subthemes/perceptions were altered according to the response.

Not one participant objected to reported themes or sub-themes. Many participants made additional comments to clarify their perceptions further. In some cases additional sub-themes arose. Some participants responded with confidential comments which could not be used for quotation purposes but were used in analysis to alter existing themes or sub-themes.

One key-informant participant did not respond when given the opportunity and was informed that the analysis would be accepted as is.

5.4 ANALYSIS OF FOCUS GROUP INTERVIEWS

5.4.1 Introduction

Transcripts from focus group interviews were analysed in very much the same manner as those from key-informants. They were analysed in subsequent order by applying the *apriori* codes while also allowing codes to emerge inductively.

Emergent themes were reported and presented to each participant after each interview and the participants were asked to comment. Comments were used to modify sub-themes/perceptions in relation to themes. Each report was developed using reflexive questions and used to focus subsequent interviews on extracting information not elucidated in previous interviews.

5.4.2 Use of the *apriori* code framework

The existing code framework (consisting of 79 core codes) was applied to each focus group transcript. New codes derived inductively were added to the core framework. In Table 5, it can be seen that a total of 25 new codes were added to the framework after conducting 4 focus groups. The total core code list after focus group interviews is attached as appendices Q and R.

Contribution of core codes, themes and subthemes per focus group interview					
Group	Additional codes	Core codes total	New major themes	New subthemes	Total subthemes
FA	5	84	0	2	33
FB	7	91	0	3	36
FC	9	100	0	4	40
FD	4	104	0	1	41

Table 5: Contribution of core codes after applying the *apriori* framework

The total major themes remained 11, and the sub-themes increased from 31 to 41. Only one new sub-theme emerged from the last focus group interview. The additional ten sub-themes can be seen in Table 6 below.

List of the additional 10 sub-themes that arose from focus group interviews	
Themes	Sub-themes
OSD and the variety of positions for pharmacists	<ul style="list-style-type: none"> • Posts/positions in other career paths require “insider” information
Being a manager of professionals	<ul style="list-style-type: none"> • Management does require clinical experience, appropriate management experience in term of management of professional staff, inter-professional skills and an interest in management as a career • Some production pharmacists are not interested in exposure to management functions. • Supervisory pharmacists (with promotional potential) are not exposed to higher management functions/tasks
Envisioning promotion	<ul style="list-style-type: none"> • New career path entry is daunting for various reasons (clinical/higher management/supervisory positions)
Pay versus responsibility	<ul style="list-style-type: none"> • Higher management devises other incentives in order to keep junior management satisfied
Pay equity and expectancy	<ul style="list-style-type: none"> • Pay expectations may be linked to the age of the pharmacist • Pay expectations may be related to the individual needs of the pharmacist
OSD and retention	<ul style="list-style-type: none"> • Pay progression is a negative retention strategy • Supervisors cannot negotiate due to popularity of the position

Table 6: Additional sub-themes from focus group interview data

The inter-data code applicability can be seen in the pie-charts in Figure 15. The largest portion of codes for each group interview comes from the core code framework.

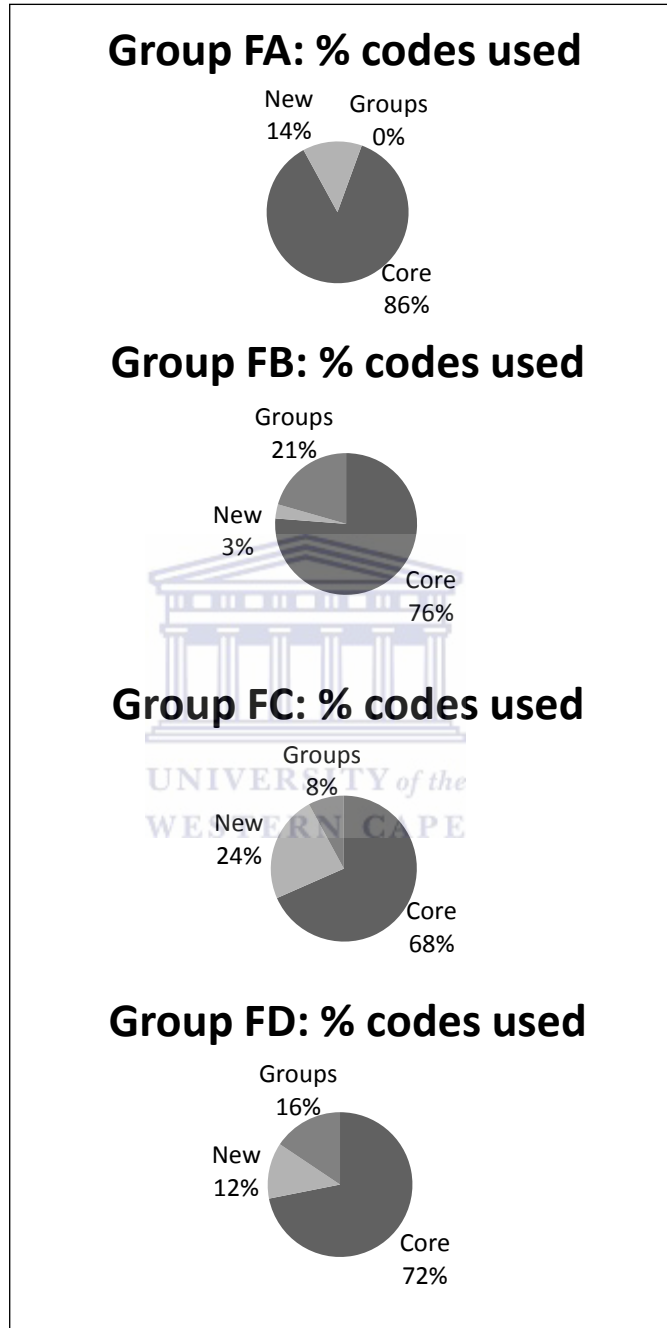


Figure 15: Percentage contribution of codes based on data from each group interview

5.4.3 The use of member checks and the application of reflexive questions

The application of Srivastava's (2009) three question framework when analysing focus group interviews was the same as for key-informant interview transcript analysis.

As with the key-informants, no participants objected to reported themes or sub-themes. Many participants made additional comments to clarify their perceptions further. In some cases additional sub-themes arose. Some participants responded with confidential comments which could not be used for quotation purposes but was used in analysis to alter existing themes or sub-themes.

With group member checks, individual feedback was sparse. At least each group report had some feedback. However, only thirteen (13) participants in total commented on the reports sent to them. Those that did not reply within the feedback period were informed that the analysis would be accepted as is.

5.5 VALIDITY AND RELIABILITY

The validity and reliability of the study were outlined in the Methodology of this dissertation in Chapter 4. In the table below (Table 7), the strategies employed to ensure validity and reliability are summarised, listing at what point in the research the method was employed and the format of such strategies.

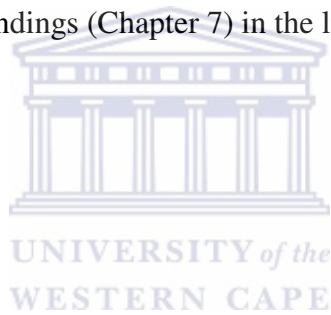
Methods employed to ensure validity and reliability of the research		
Method	Applied at what point in the research process	How the method was employed
Triangulation	Sampling	Human Resource vs employee Production level vs supervisory level
	Data collection	One-on-one interview vs focus group interview
	Research site	District health care vs tertiary level health care
Rigour	Analysis method	Thematic
	Saturation of data in analysis	Code narrowing Theme saturation Sub-theme narrowing
Researcher's position	Reflexive discussion	Discussing researcher's interpretation Presenting the counter argument
Member checks	Participant feedback	Comments on interview reports
Audit trail	Transparency recorded in analysis	Member checks
	Transferability recorded in analysis	Atlas.ti® code lists and network diagrams

Table 7: Methods employed to ensure validity and reliability

Full code lists can be seen as over-viewing network diagrams in Appendix N to R. Interview transcripts from all eight interviews are attached as Appendix S to Z. The interview transcripts are easier to follow when applying the participant demographic keys in Chapter 6 (Table 8 and Table 13).

5.6 CONCLUSION

In this section, I have summarised the process by which raw data was analysed and interpreted in order to demonstrate the validity and reliability of the research. Data was collected from a specific yet varied participant sample. Transcribed interview data was analysed using thematic analysis with the assistance of software (that acted as a reliable database). A reflexive thought process allowed for partial data interpretation before member checks of representative data, and again when discussing findings (Chapter 7) in the light of background theory.



CHAPTER 6

RESEARCH FINDINGS

6.1 INTRODUCTION

With each emergent theme and sub-theme, Srivastava's (2009) three question framework was applied. On application of these questions, themes and sub-themes could be divided into four divisions:

- Career pathing
- Pay
- Attraction and retention
- Current negotiations.

A total of eleven (11) themes with sub-themes (perceptions) have been represented in four tables (Table 9, 10, 11 and 12), one for each division. The reflexive questions also allowed the sub-themes to be categorised in their relation to the two research questions. In each table, relationship to the perception of public sector employment or career advancement has been indicated. Sub-themes were also interpreted as positive, negative or neutral. In some cases either or both key-informants and pharmacists contributed to the construction of themes (also indicated).

In this chapter, the research findings from key-informants and pharmacists are presented as separate sections. Each section includes a section map and four sub-sections focusing on the aforementioned divisions. Raw data quotations (*italics*) will be used to justify the emergent sub-themes. Sub-theme key words are found in **bold text**. The chapter is designed to assist the reader to “stay on track” as I attempt to structure the “thickly descriptive” data in proof of the arguments presented.

6.2 SECTION 1: THE PERCEPTIONS OF KEY-INFORMANTS

6.2.1 Section map and participant key

In Figure 16, a section map shows 3 levels in this section namely the perspective (6.2), the four divisions (6.2.2 to 6.2.5) and the 11 major themes in the far right boxes.

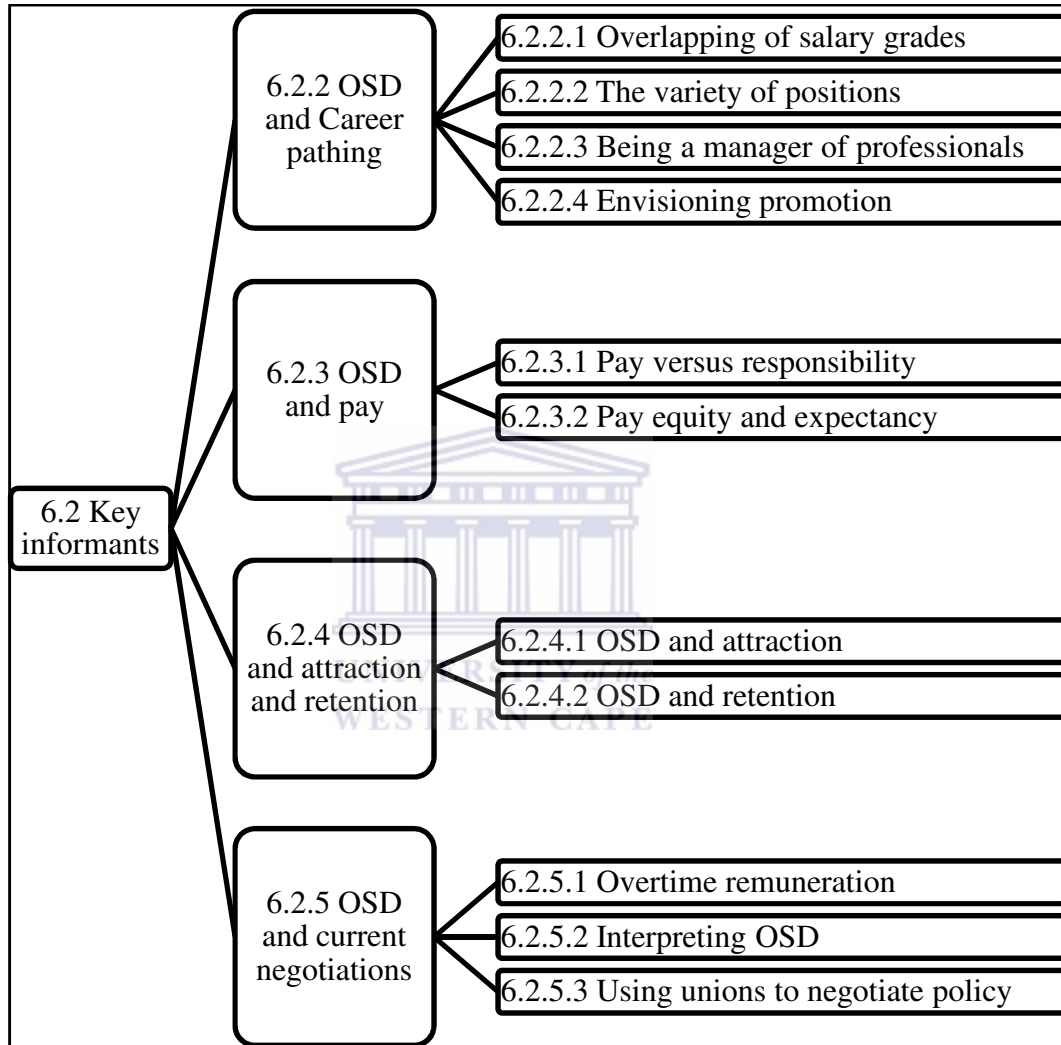


Figure 16: A section map for results from the key-informant perspective

Participants' code-names for interview transcripts and raw data quotations appear in a demographic key in Table 8 below.

Participant code names for interview transcripts and raw data quotations that appear in the text in section 1				
Participant code	Gender	Post level	Years experience	Transcript Appendix
KP	Female	Policy specialist	N/A	S
KQ	Female	Management	N/A	T
KR	Male	Management	N/A	U
KS	Female	Policy specialist	N/A	V

Table 8: Participant code names for key-informant interview transcripts and raw data quotations

6.2.2 Division: OSD and career pathing

Four themes connected to career pathing have emerged in interviews with key-informants. All sub-themes in this section are related chiefly to perceptions of career advancement. In Table 9, it can be seen that not all sub-themes emerged in interviews with key-informants. The most likely explanation is that employees do not always perceive career advancement in the same light as policy-specialists or management. This is the reason why the key-informant *a priori* code framework was not fixed and more codes were allowed to emerge during focus group interviews (data was given “open-ended” freedom).

Themes and sub-themes related to <i>career pathing</i> and their connection to the perceptions of public sector employment (PSE) and career advancement (CA) with marked contributors. Key-informant = KI, Group = GR, positive = (+), negative = (-), neutral = N					
Themes	Sub-themes	KI/GR	+/- /N	PSE	CA
Overlapping of production and supervisor salary grades	Experienced pharmacists stagnate in their career	KI +GR	-		<input checked="" type="checkbox"/>
	Inexperienced pharmacists are promoted to management	KI	-		<input checked="" type="checkbox"/>
	Does not encourage pharmacists to progress	KI +GR	-		<input checked="" type="checkbox"/>
	Permits individual freedom of career path choice	KI +GR	+		<input checked="" type="checkbox"/>
OSD and the variety of positions for pharmacists	OSD has not created a variety of positions because there are few funded posts and there is no option yet for pharmacists that want to be clinical pharmacists	KI +GR	-		<input checked="" type="checkbox"/>
	OSD has created a variety of positions since the post structure has been broadened.	KI	+		<input checked="" type="checkbox"/>
	Posts/positions in other career paths require “insider” information	GR	-		<input checked="" type="checkbox"/>
Being a manager of professionals	OSD does not encourage managers to have extensive clinical experience as a foundation	KI	-		<input checked="" type="checkbox"/>
	Years experience does not necessarily equate to good management material (management does not necessarily need extensive clinical experience but rather appropriate management experience)	KI	+		<input checked="" type="checkbox"/>

Themes and sub-themes related to <i>career pathing</i> and their connection to the perceptions of public sector employment (PSE) and career advancement (CA) with marked contributors (continued). Key-informant = KI, Group = GR, positive = (+), negative = (-), neutral = N					
Themes	Sub-themes	KI/GR	+/- /N	PSE	CA
Being a manager of professionals (continued)	Management does require clinical experience, appropriate management experience in term of management of professional staff, inter-professional skills and an interest in management as a career	GR	N		<input checked="" type="checkbox"/>
	OSD encourages immature pharmacists to enter management positions	KI+GR	-		<input checked="" type="checkbox"/>
	Production pharmacists (with promotional potential) are not exposed to management functions	KI+GR	-		<input checked="" type="checkbox"/>
	Some production pharmacists are not interested in exposure to management functions.	GR	-		<input checked="" type="checkbox"/>
	Supervisory pharmacists (with promotional potential) are not exposed to higher management functions/tasks	GR	-		<input checked="" type="checkbox"/>
Envisioning promotion	Not all pharmacists will be promoted.	KI+GR	N/-		<input checked="" type="checkbox"/>
	There is no incentive for those who will not/prefer not to be promoted	KI=GR	-		<input checked="" type="checkbox"/>
	New career path entry is daunting for various reasons (clinical/higher management/supervisory positions)	GR	-		<input checked="" type="checkbox"/>

Table 9: Themes and sub-themes related to career pathing

6.2.2.1 Theme: Overlapping of Production and Supervisor
Pharmacist salary grades

Overlapping of grade level 3 of Production Pharmacists and grade level 1 of Supervisory Pharmacists creates problems. Key-informants perceive that **it does not encourage pharmacists to progress between these grades.**

KQ: "...if you look at pharmacists' Grade one, two and three, and then we've got pharmacy supervisors. A supervisor takes a lot of responsibility in an area and so do the assistant managers but there's quite a small difference between a pharmacist Grade 3 and supervisor. So really why do you want to be a supervisor. There's no financial benefit, but you get all the added responsibilities. And that was one of our problems with the document. We felt you were not encouraging people to take on positions of responsibility."

It may actually lead to **experienced pharmacists stagnating in their career** while **inexperienced (junior) pharmacists are promoted to management.**

KP: "...the head of these positions would be occupied by pharmacists that did not go through a process before they got there. So they don't understand some of the HR issues, some of the pharmacy issues, because the people with the experience that should do that job, they weren't interested because there was very little difference in salary."

One key-informant disagrees:

KR: "I think with overlapping you have a choice. It's with the people, it's to accommodate the people that choose to stay where they are working because it suits them, they have family commitments and stuff like that but there is also the person that or somebody that wants what's important for them..."

In this case it **offers career path choice** to pharmacists with different needs or in different circumstances.

6.2.2.2 Theme: OSD and the variety of positions for pharmacists
All key-informants admit that OSD has allowed for a **greater variety of positions via a broadened post structure**. Key informant KR believes that OSD has defined career paths for clinical pharmacists and policy specialists not clearly specified under the previous remuneration structure. It has also allowed for inclusion of supervisor and assistant manager posts and has therefore broadened the post structure that previously only had a management career path option.

KR: "...it made specific...created specific places for clinical people as well as policy specialists to retain them because that was the idea,... at that stage, you had to go into management."

However, all have presented arguments for why OSD has also failed to deliver in this area. Although there is now more potential for positions, the variety of positions is **still hindered by allocation of funds**.

KS: "Our problem is that we've gone from the little section that "funded" to "in principled" which means this is on your establishment but there are no funds for it."

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There is also **the problem of the clinical career path**, a topic of much contention.

KQ: "And it comes down to funding. We don't, I think [facility name] is trying at the moment to get a clinical pharmacist post, but it's an issue of funding. If we didn't have funds for them before, it means you got to take a production post and convert it to a clinical pharmacist post. The responsibilities, or the role, I would see of that person is different, which means you then lose a pair of hands."

This key-informant believes it is due to a lack of funds that specialised posts are not created. Other key-informants disagree. They believe it's because the South African Pharmacy Council (SAPC) has not registered these pharmacists as a specialist category and defined the necessary tertiary qualifications for registration yet.

KS: "...but it would have to be very clear cut because if you going to be paying that person that kind of salary you then going to want a qualification attached to it and you have to have a very clear delegation as to what a clinical pharmacist is and what a ward pharmacist does."

KR: "... Pharmacy Council's got no standards as far as I know. There is no, at DPSA⁴ level, there is no post with a job description and standards."

It appears that both opinions may be affecting the creation and funding of such posts in the public sector. Lack of standards, qualifications and registration of the position corroborates with literature (Gray & Suleman, 2012) although the SAPC has requested amendments to the "regulations relating to the registration of persons and the maintenance of registers" for pharmacists, to include the specialisation of clinical pharmacists upon completion of a recognised masters in clinical pharmacy (SAPC, 2014). Rhodes University is currently canvassing for interested pharmacists to enroll in their Doctor of Pharmacy program, which will officially launch in 2016.

6.2.2.3 Theme: Being a manager of professionals

Being a manager of professionals requires managerial skills but also extensive clinical experience. This is not being encouraged by OSD's structure.

KP: "...you can't just say, '...well, I'll do the management thing, you do the clinical stuff.' You need the clinical knowledge. So for me, it was more of an obstacle to creating a proper career path... it actually created the reverse, because the people that would find that post attractive...would be pharmacists on a lower salary level."

OSD may be encouraging immature pharmacists to enter management positions. Since the number of years experience required to enter a supervisory post has been reduced to three years, it has become easier for pharmacists to move into more responsible, better paid posts. Key-informant KP does not think that this is advantageous since it encourages less experienced pharmacists (who earn less)

⁴Department of Public Service and Administration, South Africa

to move into positions that require mature experience while more experienced staff do not apply for these posts since the salary is not competitive enough.

KP: "...but I think managing staff, is one of the most difficult jobs...that you will ever have...as a pharmacist. ...you need to know everything. Unless you want to be a manager that doesn't know anything, and let your pharmacists do everything and you just ...fill in rosters ..., which I don't think we want our managers to be."

In the counter argument, many **years of experience** as a production pharmacist **does not necessarily equate to good management material**. Key-informant KR considers competency and appropriate skills vitally important for supervisor/management positions and not necessarily number of years employed as a production pharmacist in the public sector. The previous structure encouraged promotion by default and was not linked to management capability.

KR: "So it's about competency and then obviously before that you see what experience they have. So hopefully the supervisor, now, won't be there (be promoted) because there (was) five principal pharmacists and everybody left and it's only me that is remaining and you know..."

It seems more junior pharmacists are applying for management positions. Key informant KQ agrees with KR in that focusing on appropriate skills (regardless of age) may produce better management outcomes than outdated mindsets which equal of a long history of public sector employment with competence.

KQ: "Sometimes the problem in the past was, you know, "I've only known this way of working. And now you put me in the management position", and it carries on exactly the same way, with the same problems. Whereas if you put someone with new ideas, a new way of thinking, from the private sector, or from wherever, industry, they've got different ways of things, they've done things differently and that helps rejuvenate the process somehow. So I think it's good. As long as you've got the skills, for me, it's about the skills."

Key-informant KS agrees with both argument angles that although junior pharmacists are more willing to embrace management tasks, they are, however, **not always mature enough to perform the tasks required in management positions.**

KS: "I think we getting a whole different generation of people who are actually not prepared to be in the production group 3."

KS: "...and somebody who you thought would possibly be able to fit in there, you actually discover that they don't have the necessary skill to fill in over there..."

Key informant KS also admits that **production pharmacists cannot demonstrate competency for the management role without exposure to management tasks.**

KS: "Yes, because people can't really think themselves into a post - if they not actually doing it and if you don't expose them ...you can't expect to come in there and suddenly by osmosis they supposed to know it you know, it doesn't work like that."

6.2.2.4 Theme: Envisioning promotion

Not all pharmacists will be promoted. Promotion is logically proportional to the number of senior posts available. At higher levels there are naturally fewer posts available. Career growth needs will therefore not always be satisfied.

KR: "The problem is that from supervisor to assistant manager there (are) quite...very little posts. Then higher up it gets, (the) fewer and fewer. ...I am thinking any other organisation ... works like that."

Some pharmacists prefer the clinical/production role and may not want to enter a management position. KQ is concerned about the reward potential beyond Production grade 3, notch 5. This may compromise OSD's ability to retain experienced employees. Another type of *incentive* system may need to be developed for pharmacists that **prefer to remain at production level.**

KQ: “You know it's just the nature of the individual. So you get people now at Grade 3 after 13 years, and they've still got quite a while to go in their career, and then what happens then? So, you know, maybe, a different kind of incentive system.

6.2.3 Division: OSD and pay

Two themes have arisen from key-informant interviews concerning pay, viz. “Pay versus responsibility” and “pay equity and expectancy”. Five sub-themes (see Table 10) originally emerging from key-informants are all related to perceptions of career advancement.



Themes and sub-themes related to <i>pay</i> and their connection to the perceptions of public sector employment (PSE) and career advancement (CA) with marked contributors. Key-informant = KI, Group = GR, positive = (+), negative = (-), neutral = N					
Themes	Sub-themes	KI/GR	+/-/N	PSE	CA
Pay versus responsibility	Supervisors have a lot more responsibilities but get paid the same as production pharmacists (discouraging advancement)	KI+GR	-		<input checked="" type="checkbox"/>
	Responsibility is recognized through an improved post structure and pay will inevitably improve	KI	+		<input checked="" type="checkbox"/>
	Higher management devises other incentives in order to keep junior management satisfied	GR	N/-		<input checked="" type="checkbox"/>
Pay equity and expectancy	Supervisors at different facilities have different responsibilities but get paid the same salary	KI+GR	-		<input checked="" type="checkbox"/>
	Staff at Community Health Centers are uniquely overburdened (perceived inequity)	KI+GR	-		<input checked="" type="checkbox"/>
	Experience not recognised can lead to inequalities in pay between pharmacists in the same position (perceived as unfair)	KI+GR	-		<input checked="" type="checkbox"/>
	Pay expectations may be linked to the age of the pharmacist	GR	N	<input checked="" type="checkbox"/>	
	Pay expectations may be related to the individual needs of the pharmacist	GR	N	<input checked="" type="checkbox"/>	

Table 10: Themes and sub-themes related to pay

6.2.3.1 Theme: Pay versus responsibility

Supervisors have a lot more responsibilities but get paid the same as production pharmacists. Most key-informants agree that higher level production pharmacists are unlikely to enter supervisory pharmacist positions since there is no increase of pay and there is a lot more responsibility in the new position.

KP: "...you could get paid the same amount for taking less responsibility. So you are not going to apply for a post with more responsibility."

KP: "...It would be nice that if you apply for something [more], that you would get a different level of pay [laugh]."

KQ: "Because it's just all the challenges and no benefit, so, it's often you ask, people will say, "but why must I apply for the post, because the salary, it's such a small difference but it's all the challenges that come with position". So that was the problem between pharmacist Grade 3 and pharmacy supervisor."

KS suggests that the supervisory pharmacist's salary could be a bit higher due to the responsibility attached to the position.

KS: "...and they definitely could make it a bit more lucrative with the person in supervisor but it doesn't seem particularly damaging when you look at it realistically..."

KR believes that responsibility is **recognised via an improved post structure (unlike the previous "flat" structure) which is linked to improved pay.**

KR: "...you can be a supervisor if you are a responsible pharmacist with council...so that changes the whole thing."

6.2.3.2 Theme: Pay equity and expectancy

KR admits that **supervisors at different types of facilities** (district hospitals and community health centers) **with different ranges of responsibilities get paid the same salaries.** Some positions were not reviewed with the introduction of OSD.

KR: “Then as you know there is a gap... A supervisor at [facility name] Hospital and at [facility name] Hospital has got a different responsibility, in two ways, than a supervisor of [facility name] or a supervisor of [facility name] CHC. The weight...”

Pharmacists in Community Health Centers (CHCs) seem to be in a **unique** situation. The **burden of work** between the facilities may be seen as **inequitable**.

KS: “...the whole system has been re-engineered and moved out to primary health care, the focus is on primary health care because of the devolvement that has taken place from the tertiary hospital, a lot of the work has fallen on the CHC’s...”

Inequalities in pay may arise between pharmacists employed in the same position (leading to internal staff conflict and demotivation). This is sometimes due to **experience not being appropriately recognized**. In the first case; years of experience cannot always be proven. As a consequence, newly appointed pharmacists entering the public sector may be inappropriately graded.

KQ: “I think, one of the other things is, the proof of experience. I can understand from an administration point of view that you need that proof but the pharmacist will probably feel, that sometimes it's unfair because they don't always easily have the proof of experience. And maybe it's something we haven't advertised enough, to pharmacists as a profession, ..., it's something we've never had to do before, get certificates of service. So now you apply for a job at [facility name], and you've worked for 10 years somewhere, but that company closed down. And you never thought to get a certificate before they closed down, and you get here, and I can't recognise 10 years of service.”

Experience is not always appropriately measured. This is the case with sessional or 5/8ths pharmacists where experience is measured in hours as opposed to tasks

performed on a daily basis. 5/8ths pharmacists are those employed in “half-day” posts, who work 5 hours of an 8 hour day.

KQ: “It's a tally of hours versus a tally of experience and maybe that's unfair. Because if you look at the 5/8th's pharmacist, true they only do 5/8ths but you've practiced as a pharmacist for that day, and then you should be given recognition for that experience... I can understand if you work 3 hours a day. That's different, but if you've worked for 5 hours there, that's a significant portion of your day.”

6.2.4 Division: OSD and attraction and retention

In this division, the findings of two themes will be presented, namely “OSD and attraction” and “OSD and retention”. Six sub-themes have emerged with regards to attraction and all are related to perceptions of public sector employment. With regards to the theme, “OSD and retention”, only the first three sub-themes (see Table 11) emerged from key-informant interviews (the other sub-themes surfaced in focus group interviews). All three themes are related to the perception of public sector employment as well.

Themes and sub-themes related to <i>attraction and retention</i> and their connection to the perceptions of public sector employment (PSE) and career advancement (CA) with marked contributors. Key-informant = KI, Group = GR, positive = (+), negative = (-), neutral = N					
Themes	Sub-themes	KI/GR	+/- /N	PSE	CA
OSD and attraction	OSD offers a competitive (market related) remuneration package	KI+GR	+	<input checked="" type="checkbox"/>	
	OSD is attracting a better calibre of professional	KI+GR	+	<input checked="" type="checkbox"/>	
	OSD ensures that the entry level posts are extremely attractive	KI+GR	+	<input checked="" type="checkbox"/>	
	OSD is attracting more junior pharmacists due to management opportunities	KI	+	<input checked="" type="checkbox"/>	
	The post structure has been enlarged by OSD and therefore more posts are available for employment	KI	+	<input checked="" type="checkbox"/>	
	OSD has encouraged pharmacists to apply for rural positions	KI	+	<input checked="" type="checkbox"/>	
OSD and retention	Many pharmacists make a choice to be employed in the public sector for other reasons despite the remuneration offered	KI+GR	+	<input checked="" type="checkbox"/>	
	Retention strategy for experienced pharmacists tends to be neglected	KI+GR	-	<input checked="" type="checkbox"/>	
	Some work related factors nullify retention strategies	KI+GR	-	<input checked="" type="checkbox"/>	
	Pay progression is a negative retention strategy	GR	-	<input checked="" type="checkbox"/>	
	Supervisors cannot negotiate due to popularity of the position	GR	-	<input checked="" type="checkbox"/>	

Table 11: Themes and sub-themes related to attraction and retention

6.2.4.1 Theme: OSD and attraction

All key informants agree that OSD is attracting pharmacists to the public sector by **offering a competitive or market related package.**

KS: "...and also the salary looked much better than out in the private sector."

What is more interesting is that all key-informants agree that OSD is now **attracting a better calibre of professional.**

KP: "I think since the OSD, things have improved significantly. I've had calls now from pharmacists saying they are struggling to get back ...into the state... . I've seen us recruit very good pharmacists now. I've seen us recruit passionate pharmacists and they appreciate what they've got. I've seen a lot of the pharmacists that have left, that have come back. You know, ...it had an impact."

KR: "...now you need to have appropriate experience so....so in that way... for the service it's better because they (are)getting people in higher ranks with more appropriate experience..."

It seems that post-OSD there are more **junior pharmacists** seeking **management opportunities** due to the reduction in the years experience required to apply for management posts.

KQ: "Whereas now I could have been only working for 5 years but I have the skills to be in the management position. So I think from that point of view, it's good. It's brought in new ideas, new blood, but also new ways of thinking."

There is no consensus on whether appointing junior pharmacists into management positions is positive or negative. As can be seen above, new blood may mean new ideas. However, pharmacists entering management may need experience in a number of areas in order to manage mature professionals below them.

KP: "...but I think managing staff, is one of the most difficult jobs...that you will ever have...as a pharmacist. ...you need to know everything. Unless you want to be a manager that doesn't know anything, and let your pharmacists do everything and you just ...fill in rosters ..., which I don't think we want our managers to be."

Occupational Specific Dispensation (OSD) has ensured that the **entry level posts appear extremely attractive.**

KQ: "I think definitely, OSD has addressed one concern, which was recruiting staff. It has made the entry level extremely attractive."

KR: "I would say it is reaching it for the...especially the entry level pharmacists. It makes a huge difference. Previously the intern, Comm Serve, it was very, it was based on the old levels..."

OSD has encouraged a larger post structure thus offering more positions of employment.

KR: "...we had a tremendous increase in posts, what I have seen in the four years. And that is the ARV⁵ program, meeting that need and so on, so it will be interesting to see how many we retain after five or ten years."

OSD has encouraged pharmacists to apply for rural positions.

KS: "...and you know and they've now actually filled those posts [on the West Coast] so we don't actually need the CSPs⁶ to come in there."

6.2.4.2 Theme: OSD and retention

Pharmacists who may want to remain in public sector employment for many years cannot rely on "pay" as the sole reason for staying in their posts since pay progression is perceived as being "slow". **OSD as a retention strategy for**

⁵Antiretroviral

⁶Community Service Pharmacists

experienced pharmacists may not be sufficient and can therefore be seen as **negligent**.

KQ: “I think, my concern is, it's still didn't address the more senior levels in pharmacy. So the career progression, that part of it, wasn't, it didn't do justice to that part. ... We managed to attract people to the service, but then if you've been in the service for a while, if you've gotten to a certain level, it's no longer attractive. And that's the gap for OSD.”

KQ: “...So you move to Grade 2 and then do you really want to stay here for 13 years before you move to the next Grade. You know that kind of thing.”

To counter the argument above, some pharmacists will still choose or remain in **public sector employment, despite the remuneration offered for various reasons**. These reasons include comfortable working hours, stimulating work experiences, the location of the employment and an improving infrastructure.

KP: “... but then they are there for other reasons. They are there for the hours. ...they are there because of the exposure, ...some of them feel that they learn more, ...they can get involved in projects ...so I think pharmacists that actually come to the state, they want more than just ...dispensing.”

There are many possible influences to drive pharmacists to leave the public sector, such as high work load due to lack of appropriate staff numbers. **These work related factors may nullify retention strategies**.

KS: “...because they never had sufficient staff and because they couldn't replace the staff, the existing staff were just completely over-burdened and then left and that's why the tertiary institutions bled out like that because of the work load...”

6.2.5 Division: OSD and current negotiations

Themes that focus on current negotiations are issues that are still being addressed after the initial agreement of OSD for pharmacists. All five sub-themes have arisen in interviews with key-informants. Key-informants were involved in the initial negotiations and are therefore aware of current concerns after the implementation of OSD. Two themes are related to the perception of public sector employment and three are related to career advancement (Table 12).



Themes and sub-themes related to <i>current negotiations</i> and their connection to the perceptions of public sector employment (PSE) and career advancement (CA) with marked contributors. Key-informant = KI, Group = GR, positive = (+), negative = (-), neutral = N					
Themes	Sub-themes	KI/GR	+/- /N	PSE	CA
Over-time and after-hours remuneration	The negotiated rate is poor (capped at level 8, below standard production pharmacist level 1) and problematic (causes discontentment)	KI+GR	-		<input checked="" type="checkbox"/>
	Flexi-time/extended hour's policy with improved over-time rate may improve pay satisfaction, but is not universal	KI+GR	+/-	<input checked="" type="checkbox"/>	
Interpreting OSD	Some positions have not been recognised correctly after translation to OSD	KI	-		<input checked="" type="checkbox"/>
	There may be inter-provincial discrepancies between posts due to different interpretations of OSD	KI	-/N	<input checked="" type="checkbox"/>	
Using unions to negotiate policy for professionals	We require union's experience with technical proficiency and labour negotiations to assist us. Professionals are not comfortable with negotiation via a third party	KI	-		<input checked="" type="checkbox"/>

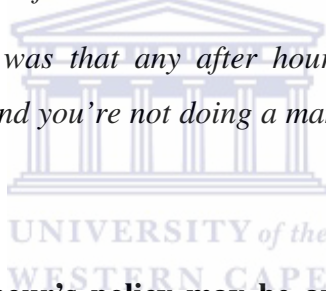
Table 12: Themes and sub-themes related to current negotiations

6.2.5.1 Theme: Over-time and after-hours remuneration

The negotiated rate for over-time is poor. After-hours is capped at level 8, which is below the standard production pharmacist level 1's salary (entry level), irrespective of the pharmacist's number of years experience or the level post that that he/she is currently employed in. Most pharmacists on higher levels find the pay unacceptable and many managers have to bend human resource rules in order for the remuneration to become acceptable. Some managers claim over-time for their employees via agencies at locum rates. This seems counterproductive in terms of the original reasons for implementing Occupational Specific Dispensation (OSD).

KR: "...the problem, the big problem with OSD is that... they did not... bargain a very good after hour/ extended hour remuneration."

KP: "Their thing was that any after hour work, you do on production pharmacist level, and you're not doing a manager's work. So they maximise that"



A flexi-time/extended hour's policy may be an option to solve some of the operational problems.

KS: "Now the same thing happens with pharmacy, when we close our doors, our nurses land up dispensing scripts."

KS: "...you have got this particular service area that is generating prescriptions and because it is generating prescriptions, it then needs that pharmacy to be in action, it can't really close down..."

The over-time pay rate, however, will still need to be improved.

KS: "... the over-time remuneration where pharmacists are remunerated at level 8...It's absolutely crazy, people are not prepared to do it anymore, they prepared, they know within their contract they've got a situation whereby you know, if you are required to do over time because you go into

a situation which is not regular, you will jump in and we will help but if it's a situation where you are doing it regularly then people just say 'No, this is not on, this is not in my contract to actually do that...'”

A flexi-time policy may improve pay satisfaction but is not universal. Staffing models will need to be amended in order not to compromise existing employment.

KS: “...people have just said you know it's actually better if we come in on a Sunday as well, but then again you doing that to the staff. You then again pulling that elastic band of the available staff that you have to cover for those periods of time and there is just so far you can pull it before something gives...”

6.2.5.2 Theme: Interpreting OSD

The Department of Health in various provinces has **interpreted OSD differently causing inter-provincial discrepancies.**

KQ: “...OSD in a way should have addressed the inequalities between the various provinces. When it was difficult filling posts, lots of provinces took an independent decision to move people up a level. Whereas the Western province refused to do that... but with OSD, instead of correcting it, as we'd hoped it would, people that were now on a higher level, still went on a higher level. So our pharmacists were still disadvantaged,...So it's just that they will still be, in a supervisor position, but they should have been a pharmacist. But with the translation, when they got translated, then they got translated into the higher position...”

It may be more difficult for facilities in the Western Cape to attract production pharmacists from other provinces in South Africa.

During the implementation of OSD, Human Resource Management was permitted time to determine the level of each filled post by comparing the stipulations of the old and new policy structures. Each post could then be “translated” by using stipulations (key performance areas and job descriptions) as a guide. There are

still unresolved disagreements concerning **translated** posts. Some pharmacists that perform supervisory functions have still not been **recognised** as supervisors.

KQ: "...it was such a battle for us, because we had to fight to recognise our pharmacist's in supervisory positions. I think the biggest battle for the province, was getting the pharmacy supervisors recognised, and even to date there's some people that in certain positions, they wouldn't recognise it as a supervisor,..."

6.2.5.3 Theme: Using unions to negotiate policy for professionals
Using unions to negotiate policy for professional careers is complicated. Labour law and regulations require negotiation on collective labour agreements to transpire via the Bargaining Council Chamber. This means that unions are drafted to negotiate the needs of professions that are specific and independent and professionals may deem this form of negotiation inappropriate. **Professionals may not be comfortable with negotiation via a third party.**

KQ: "...From the department side I felt that they were not listening enough to what the concerns of the pharmacists were and there were real concerns about the document that was put out. We had to go and fight the battle via the unions. Whereas it should be... as government, this is what our pharmacists are saying and we put forward a document to address that. We had to go almost a side route by involving the unions to go that route."

KP: "The only way we can negotiate our salaries is through the unions. And, they don't have much experience, dealing with unions, and unions ...(they) don't have much experience of our work and what we see as appropriate..."

KP: "...and ...that union member must go and talk for you in the bargain chamber. So he needs to be adequately informed. ...there was no process ...it was left up to us to find our unions and deal with them and inform them..."

In the counter argument, KR suggests that pharmacists do not have the **technical proficiency for labour negotiations** they are a minority group amongst other professional groups in the public sector (e.g. nurses and doctors).

KR: "...interestingly enough, many of the unions have got the technical knowhow of this stuff where we honestly... because there is certain common stuff that works across in any workplace for ranks of people and HR..."

KR: "...so I don't see it as a negative, because pharmacy is still a very small group... in the public sector, it's extremely small... in the facility they are outnumbered, I mean."



6.3 SECTION 2: THE PERCEPTIONS OF PRODUCTION AND SUPERVISORY PHARMACISTS

6.3.1 Section map and participant key

In Figure 17, a section map shows 3 levels in this section namely the perspective (6.3), the four divisions (6.3.2 to 6.3.5) and the 9 major themes in the far right boxes. Two themes that were not discussed in focus group interviews were “interpreting OSD” and “using unions to negotiate policy” which fall into the final division of “OSD and current negotiations”.

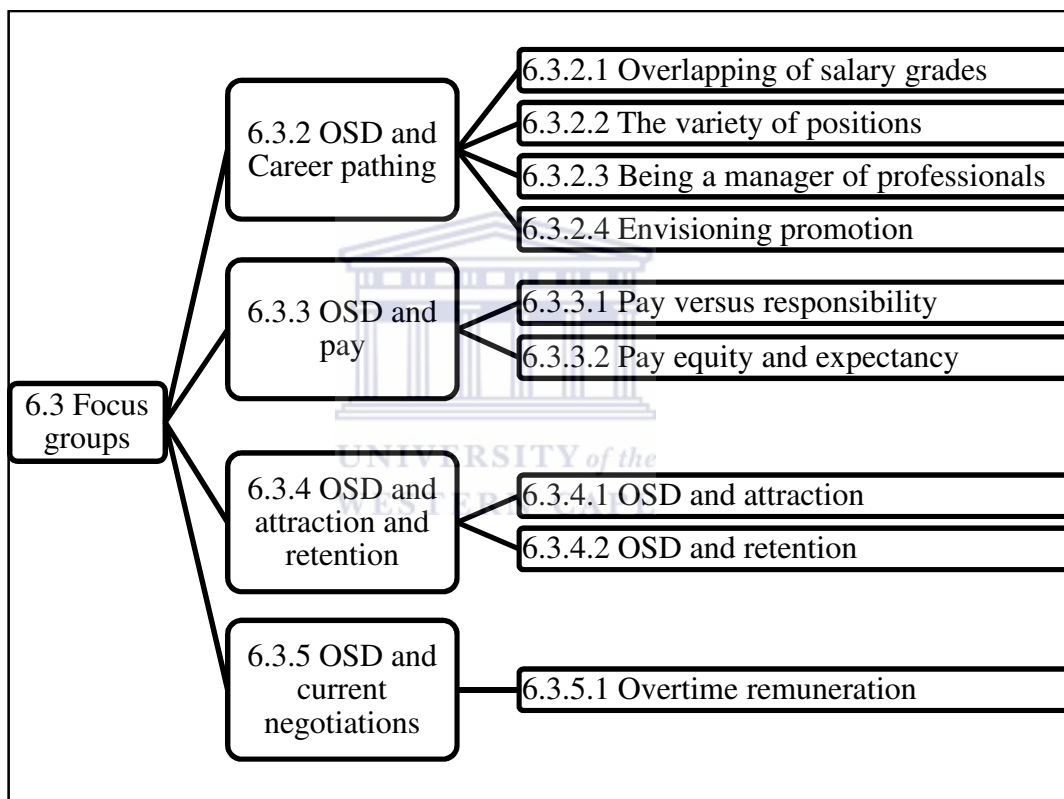


Figure 17: A section map for results from the perspective of focus group participants

Participant code-names for interview transcripts and raw data quotations appear in a demographic key in Table 13 below.

Participant code names for focus group interview transcripts and raw data quotations that appear in the text in section 2					
Group	Assigned number	Gender	Post level	Years experience in public sector	Transcript Appendix
FA	1	Female	Supervisor	6	W
FA	2	Male	Supervisor	7	W
FA	3	Female	Supervisor	5	W
FA	4	Male	Supervisor	8	W
FA	5	Female	Supervisor	8	W
FA	6	Female	Supervisor	5	W
FA	7	Female	Supervisor	7	W
FA	8	Female	Supervisor	8	W
FB	1	Female	Production	4	X
FB	2	Female	Production	3	X
FB	3	Female	Production	4	X
FB	4	Female	Production	<1	X
FB	5	Female	Production	4	X
FB	6	Female	Production	2	X
FB	7	Female	Production	3	X
FB	8	Male	Production	<1	X
FB	9	Female	Production	<1	X
FB	10	Female	Production	4	X
FB	11	Female	Production	4	X
FB	12	Male	Production	<1	X
FC	1	Female	Supervisor	13	Y
FC	2	Female	Supervisor	10	Y
FC	3	Female	Supervisor	8	Y
FC	4	Female	Supervisor	14	Y
FD	1	Female	Production	5	Z
FD	2	Male	Production	5	Z
FD	3	Female	Production	3	Z

Table 13: Participant code names for focus group interview transcripts and raw data quotations

6.3.2 Division: OSD and career pathing

The number of themes remained the same after focus group interviews. According to Table 9, many of the existing sub-themes were mentioned by focus group participants apart from four (one under the theme “overlapping of production and supervisor salary grades”, one linked to the theme “the variety of positions for pharmacists” and two under “being a manager of professionals”. Five new sub-themes arose during focus group interviews. All sub-themes are related to perceptions of career advancement.

6.3.2.1 Theme: Overlapping of Production and Supervisor Pharmacist salary grades

Overlapping production level 3 and supervisory level 1 pharmacist grades (5 notches) **does not encourage pharmacists to progress between these grades.**

FB7: “I am now at grade 3. Yes indeed I feel why should I apply for the supervisor post, when I am earning the same salary.”

There needs to be a clear incentive as recognition of pharmacists in positions of responsibility in order to attract pharmacists into those positions.

FD3: “...I was like ‘Whoa, here is a position open as a supervisor and by that time I was sort of like ...almost knew all the responsibility of that and then like I was saying, when I saw the salary I am like ‘No! I am not going to tire myself out during the day for this,’ you know. I will if it’s definitely more.

Overlapping has led to experienced staff stagnating in their career (which means the skills of experienced staff are underutilised). Supervisors may perceive this as unfair.

FC3: “... and she is like ‘No, I will take the grade 3 job because I am over responsibility, I’ve had enough and I am going to earn the same as what I would earn as a supervisor.’”

FC1: “She was earning actually earning more than us because we were all on grade 1...”

For production pharmacists, career growth needs may not be realised.

Michelle (researcher): "...production 3 you've been with the government for what? Maybe twelve years or thirteen years and you come into that. What do you do?"

FD3: "Now you just stick to being a pharmacist."

Michelle: "Do you want to go to supervisor? I don't know?"

FD3: "No."

In the counter argument, some pharmacists may perceive the overlapping as a problem in terms of similar salaries being paid to different ranking pharmacists. However, OSD offers **career path choice to pharmacists with different needs or in different circumstance**, i.e. employees seeking career growth along a different career path.

Michelle: "...so do you think the overlapping thing is a big deal then or not?..."

FD2: "Not for me."

FD1: "Ja, so I feel I have to go up, I can't just, just be a pharmacist and just be that."

FB2: "I am a Grade 3 pharmacist and no, the lack of salary increase would not be a problem."

6.3.2.2 Theme: OSD and the variety of positions for pharmacists
OSD has not offered a greater variety of positions. The Clinical Pharmacist career path has been included in the structure but there are as yet no official posts that have been created. Production pharmacists see this as an essential role in academic hospitals and are interested to apply. Some supervisory pharmacists would be interested in pursuing this career path.

FB2: "I also said what we should have is a clinical pharmacist because why, are we the pharmacists, but the expertise is going to Prof [surname] or

someone else. Yes, he would be a backup, but why don't we have one person who is training up one or two other people who is the centre of information..."

FA1: "I've checked this clinical...but the moment they put up a post and I see that there's a trend: the following year there will be 2 or 3, then I would go into it."

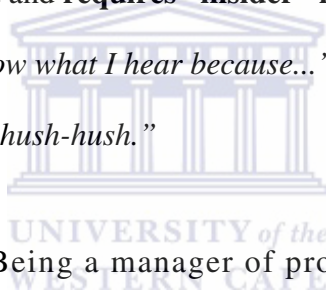
FA7: "So will I."

Michelle: "Clinical? Interesting."

Pharmacists are aware of other career paths in OSD's structure but only have very little idea of what positions or posts are offered in each career path. OSD's career pathing is not transparent and **requires "insider" information.**

FD1: "I just know what I hear because..."

FD3: "It's very hush-hush."



6.3.2.3 Theme: Being a manager of professionals

OSD may encourage immature pharmacists to enter management positions. Freshly qualified community service pharmacists have been appointed in supervisory positions (certainly due to lack of applicants) without the minimum required experience of 3 years. These pharmacists have been appointed on the same salary level as senior supervisory pharmacists with extensive experience. This may be viewed as lack of recognition of seniority.

FA4: "...I've been working for 40...50 years,...it took me a year to get the supervisor post and these little pipsqueaks that had just qualified...they'd just qualified, they'd just done their comm-serve, got the same salaries, the same post as I did."

There appears to be a lack of exposure and training to develop production pharmacists with potential for a management positions. This discourages promotion of production pharmacists into supervisory posts.

FB2: “They have not replaced that person, they have not given anyone an opportunity, they have not mentored someone into a supervisory role to give them a chance to try if they don’t like... or give 4 people, put them in for a month at a time but give everyone some exposure – you never get exposure to anything, you don’t get exposure to ordering, too... you know, anything that is mainly minimally management functioning so how can you grow? Then they take you with no experience and they stick you in a supervisor position.”

There also appears to be a **lack of exposure and training to develop supervisory pharmacists for higher management positions.**

FB2: “To me the supervisors should be involved in the financial reporting, PTC⁷ meetings, Provincial and local changes and challenges, interaction with the Day hospitals and clinics.....how on earth do they learn so they can move up in Pharmacy...”

FC3, a supervisory pharmacist, admits that she didn’t have all the skills required when she started in her new position but that she had the right attitude.

FC3: “... so I don’t think I had all the skills I needed, I don’t think any of us felt that but I was ready for the challenge and I think I’ve learnt a lot and I think we’re also in quite a unique situation in that none of us studied to be managers.”

Michelle: “No.”

FC3: “We studied to be pharmacists and we figured it out along the way, you know...”

⁷PPTC- Provincial Pharmacy and Therapeutics Committee

Supervisory pharmacists also attempt to **expose production pharmacists to management functions** which could lead to the development of future management material. They, however, admit that **not all production pharmacists are interested** which could lead to production staff conflict.

FC2: “So then there is exploitation, okay. From our side it looks like to them that we are exploiting some of the staff and from other side it looks like we are letting other people get away with murder which is not the case because every person is different and you have to deal with staff each a different way. They need to understand that it is for their enrichment, not that we doing it because we want them to take over our responsibilities and our work, we know what our responsibilities are.”

Being a manager of professionals requires clinical experience, good inter-professional and people management skills. Clinical skills are often neglected after entering the management position (for lack of contact or time) and pharmacists are minimally trained in management sciences.

FC4: “...and you need to go and read, when they all talking about everything on the pharmacology side of it, ward pharmacist and everything, you think, okay, I need to catch up.”

FC3: “...you figured it out and then you’re expected to manage. I think the hardest part is managing the people.”

Production pharmacists are minimally trained in *management* sciences (at university level) and may therefore not be **appropriately qualified** (or interested) when considering a supervisory position.

Michelle: “...about how to manage people at the end of the day because that’s actually the hardest thing and I know that’s the challenge.”

FD3: “And that’s why I don’t want to be a supervisor.”

FD1: “You have to know how to speak to people.”

FD1: “Most of the times when he (supervisor) deals with the doctors, that’s when I am glad he is there and it’s not me, especially staying to the code list...”

Junior pharmacists may demonstrate the ability to perform well as pharmacists but lack management skills (which comes with some experience and applicable training).

FB1: “The problem is you’ve got some very nice supervisors, very nice people, they got their jobs... they were young, they got their jobs sometimes straight out of their comserv year because nobody wanted to work for the government; they were, like, the only permanent staff here. They’re very nice people, they’re very good pharmacists often, but they’re not management material, so we have a problem with them actually managing staff, managing...”

6.3.2.4 Theme: Envisioning promotion

Not all pharmacists will be promoted. Promotion is logically proportional to the number of senior posts available. At higher levels there are fewer posts available. Career growth needs will therefore not always be satisfied.

FA3: “I want to say something about progression possibilities in the public sector, actually in retail as well, because our job is so specialised. ...You can only move on from a production pharmacist 1 to 2 to 3 to supervisor or maybe join the head office but then you have to travel on the highway so I think our job doesn’t give lots of opportunities for, to progress.”

FC1: “That, actually, I think, is one of the disadvantages of working in the state, there isn’t really post above (us) and there is an assistant manager post, but usually one per facility...”

Another type of incentive system may need to be developed for pharmacists that prefer to remain at production level. Some pharmacists prefer the

clinical/production role and may not want to enter a management position. There is a concern about the reward potential beyond Production grade 3, notch 5. This may compromise OSD's ability to retain experienced employees.

FB1: "I think - I honestly don't think the salaries are bad. I really don't. I think the salaries are... the only problem again, I say, is the ceiling, you know? If you want to break that ceiling, you need to get out of traditional pharmacy."

New career path entry may be daunting. The clinical career path may be an exceptionally challenging position to embrace.

FB1: "It's a tough job. I discussed it with (confidential) and he said in a teaching hospital you almost need a clinical pharmacist per department because he said things change all the time and he said if you want to keep up with the gynie profs and the medical profs and the urology profs and the...he says they're at conferences, he said things change like almost daily and for one pharmacist to keep on top of all these policy changes, he says it's quite tough so he thinks you need more than one. It needs to be more than one."

Experienced pharmacists have underutilised skills but are cautious to apply for the supervisory role due to lack of a solid "support" structure.

FB7: "I would apply for supervisor post but not here and that I've made up my mind. I've been a team leader before and many times (unclear) but I wouldn't apply here and I also feel that..."

FB1: "Why? Out of interest, why?"

FB7: "Ok I was a team leader, it was a smaller group and like I said there was things in place, your protocols, your policies, communication, disciplinary, so you have a back up and there is accountability and here I don't feel that."

Higher management positions have challenges such as: job requirements of travel, greater responsibility, disruption of work-life balance, family responsibility and leaving the comfort zone of job familiarity.

FC4: "...she had a post and I think it entailed travelling, sleep over in George or whatever...I have a three year old... I'm like, okay, it was appealing before you told me I have to travel and sleep over, where's my child at that time but I do like her job but it's the frills that comes with it. I don't mind travelling, but maybe if it was five years ago or ten years ago I would go for it."

Michelle: "It comes with a lot of responsibility?"

FC3: "Extra responsibility, a lot of extra time and a lot of extra headaches."

FC4: "I think just the feeling of going through the training phase again, feeling stupid at times."



6.3.3 Division: OSD and pay

In this division, themes are expanded by focus group participants with the addition of three new sub-themes. According to Table 10, two new sub-themes arise with a focus on "pay equity and expectancy" and particularly in the area of "pay needs". These themes are related to perceptions of public sector employment whereas the others are linked to perceptions of career advancement.

Four of the five sub-themes that emerged in key-informant interview are touched upon at some point by focus group participants.

6.3.3.1 Theme: Pay versus responsibility

Pay and responsibility are not always matched. In this case, pay is not scaled according to your decision-making level. Pharmacists in **supervisory** positions have a **great burden of responsibility** (managing other professionals and being accountable for administration) and are therefore **not satisfied with being paid the same salary as production pharmacists.**

FA3: “My staff thinks it is easy to be a Pharmacy Supervisor in the DoH⁸. ...They are not aware of what is going on behind the scenes. Maybe they think we just walk around and make conversation; go to meetings for the eats. Some members of staff are simply not interested in growing and developing, the solid citizens, who are happy to come to work, do their allocated duties and go home. I often get very frustrated with their lack of interest in their workplace. Content with stagnating and picking up their salary cheques at the end of the month.”

Some production pharmacists perceive that supervisory pharmacists are not compensated according to their duties/responsibility. Higher level production pharmacists are unlikely to enter supervisory pharmacist positions since there is no increase of pay and would entail a lot more responsibility.

FD2: “...I think what she does as a supervisor pharmacist, she should get much more. It's not that I want the job but I think she should be compensated more for being a supervisor.”

FD3: “...I wanted to apply for the supervisor post but then I eventually, when I got to see the salary I was like, ‘I am not going to, sorry for the word, take this (rubbish) from other people all the time and that responsibility for what?’...”

Higher management devises other incentives to keep junior management satisfied. One of these incentives is to exclude supervisors from “on-call” duty. This means that they are not required to be on the emergency response list at the hospital for calls from doctors and nursing sisters.

FC2: “I think our head of department also tried to remedy that by giving us some incentives but the incentives are like not really...minimal.”

Michelle: “Was it money or what was it that they gave you?”

FC2: “It was the on-call list...”

⁸Department of Health

6.3.3.2 Theme: Pay equity and expectancy

Supervisors at different types of facilities(district hospitals and community health centers) with **different ranges of responsibilities**(job descriptions) **get paid the same salaries**. This may be perceived as being inequitable.

FA5: "...Also the experience of the RP at hospitals is very different, they do not have the same working environment, where the RP's at CHC level are working as both RP and still doing the work of production pharmacists (a dual role as there is generally not enough staff), the hospital RP only really performs functions of RP and as such has more time to adequately perform (their) duties. I feel that due to this we are inadequately remunerated, also most of RP's at CHC are taking work home as there is no time to do the work of two people during office hours."

Staff at Community Health Centers (CHCs) are uniquely overburdened.

Supervisory pharmacists agreed that CHCs that employed a single pharmacist were the most challenged. Administration is always completed after hours or at home.

FA5: "...Because in the case of FA2, FA7 and FA8, I don't know about anybody else, but there is more and more paperwork that we have got to do. I don't know when you guys are finding the time, in all honesty to do...I don't find it ...on a Monday and a Tuesday I don't even go walk into the office, I don't turn on the PC to check an e-mail – I am in front..."

Experience not recognised can lead to inequalities in pay between pharmacists in the same position. As a consequence, newly appointed pharmacists entering the public sector may be inappropriately graded.

FD3: "...obviously by now I am supposed to be actually very high grade 2 but according to, you know they go according to specific day to day whatever to grade me..."

Pay expectations may be related to the age of the pharmacist. Young pharmacists are not convinced that the package offered by the public sector to pharmacists is competitive enough (this may be related to age needs and perceived responsibility level).

FA1: “Exactly. The reason I am asking Michelle, okay, I’m this type of person who always likes to compare my salary with other professionals. You know, when I look at the Department of Justice packages and then look at Department of Health, I’m like, ‘geez’, why did I do pharmacy? ...You see I just say ‘my goodness, I should have gone and done law’.”

Older pharmacists may think the package offered is acceptable (due to age related needs and impending retirement).

FA4: “I’m happy with the salary because I am, ‘older’...”

Pay expectations may be related to the individual needs of the pharmacists.

In some cases OSD had fulfilled pay satisfaction needs.

FC3: “I mean, obviously more money would be nice but I am not uncomfortable with what I earn...”

FD2: “I am quite happy with my salary and like you said, I wouldn’t like to be a supervisor for a few rand more than we get now.”

Not all pharmacists are convinced that the package offered by the public sector to pharmacists is competitive enough. This is often the case when potential/new employees discover that the salary offered is a “package deal”.

FC2: “... the package does look very appealing, for private especially, but when they really break it down it’s actually not what they want.”

OSD allows for no negotiation or flexibility to satisfy individual pay needs.

FB7: “I think the salaries are competitive but it’s not negotiable, so I think it will be on an individual person’s situation.”

6.3.4 Division: OSD and attraction and retention

Two new sub-themes emerged in the focus group interviews namely, “Pay progression is a negative retention strategy” and “supervisors cannot negotiate due to popularity of the position”. Both are connected to retention of pharmacists.

In Table 11 it can be seen that three sub-themes were not discussed by focus group participants with regards to attraction, that is, “OSD is attracting more junior pharmacists due to management opportunities”, “more posts are available for employment” and “pharmacists are encouraged to apply for rural positions”. All sub-themes are related to perceptions of public sector employment.

6.3.4.1 Theme: OSD and attraction

OSD attracts professionals by offering a competitive (or market related) remuneration package.

FB1: “...so things have improved a lot. I think they’ve (private employers) had to, because they have had to follow the government. You know the government laid down the new sort of ground rules (concerning pay). Everybody else had to basically keep up.”

FD2: “I think because of the package as well. The package is actually very good.”

OSD is attracting a better calibre of professional. This is the result of a larger pool of pharmacists applying for positions in the public sector (due to the competitive offer) and thus allowing the government to be more selective on who they appoint to the position.

FD1: “No it’s not. It’s not like in the olden days, it used to be you don’t want to work in state but that’s changed...”

FD1: “I applied for 16 positions before I got mine.”

OSD ensures that entry level posts are attractive.

FB1: “I asked and it depends what you looking at. The private hospitals, if you’re a level 1/level 2 pharmacist, it’s pretty much on a par. Once you get to level 3 it starts to fall behind...”

6.3.4.2 Theme: OSD and retention

Many pharmacists make a choice to be employed in the public sector despite the remuneration offered. This sub-theme was discussed in all the focus group interviews. The following reasons were give namely, comfortable working hours, remuneration related benefits, stimulating work, an opportunity to “give back” to society, being in a “comfort zone”, employment security and inter-professional respect.

FB2: “I think also the hours. In retail...in private, your hours are horrendous.”

FA3: “The benefits, that’s a big thing.”

FB1: “You learn a lot more in the state. It’s a constant learning curve, while outside maybe not so much, especially retail.”

FD2: “It’s quite rewarding for me to help the community, the poor...”

FC3: “I think so - the comfort.”

FC2: “And it’s stable as well, even when times were tough, even... I remember, when was it so bad that companies, some companies were closing, they were only working opening three days a week...remember that time?”

FD2: “You work as a team.”

However, there are many possible influences to drive pharmacists to leave the public sector(**these work related factors may nullify retention strategies**). These negative influences include high work load, aging infrastructure, outdated technology and lack of support, poor internal communications, limited resources

(affected by thinly spread staff and stock-outs), and time spent commuting to work, lack of accountability (staff and management), language barriers (with patients) and administrative incompetence of support departments (i.e. human resource administration).

FB1: "I think it's also the out-patient pharmacy and the in-patient pharmacy have not changed one millimetre in their layout, in the way things operate and the way they layout their stocks in how many years..."

FB7: "What she says also leads to my next point of accountability. Whereas in private you have disciplinary action if you don't perform, if you don't produce while here, the disciplinary action for a person will take a year and it will fall off...there is no accountability..."

FB7: "I agree with FB2 about technology, we are so backwards in the sense that in a pharmacy changing environment, the policies coming through from provincial, we don't have a system, an I.T. system, computer system where everybody...we use our personal e-mails and we don't have a computer system or anything."

FB2: "I think just from a communication point of view, like, we haven't had Sorbitol, we're not going to have Sorbitol for I don't know how long but hasn't a notice gone to the doctors saying, 'Please stop writing Sorbitol'..."

FC2: "At the beginning, it was first when we got translated, we didn't actually realise how much stuff that they actually expected us to do. They expecting more and more every single time and just...it's like they add on and add on and add on constantly."

FD3: "...like our HR, that's one thing of government I just can't get. I've had so many struggles and we at the moment struggling with our beneficiaries, for our pension funds."

FD2: "What I find frustrating is also the language thing. It's quite frustrating if you hand out medicines and the person looks at you, you know that they don't understand..."

A long term retention strategy for experienced pharmacists seems to be neglected. The responsibility of the supervisory position is overwhelming and most experienced pharmacists may seek less responsible or higher paying positions when they reach the ceiling of their salary grades.

FB1: "I think - I honestly don't think the salaries are bad. I really don't. I think the salaries are... the only problem again, I say, is the ceiling, you know? If you want to break that ceiling, you need to get out of traditional pharmacy."

FC1: "I think initially we were very unhappy and we all sort of threatened that once we actually reached 13 years we will leave..."

FC2: "We will translate back to grade 3..."

FC1: "... back to grade 3 than have all that responsibility."

Pay progression is a negative retention strategy. OSD still seems to offer very small increments in pay.

FB2: "...and there doesn't seem to be any progress. You stay here 5 years, you go up a notch in salary. You stay 100 years you go up a little notch."

FC1: "...and share bonuses and things like that. We don't really have anything to look forward to... and the portion between the different notches it's basically actually nothing. I think you don't really see it..."

Supervisors feel they don't have the power to negotiate for other forms of reward due to the **popularity of the position** and fear of being easily replaced by junior pharmacists who are seeking a quick pay increase.

FC1: "...but it's so easy nowadays to get someone in a supervisor post so it's not like they will take our threats seriously. They will let you go because someone else with now 3 years of experience can come in as a supervisor."

6.3.5 Division: OSD and current negotiations

Only two sub-themes were covered in focus group discussions under the theme “over-time and after-hours remuneration”. As previously mentioned, this can be expected since very few production and supervisor level pharmacists were involved in translation of posts or labour negotiations. As can also be seen in Table 12, the over-time rate may influence perceptions of career advancement whereas flexi-time policy may affect the perception of public sector employment.

6.3.5.1 Theme: Over-time and after-hours remuneration

Over-time or after-hours remuneration for pharmacists in the public sector is poor. The rate is not influenced by the pharmacist’s experience or post level. Most pharmacists on higher levels find the pay rate unacceptable and are unwilling to work extra hours. Many managers have to bend human resource rules in order to compensate. Some managers allow their employees time-off instead of claiming over-time.

FA2: “Ja, and coming back to the over-time, I did my sums...And it works out after taxes and all that, R89 an hour, if you lucky.”

FA3: “It’s an insult”

FA2: “...The government policy, as she says, you cannot take time off, you have to claim for over-time. That’s the government policy. ...It’s an internal arrangement we have, is we take the time off.”

FC3: “If you’re going to pay me my normal salary over-time, I will be much less reluctant to do it, let’s put it that way...”

The flexi-time employment option may only be suitable for certain facilities (district hospitals) but is not a solution for CHCs and implementation may introduce other problems.

FA1: “And the flexi-time, with my facility, it doesn’t work ... let’s say the flexi-time people must leave at 3, I’m just making an example, that’s when the patients are there all over the waiting room and that’s when the people

who are left behind (finish) the work. If one person is not there, it's a train smash."

FC2: "One of the other concerns is that... the later we stay open, the later we get patients because there is no pressure from the clinics and the doctors, you know..."

6.4 SUMMARY OF FINDINGS

In summary, four major themes arose concerning career pathing. Associated sub-themes in this division were connected to the perceptions of career advancement. The most prominent theme focused on the consequences of overlapping of pay grades being the discouragement of progression between these career paths (production and supervisor pharmacists). There also appeared to be a lack of consensus as to what type of experience would be suitable for management positions.

Two major themes arose in the division of pay, with the major focus on the discrepancy between pay and level of responsibility. Focus group participants raised extra information concerning pay needs of individuals with an emphasis on the age of the professional. Sub-themes linked to pay are chiefly associated with the perception of career advancement.

In the division related to the influence that OSD plays in attraction and retention of employees, sub-themes are related to the perception of public sector employment. While the main consensus is that OSD has done well to attract new employees, long-term employee retention is in question. This will be discussed in more detail to follow.

With current negotiations, key-informants and focus group participant are disgruntled with the rate of over-time pay. The other two themes touch on discrepancies in the interpretation of OSD between provinces and translated posts and the use of unions to negotiate policy. Over-time pay can be connected to both perceptions of public sector employment and career advancement.


In Table 14, the contribution of the four divisions of major themes to positive and negative perceptions has been summarised. This conclusion aims to amalgamate both human resource and career perspectives.

Positive and negative perceptions of public sector employment (PSE) and career advancement (CA) in relation to theme divisions				
Theme divisions	Perceptions of public sector employment (PSE)		Perceptions of career advancement (CA)	
	+ve	-ve	+ve	-ve
Career pathing			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Pay	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Attraction and retention	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Current negotiations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

Table 14: The contribution of the four theme divisions to positive and negative perceptions of public sector employment (PSE) and career advancement (CA)



In Table 15 that follows, the sub-themes of key-informants and focus group participants are summarised as arguments and counter-arguments and in some cases possible argument reconciliations.

Final summary of perceptions connected to each theme as arguments, counter-arguments and argument reconciliations.		
ARGUMENTS	COUNTER-ARGUMENTS	POSSIBLE RECONCILIATIONS
THEME: Overlapping of salary grades		
Does not encourage experienced pharmacists to progress. May encourage inexperienced pharmacists to seek promotion	Permits individual freedom of career path choice	
THEME: Variety of positions		
Created a greater variety of positions	Lack of public funding for posts Career paths are not transparent enough	
THEME: Being a manager of professionals		
Structure does not encourage supervisors to first gain experience as a production pharmacist	Experience as a production pharmacist does not necessarily equate to good management material 	Production pharmacists cannot demonstrate competency for the management role without exposure to management task Being a manager of professionals requires the full package which is not provided by university training alone
THEME: Envisioning promotion		
Not all pharmacists will be promoted	Another type of incentive system may need to be developed for senior pharmacists New career path entry may be daunting	
THEME: Pay versus responsibility		
Senior production pharmacists not attracted to supervisory positions Pay and responsibility are not matched	Responsibility is recognised via an improved post structure which is linked to improved pay	Higher management devises other incentives to keep junior management satisfied
THEME: Pay equity and expectancy		
Same salaries for supervisors at with different responsibilities (perceived inequity) Previous experienced not recognised leads to unequal pay between pharmacists in the same position Pay is linked to age Pay is linked to individual needs (is pay flexible?)		

Final summary of perceptions connected to each theme as arguments, counter-arguments and argument reconciliations, continued.		
ARGUMENTS	COUNTER-ARGUMENTS	POSSIBLE RECONCILIATIONS
THEME: OSD and attraction		
OSD is perceived to have accomplished: Market-related package Attraction of a better calibre of professional Attraction of junior pharmacists into management Attraction to entry level posts More positions are offered Rural positions are attractive		
THEME: OSD and retention		
Retention strategy for senior pharmacists neglected Work related factors may nullify retention strategies Pay progression perceived as negative strategy Supervisors may not feel empowered to negotiate pay or “perks”	Public sector may be choice despite remuneration offered	
THEME: Over-time and after-hours remuneration		
The over-time rate is poor regardless of position and experience	A flexi-time policy may improve pay satisfaction but is not universal. Staffing models will need to be amended in order not to compromise existing employment	A flexi-time/extended hour’s policy may be an option to solve some of the problems.
THEME: Interpreting OSD		
Inter-provincial discrepancies There are still unresolved disagreements concerning translated posts		
THEME: Using unions to negotiate policy for professionals		
Professionals are not comfortable with negotiation via a third party		

Table 15: Summary of findings presenting sub-theme/perceptions as arguments

6.5 CONCLUSION

It was found that four divisions of themes arose during interviews with key-informant, namely, themes related to career pathing, pay, attraction and retention and current negotiations. Major theme saturation occurred at the point of the second key-informant interview to amount to a total of eleven major themes.

Occasionally key-informants have disagreed on sub-themes which are presented as counter-arguments in the findings. Focus group participants touched on sub-themes that were within their scope of exposure. Focus group participants were either in agreement with sub-themes or counter arguments or expanded the existing sub-themes by adding additional information. This gave rise to agreement or conflict in perspectives which will be discussed in Chapter 6.



CHAPTER 7

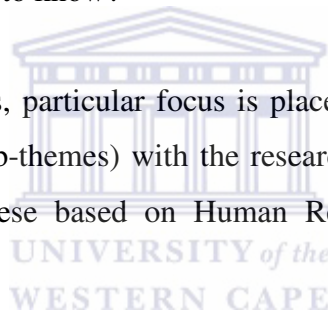
DISCUSSION

7.1 INTRODUCTION

The emergent eleven (11) major themes are discussed in four sections; themes related to career pathing (4 themes), pay (2 themes), attraction and retention (2 themes) and current negotiations (3 themes). These sections follow from 7.2 to 7.5. With each emergent major theme and sub-theme, Srivastava's (2009) three question framework was applied. The questions are restated below:

1. What is the data telling me?
2. What is it I want to know?
3. What is the dialectical relationship between what the data is telling me and what I want to know?

In discussing the themes, particular focus is placed on question 3 by comparing the data (themes and sub-themes) with the research questions and validating the connections between these based on Human Resource and Work Motivation Theory (Figure 18).



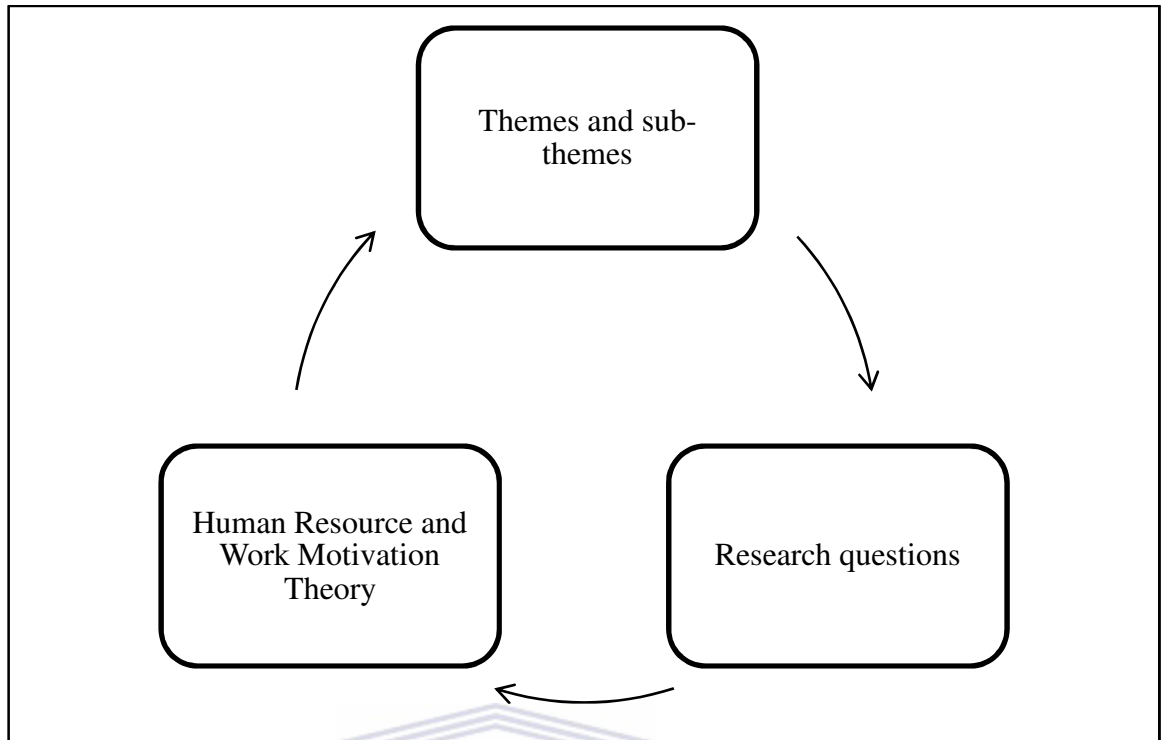


Figure 18: the reflexive model based on Srivastava's third reflexive question

Both human resource and career perspective are discussed under each theme using “thick” descriptions. (Merriam, 2009) Given the quantity of results and the style, I have chosen to include maps for each section to sign-post the course of discussion.

7.2 SECTION 1: THEMES RELATED TO CAREER PATHING

In Figure 19, a section map illustrates themes discussed relating to career pathing (sub-section 7.2.1, 7.2.3, 7.2.5 and 7.2.7). After each theme, a short reflexive conclusion has been included (sub-section 7.2.2, 7.2.4, 7.2.6 and 7.2.8).

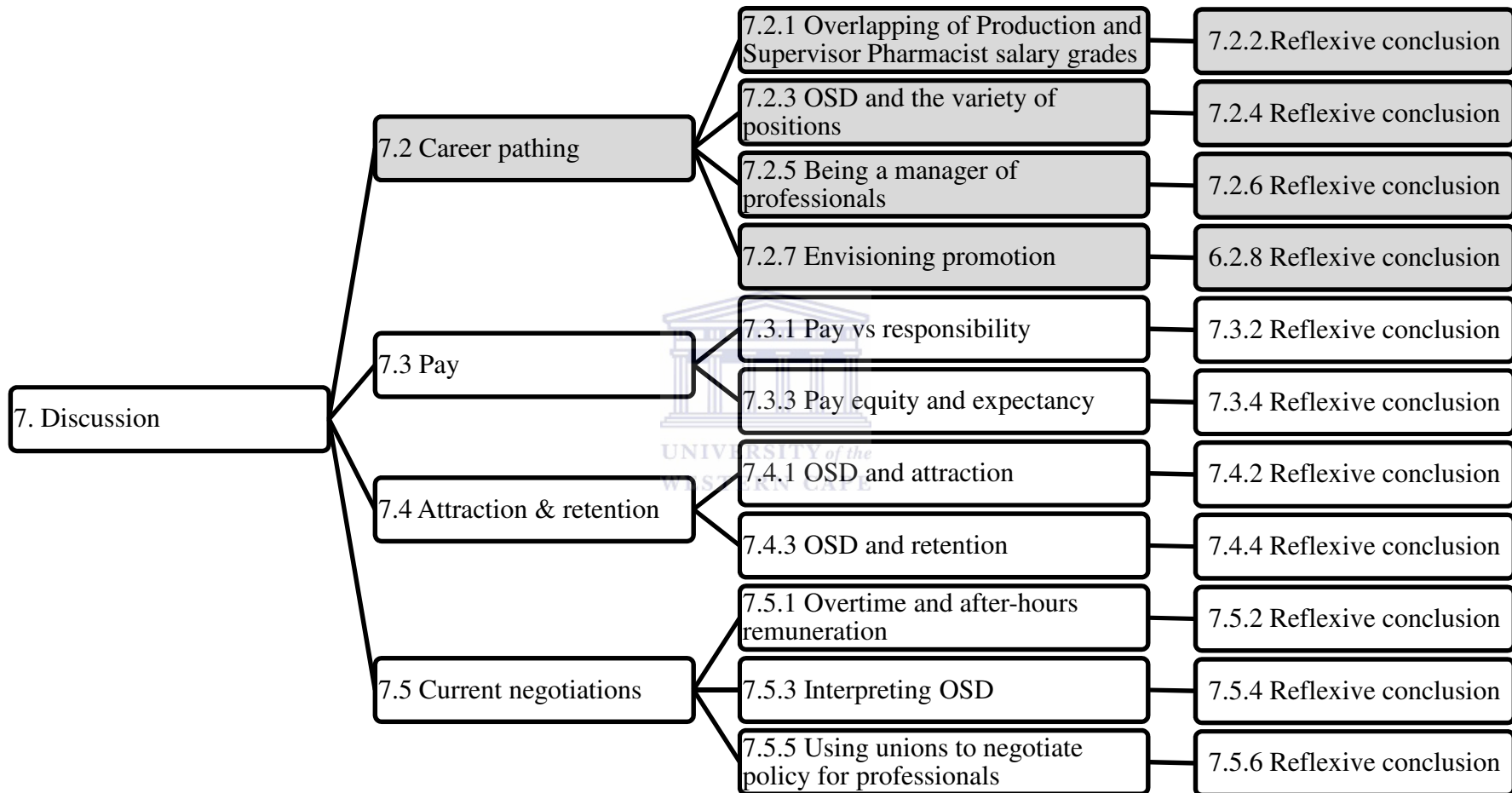


Figure 19: Section map of themes related to career pathing (shaded in grey)

7.2.1 Theme: Overlapping of Production and Supervisor Pharmacist salary grades

From the human resource perspective, pharmacists with experience may lose career commitment due to lack of career mobility or advancement (Lesabe & Nkosi, 2007). According to Maslow's Hierarchy of Needs (Maslow, 1943), the pre-potent need for economic security will outweigh the need for self-actualization and self-esteem. According to Maslow's ideas, a senior production pharmacist with 13 years experience may be reluctant to seek career growth, if the salary is not sufficient or competitive with other sectors. This is also in agreement with Adams' Equity Theory (Campbell & Pritchard, 1983) where a senior experienced pharmacist may perceive his/her "input" inequitable to taking a position with more responsibility for thrifty "outcomes" afforded by pay grade overlapping. Junior pharmacists are, however, still at that point in their career where the increase in pay for a promotion will be substantial and therefore in terms of the Equity Theory, a junior pharmacist may see the "inputs" of three years experience equitable to the "outcomes" of a leap forward in remuneration.

Herzberg's Two-Factor Theory (Herzberg, 2003) may partially support the counter-argument. The dual career path ensures that the "intrinsic" factors or "motivators" that lead to career satisfaction and motivation are at least offered. Junior pharmacists that change career path will have both "hygiene" and "motivator" needs fulfilled. Experienced pharmacists will, however, be dissatisfied with regards to "hygiene" needs but will have their "motivator" needs satisfied. A senior pharmacist may still be motivated to move into a supervisory position, although the chances are far less according to Maslow and Adams.

Pharmacists in production and supervisory roles agree with both the above presented arguments, that is that grade 2 and grade 3 level pharmacists are not keen to enter supervisory positions because of the lack of improved remuneration but some pharmacists will seek that promotion despite remuneration for other reasons like job satisfaction. Production level 3 pharmacists may even be termed

“complacent” because they see no problem with earning the same as supervisory pharmacists (for obvious reasons). In fact, supervisory pharmacists perceive they have been cheated. This type of reaction and perception is in line with Adams’ Equity Theory that the comparative “other” (production pharmacist) is perceived as having a better “income/outputs” ratio.

7.2.2 Reflexive conclusion: Overlapping of Production and Supervisor

Pharmacist salary grades

Senior production pharmacists may perceive that OSD does not offer sufficient career mobility. This may negatively affect organisational commitment and lead to a loss of valuable skills for the public sector. There needs to be a clear incentive as recognition of pharmacists in positions of responsibility in order to attract experienced pharmacists into those positions if they desire to choose a different career path.

Supervisors that become aware of the problem of overlapping pay grades may alter their behaviour. Ramlall (2004) explains behavior predictions to bring about perceived balance in the inequality such as increasing ones “inputs” or increasing the “inputs” of the comparative “other” (Champagne & McAfee, 1989). If either of these is not possible, the pharmacist may simply seek other employment opportunities and abandon the position.

The question of why the career paths cannot simply be offered without overlapping to avoid such complications needs to be considered.

7.2.3 Theme: OSD and the variety of positions

The opportunity to grow and advance in one’s career can be linked to organisational commitment and retention (Lesabe & Nkosi, 2007). The opportunity must be provided in the organisation to afford interested parties that growth. OSD has provided a greater variety of career streams with the introduction of management, clinical and policy specialist career paths (DPSA, 2010c). The consequence of more career paths is a broader post structure that

provides more employment posts. From the human resource perspective, more opportunity for career growth needs have been afforded by OSD. However, in the counter-argument, in the clinical career path no posts have been created and many posts in the production and supervisory career path are not funded or remain “frozen” due to public sector financial constraints.

It appears that professionals need stimulation. With a defined professional scope of practice, pharmacists often experience job monotony. Self-actualization (Maslow, 1943) is at the pinnacle of needs according to Maslow’s Hierarchy of Needs. As professionals, many of the lower (pre-potent) needs are satisfied easily by the type of work pharmacists do and the improved remuneration (with benefits) that OSD offers. The next step would therefore be self-fulfillment by accepting more challenging work. Champagne and McAfee (1989) suggest providing challenging work and encouraging creativity as a form of fulfilling the self-actualisation needs.

From the career perspective of production and supervisory pharmacists, they show interest in career path change or “climbing the ladder” as foundational literature suggests. The problem is that there is much confusion about how to embark on a new career path, what those positions entail, what experience is required and where those positions are situated. Many production pharmacists have very little knowledge of the functions of a clinical pharmacist. Often they confuse a ward pharmacist with a clinical pharmacist.

Pharmacists are also not aware that specialists can no longer work in general fields and require an extra clinical degree. I admit that I myself had a very vague idea of what a clinical pharmacist was before committing to research in this area.

At this point there is no specialist registration for clinical pharmacists with the South African Pharmacy Council (SAPC) since it is still in the development stages. Posts cannot therefore be created in the government until the SAPC and universities agree to what this specialist scope will entail (Gray & Suleman,

2012). The clinical career path is therefore redundant at this point in time with a possible resurrection in the future.

Another point made from the human resource perspective is that the role of pharmacists is being redesigned, it's changing. This is due to the advent of Pharmacist Technicians, dispensing Clinical Nurse Practitioners (CNP) and Professional Nurses (PN) and the need to spread funds by utilising the appropriate staff categories. The tasks of the pharmacist will shift to management or supervision and education of assistant staff. Ward-based pharmacy, which is linked to clinical pharmacy, is already becoming popular in larger facilities to ensure better financial control of medicines.

There seems to be some conflict here in that OSD has broadened the post structure with more posts being provided, but the public sector in the Western Cape requires fewer pharmacists due to the introduction of technicians and dispensing nurses. The outcome may be one of two things: either medicines will reach more members of the public via more posts being created and funded on all levels, or pharmacists will be spread too thinly.

In a manner, internally re-designing the job of pharmacists may be an answer to the fulfillment of Maslow's Theory of Self-Actualisation.

7.2.4 Reflexive conclusion: OSD and the variety of positions

Some opportunity for career growth has been created in the variety of career paths that OSD offers. Unfortunately, limitations of funding and defining clinical specialists have not been realised yet. Re-designing the job of pharmacists may satisfy some individual's career growth needs, but it is not comprehensive.

A suggestion would be to provide clear and easily available information on career paths, available posts, training and development, experience requirements and governments' progress with the creation of clinical posts to pharmacists employed in both the public and private sectors. This can be done by conducting workshops

or launching a dedicated website for professionals. This will satisfy both the employee needs to plan and achieve career growth and advancement and employer needs by providing access to a larger pool of professionals to choose from.

7.2.5 Theme: Being a manager of professionals

In Annexure A2 of resolution 1 of 2010 (DPSA, 2010b), the number of years of appropriate experience required to enter a supervisory pharmacist position has been reduced from the initial agreement of five years to three years. This amendment ensures that the rate of applications for management positions is improved. The statement “appropriate experience” also ensures that senior pharmacists employed in the public sector for extended periods cannot simply expect promotion into management positions by default. Pharmacists qualified for a shorter period after qualification also now have the opportunity to move into the management career path if that is their desirable direction of career growth.

As a general human resource perception, the reduction in years experience required is a good thing. It encourages the application of appropriately skilled candidates and the possible introduction of a younger generation of managers with fresh ideas. However, some pharmacists have pointed out that some junior pharmacists that were appointed into supervisory positions were not competent as managers even though they may have been very good pharmacists. Others were employed into supervisory positions directly after completing their community service.

According to Adams’ Equity Theory (Campbell & Pritchard, 1983), pharmacists are going to compare the ratio of their “inputs” and “outcomes” of their work with other individuals and if they recognise inequalities, there may be feelings of “unfairness” and possible behaviour changes. Ramlall suggests that the organisation must make an effort to ensure equitable rewards (Ramlall, 2004). Senior experienced production pharmacists frown upon what they see as inexperienced supervisors/managers which may promulgate possible disrespect

between production staff and management. Supervisors also compare themselves to other supervisors.

Some young supervisory pharmacists confirm that they did not have the maturity or experience to enter management but they were willing to give it a try and so appeared to have been employed based on attitude and lack of applicants for the position.

In the counter argument of the human resource perspective, pharmacists must have a long-term production background with extended exposure to clinical cases in the pharmacy.

To endorse the counter argument, production and supervisor pharmacists believe you need the full package in order to manage other professionals. Managers or supervisors need to have good clinical experience, communication experience and management experience (which is not always afforded at university level). It is evident that junior pharmacists are keen to be managers for many reasons (such as job satisfaction and financial gain). How will a higher calibre of supervisory pharmacist be ensured so that all parties are satisfied?

Herzberg suggests “vertical loading” (Gruneberg, 1979). “Horizontal loading” means giving more (or different tasks) of the same difficulty to employees. This can be also phrased as “job-rotation”. In “vertical loading”, you give employees some tasks that are not usually at the regular level of difficulty they expect. This is also a means of “job enrichment”(Herzberg, 2003). It psychologically challenges employees to grow and is used to motivate and establish employee commitment.

7.2.6 Reflexive conclusion: Being a manager of professionals

In Table 9 (Section 6.2.2), three sub-themes are shown that are of great concern and are the keys to solving some of the issues of being a manager of professionals:

- Production pharmacists are not exposed to management tasks
- Production pharmacists are not interested in exposure to management tasks
- Supervisors are not exposed to higher management tasks.

The human resource perspective of both perceptions that junior managers bring fresh blood but extended experience is vital, must be jointly considered. Employing pharmacists who have just completed their community service as supervisors is risky. As a solution, a programme to ensure regular exposure to management tasks on all levels may solve a number of inequitable perceptions. Long standing production pharmacists may gain respect for junior supervisory pharmacists. Junior pharmacists would gain competencies and Human Resource Departments would have a pool of internal candidates to choose from.

One key-informant has suggested a mentorship programme which seems to confirm Herzberg's idea of "vertical loading" (Ramlall, 2004).

7.2.7 Theme: Envisioning promotion

The idea of "how" promotion can be envisaged is presented in this theme. The answer will give insight into perceptions of career advancement.

From the human resource perspective, the idea that not everyone will be promoted is offered as a reasonable fact. This may be for many reasons but the most logical reason is that fewer managers are always needed in relation to "workers". If career mobility cannot be satisfied, how does the public sector ensure retention? Production and supervisory pharmacists are aware that their chances of promotion are limited.

In reflection, the need for self-actualisation (Maslow, 1943) may not be fulfilled in the form of a new challenging position. Some pharmacists may be seeking promotion to fulfill other levels of Maslow's Hierarchy such as the need for security in the form of higher pay or the need for esteem in the form of a job title or supervising others. Lack of promotion, if not recognised and remedied through other avenues, may lead to resignation.

Some pharmacists prefer to be in the production role (which we have seen may also be problematic under the theme of overlapping of pay grades). In both cases, long-term employment as a production pharmacist must be recognised somehow. Grade 3 pharmacists will hit a remuneration "ceiling" between 12 and 18 years after qualification, depending on performance. Another means of reward may need to be considered in order to retain more experienced pharmacists that do not desire or will not attain promotion.

This can be achieved by offering a long-term financial reward strategy. This may already be offered via SPMS (Staff Performance Management Systems) but cannot be commented on in this discussion since it was not included in the exploration of this study. The other solution may be to improve non-promotion "motivators". Herzberg (Campbell & Pritchard, 1983) lists them as achievement, recognition, responsibility, growth and the work itself. SPMS relies on an agreement between management and employee that the employee will endeavour to achieve a number of annual goals in some of these areas and can therefore also be offered as a possible solution to this problem. In that case, the success of SPMS will need to be investigated.

An extra sub-theme is raised from the career perspective that "new career path entry may be daunting". This may be another reason why production and supervisory pharmacists do not prefer promotion. It seems that some pharmacists would like to consider promotion but are apprehensive to proceed.

There are many reasons why pharmacists are apprehensive to apply for promotion even though they have the skills. The most prominent is fear of an excessively challenging position, too much competition with home-life and a lack of support from management after entering the position. According to Victor Vroom's Expectancy Theory (Lawler III & Suttle, 1973), an employee may believe that they will make a great effort in a new position but if the perceived outcome is going to be failure due to lack of support or possible burn-out, the perceived reward has no value and they will not be motivated to enter that position.

7.2.8 Reflexive conclusion: Envisioning promotion

As a solution to retaining long-term production pharmacists (beyond the 12 to 18 year notch and grade climbing), another strategy in the form of financial reward and developing job "motivators" must be addressed. If the idea is to achieve this via SPMS, the successful use of this reward strategy must be explored to ascertain its retention ability.

Apprehension of promotion can be dissolved by changing the expectancy of the interested party. Once again this can be achieved by exposing production and supervisory pharmacists to management tasks. There are however other career paths that are not always in reach of exposure. Management is often in direct contact and communication with employees but those in more specialised roles often don't have direct contact with production and supervisory pharmacists. A solution may be to devise a plan whereby facility staff takes turns to work on projects in other areas i.e. clinical, policy or management. Does the public sector have resources to develop such plans? The most problematic is that facilities often don't have enough staff to lose a pair of hands. On the other hand, potential employees for other roles may be lost to other sectors if not discovered internally.

7.3 SECTION 2: THEMES RELATED TO PAY

In Figure 20, a section map illustrates themes discussed relating to pay (sub-section 7.3.1 and 7.3.3). After each theme, a short reflexive conclusion has been included (sub-section 7.3.2 and 7.3.4).

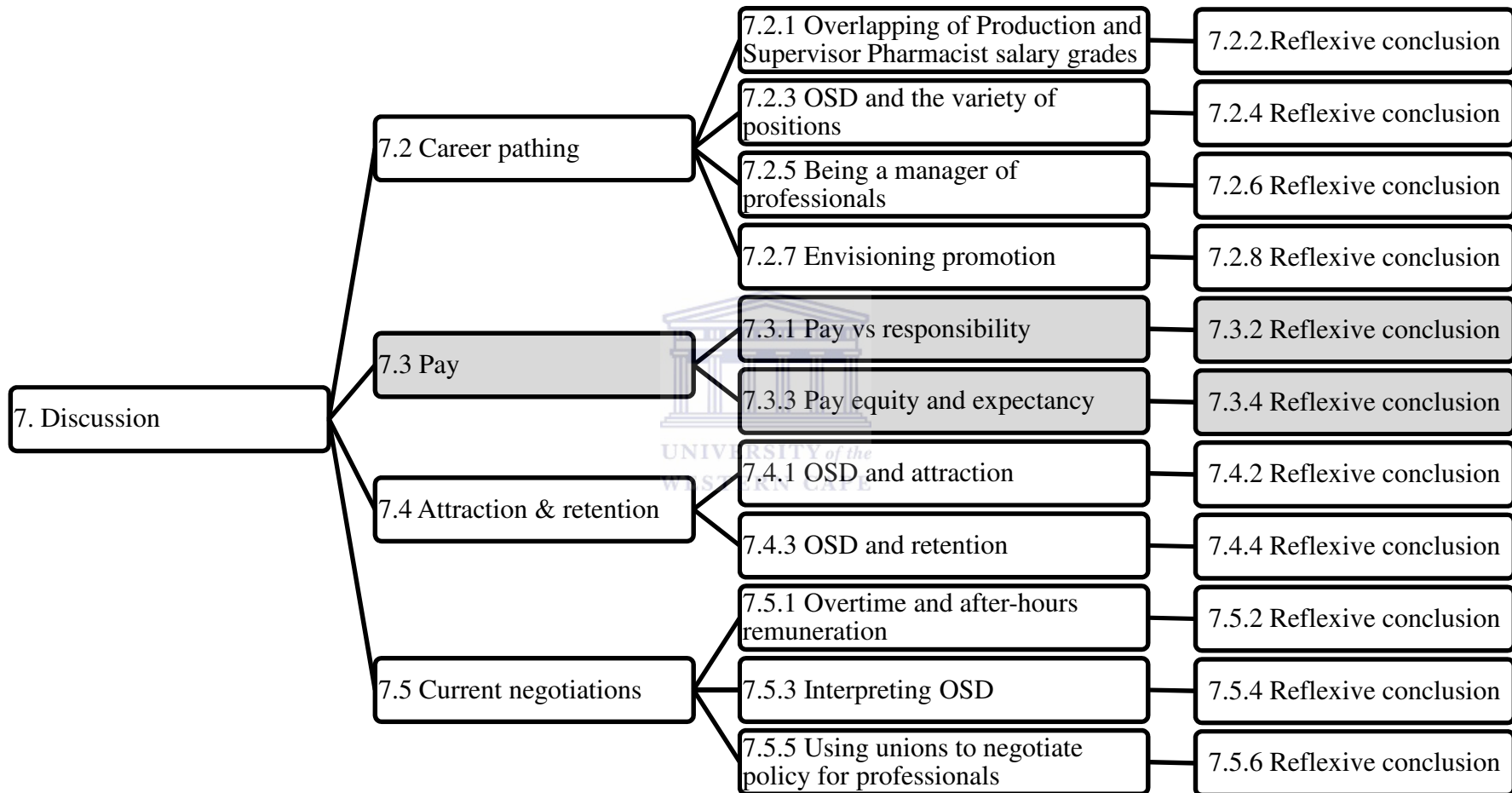


Figure 20: Section map of themes related to pay (shaded in grey)

7.3.1 Theme: Pay versus responsibility

From the Human Resource perspective, key-informants are of the opinion that those in positions of responsibility must be recognised. Although theoretically, there are many ways to recognise responsibility, first and foremost recognition should be in the form of remuneration. This becomes a problem with pay grade overlapping of production and supervisor pharmacists. This sub-theme is directly linked to the arguments that occur in Section 1's sub-theme of "overlapping and career pathing", but places emphasis on responsibility and its connection to recognition.

Supervisors and production pharmacists confirm the opinion of key-informants by admitting that they either feel frustrated by not being recognised (as is the case with supervisors) or that they prefer not to seek promotion (as is the case with production pharmacists).

In the counter argument, entering a new career path, in this case supervisory, ensures greater earning potential. Once beyond Grade 1, Grade 2 supervisors will earn more than production pharmacists. Why are pharmacists not appeased by this fact? One answer could be that it's a matter of the requirements to achieve notch or grade progression. It may take between 3 and 7 years (or more) to achieve grade progression based on performance evaluation and type of post appointment. A three year wait may seem reasonable but relies on 3 years of cumulative above average performance assessments, which is unlikely. This does not account for a possible probationary period or notch qualification stipulated in the incentive policy framework (DPSA, 2012). Pharmacists may be frustrated by carrying extra responsibility for many years while being remunerated less or on par with production counterparts.

Once again this is confirmed by Adams' Equity Theory of comparing ones ratio of "inputs" and "outcomes" to the "comparative other" (Campbell & Pritchard, 1983). According to Ramlall (2004), the employee will take appropriate action to bring back balance. Management being aware of the problem tries to compensate

by devising other reward plans. In one case, supervisors were granted exclusion from being placed on overnight or weekend call duty.

7.3.2 Reflexive conclusion: Pay versus responsibility

Patterson's idea of grading employees according to their level of decision-making is the most appropriate structure to apply to professional careers. Unfortunately, determining pay grades is based on setting an acceptable (market influenced) pay range which overlaps with other pay grades' ranges (Bussin, 2010) and does not consider the individual or the variation that may occur in each band. In theory, remuneration should match responsibility.

If overlapping pay grades cannot be altered, responsibility (and decision-making) will need to be recognised by introducing rewards of a non-financial nature. If there are non-financial "perks" to being a supervisor, career progression may be more attractive for those that are interested and this will affect organisational commitment and retention of pharmacists. As previously stated (in the literature review), OSD's focus is primarily financial and in the opinion of employees, fails in some financial areas. Re-evaluation of certain career paths (i.e. supervisory) and in addition, development of non-financial benefits, may need to be considered.

7.3.3 Theme: Pay equity and expectancy

"Pay equity and expectancy" is connected to the theme "pay versus responsibility" in that it addresses the variability between posts within the same career path (also called streams or bands). Key-informants and pharmacists point out that supervisors in different facilities all perceive their work differently. While all find their work challenging with regard to the level of accountability and responsibility, supervisors employed in community health centers (CHCs) are exceptionally burdened due to patient overload, the extent of supervision and in some cases, being a single pharmacist per site.

The responsibility of a supervisory pharmacist seems to be inequitable between sites and yet the remuneration remains the same for all pharmacists employed in this career path. If the career path structure is set, how will the employee rectify the perceived inequality that Adams' predicts (Campbell & Pritchard, 1983)? Pharmacists in a supervisory role may be satisfied with their level of pay, but if the reward is tainted by the excessive stress of working in a CHC, the employee may place very little value on their salary. The consequence may be eventual loss of pharmacists or avoiding appointment to posts in CHCs. Career advancement and retention are thus negatively affected.

Since grading a pharmacist appropriately relies on producing proof of experience in term of the number of years of employment post-qualification, years experience in the public sector and proof of experiential competencies, many pharmacists are graded incorrectly. Those most affected are 5/8ths, 6/8ths pharmacists and those employed in the public sector for the very first time. Those employed for fewer hours per day are only granted grade progression on accumulation of hours as opposed to the type of tasks undertaken and the volume of work covered in those hours. Incorrect recognition of experience can also lead to perceived inequality and consequential loss of staff.

The age of the pharmacists may determine work needs. Age-related needs fulfillment will determine whether the public sector will be perceived as the employer of choice. It seems that some young pharmacists do not deem the entry level salary adequate to fulfill their needs. Young pharmacists may have greater financial needs to establish family foundation or enter the property market. This is confirmed by Maslow's idea that employees are motivated to achieve "safety needs" in life and work before higher levels of Maslow's Hierarchy of Needs are considered (Maslow, 1943). This could also be another reason why younger pharmacists are applying for supervisory positions. Policy informants must thus ensure that the opportunity to earn more is afforded by OSD's structure. OSD has already provided opportunity by reducing the number of years experience required to be eligible to apply for such positions.

Pharmacists that are mature, in terms of age, may no longer have “safety needs” and may therefore not feel it is necessary to earn larger salaries. This is a general assumption and the retirement needs of a mature pharmacist may also propel them to seek positions of larger income. The sub-theme “pay needs may be related to the individual needs of the pharmacist” is a more likely explanation for earning level choice. This sub-theme questions earning potential and flexibility. Does the structure of OSD allow salary flexibility and afford opportunities to earn more when needed?

According to circular 4 of 2009 (DPSA, 2009), OSD provides flexibility through built-in benefits and earning potential based on performance evaluations. Production and supervisory pharmacists disagree. They perceive the offered package to be misleading and the performance bonuses (via notch acceleration) as poor and sometimes inaccessible.

When earning flexibility is desired, many professionals will work extra hours as a locum in the private sector. This is not encouraged by the RWOPS (Remunerated Work Outside of the Public Sector) policy which encourages sole organisational focus by preventing employee fatigue. It is therefore important to offer an internal substitute to ensure flexibility

If the “acceptable performance” is not going to lead to a “desired reward” or if the “value of the reward” is perceived as low, the employee is not going to feel very motivated to perform (Lawler III & Suttle, 1973).

7.3.4 Reflexive conclusion: Pay equity and expectancy

Two very good suggestions were made by supervisory pharmacists to solve the challenges faced by community health centre (CHC) pharmacists:

1. Single-pharmacist CHCs require a special pharmacy staffing model
2. Supervisors at single-pharmacist CHCs require a special allowance based on patient load

Policy specialists admit that re-engineering of the health system to make health care accessible has created the problem of high patient volumes in CHCs. Policy specialists are currently working on updated staffing models for CHCs.

For grading purposes, the best solution is to educate pharmacists on what is required to enter pharmacist positions in the public sector. As mentioned before, this can be achieved through a website, pamphlets available from human resource offices or workshops. Improving accessibility to information also creates a trust impression for potential employees and can enhance the image of the organisation.

If a performance management system is not viewed as a successful reward strategy and salary packages do not offer more or innovative flexibility, the organisation may not be perceived as the employer of choice. Employees very often research employment offers made in the job market. Pharmacists may not be attracted to employment in the public sector if they discover that the flexibility to earn more when needed is stifled by structure or budget constraints.

7.4 SECTION 3: THEMES RELATED TO ATTRACTION AND RETENTION

In Figure 21, a section map illustrates themes discussed relating to attraction and retention (sub-section 7.4.1 and 7.4.3). After each theme, a short reflexive conclusion has been included (sub-section 7.4.2 and 7.4.4).

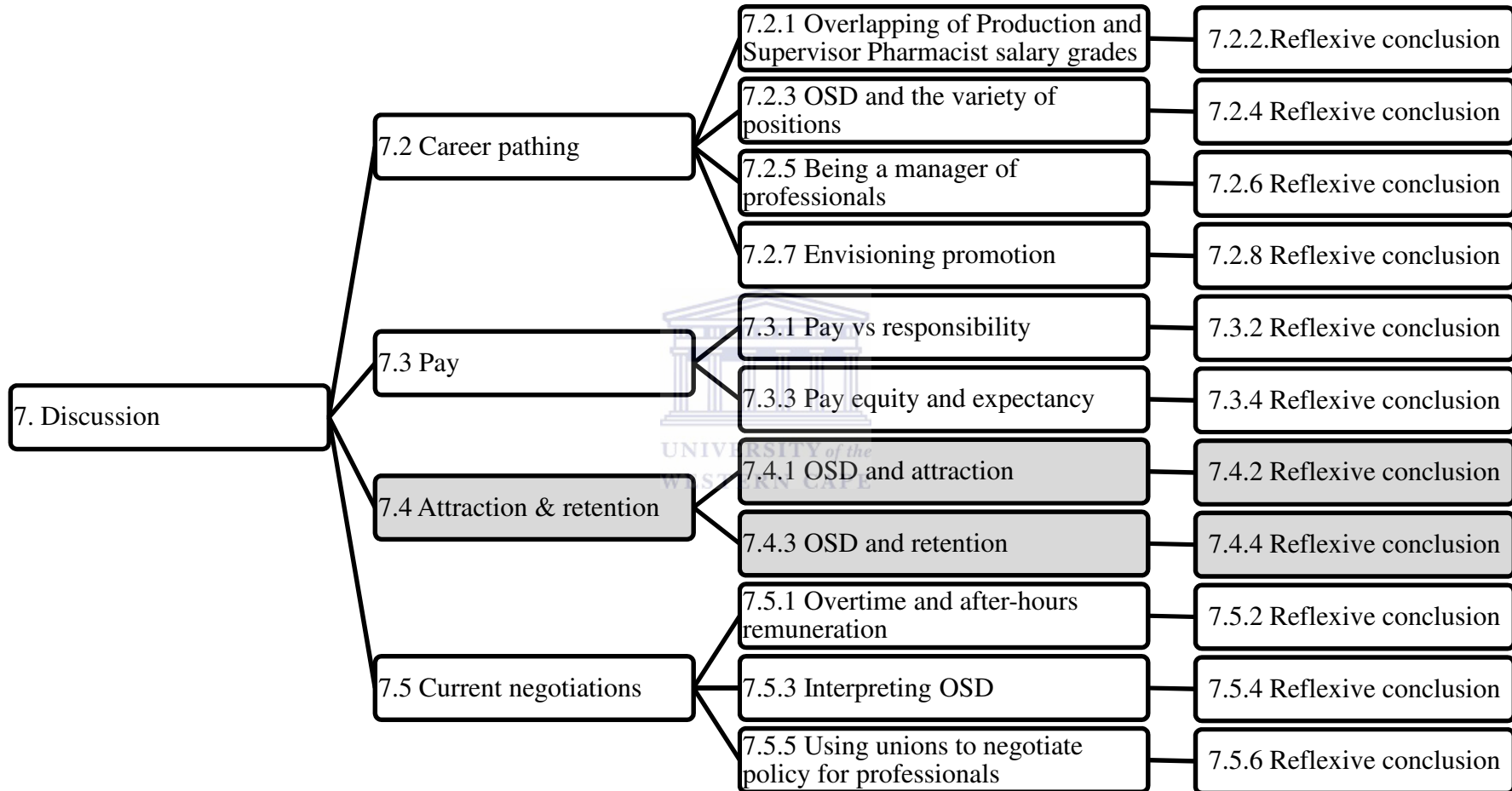


Figure 21: Section map of themes related to attraction and retention (shaded in grey)

7.4.1 Theme: OSD and attraction

Occupational Specific Dispensation (OSD) has most certainly addressed one level on Maslow's Hierarchy of Needs (Maslow, 1943). In terms "safety" (or economic security), by providing a competitive income, at entry level, which includes a number of benefits that are also all related to safety (i.e. medical aid, pension fund and fringe benefits), OSD has motivated pharmacists to apply for entry level posts. This is in line with current human resource literature that suggests "pay" as the key instrument of enticing new employees (Coetzee, 2010). OSD has also certainly enticed pharmacists to take employment in positions that were not previously attractive due to their geographical position. More pharmacists are willing to work and live in rural areas now, due to competitive salaries.

It has also motivated junior pharmacists to apply for management positions. This may be linked to Adams' Equity Theory. OSD for pharmacists now includes the phrase "appropriate experience" within their appointment requirements. This means that OSD now allows appointment of pharmacists based more on their skills, competency, education and training rather than just the number of years that they have been employed as a production pharmacist. If the junior pharmacist perceives that his or her "inputs" are fairly correlated to the "outcomes" (the remuneration package), the pharmacist may be more motivated to apply for the position (Campbell & Pritchard, 1983). This also applies with regards to OSD's ability to attract a better calibre professional. Professionals with higher work standards and career proficiency may not have been attracted to public sector employment before OSD, simply because they valued their "inputs" inequitable to the "outcomes" (poor remuneration).

Appointing junior pharmacists with "appropriate experience" must however be performed with care. Since "appropriate experience" is such a general statement, the skills to fulfill key performance areas (KPA's) and job descriptions (JDs) will need to be determined. Interviews should ultimately test personality traits and attitudes to ensure organisational "fit" (Ramlall, 2004) since the ability to

complete management administration tasks is quite different from the skill required to manage staff (and particularly professionals).

7.4.2 Reflexive conclusion: OSD and attraction

The collective opinion is that OSD has positively altered the perception of pharmacists with regards to entry level posts which may be linked to the offer of a market related package. All key-informants also agree that junior pharmacists are more interested in management positions.

7.4.3 Theme: OSD and retention

It is evident that OSD is adequate to attract pharmacists into entry level production posts and junior pharmacists into management. Is OSD able to improve the retention of pharmacists after a number of years?

At a glance, the sub-themes tell most of the story with regards to key-informants and pharmacists opinions on retention. Despite improved remuneration through OSD, some pharmacists are interested in being employed in the public sector because of its traditional image, that is to provide public servants with comfortable and secure employment. In the medical division, public sector has always offered an academically linked career (the medical team may be challenged by the “patient-disease” profile) which provides for a mentally stimulating job.

Although the infrastructure is improving in the public sector, it is still outdated in the eyes of the employees. This is compounded by the low levels of staffing in facilities and other work related factors. An employee may enjoy their work and may consider the salary sufficient but may not be able to tolerate the high workload and regular setbacks for extensive periods. Pharmacists complain that some issues have not been solved for many years.

Champagne and McAfee (1989) divides Maslow’s (1943) “safety” or “security needs” into three sections, namely economic, psychological and physical needs. OSD may fulfill the economic and some of the psychological needs of the

employee by offering a good salary with benefits and some performance based rewards, but it cannot fulfill other psychological and physical needs (employee problems and working conditions). If these pre-potent needs are not fulfilled, how will the employee move to other levels of affiliation, esteem and self-actualisation in their job?

Failure to focus on enhancing work related factors may present a negative picture of public sector employment, especially for employees with long term goals. Another consequence will be long-term employee turnover.

Both key-informants and pharmacists argue that a long-term retention strategy seems to be neglected. Experienced production pharmacists are limited by a “pay-ceiling” and experienced supervisors have the same problem, but with a greater responsibility. If these employees are not interested in promotion, how will they stay committed to the job? Motivation must be stimulated via Herzberg’s (Campbell & Pritchard, 1983) non-promotional intrinsic factors viz. achievement, recognition, responsibility and the work itself. It is important to recognise senior pharmacists (in all career paths) with rewards based on achievement or responsibility.

A suggestion may be to re-design senior pharmacist’s job descriptions to focus on mentorship with a level of responsibility over junior pharmacists and to include some project leadership and job-rotation.

Linked to the lack of long-term retention strategies, pharmacists don’t perceive OSD’s style of pay-progression in a positive light. The pay increments are considered to be very small and the onset of notch progression is delayed, a fact which is not known to most new pharmacists. Notch progression is based on performance evaluation which may be viewed as partly subjective and bonuses above standard notch progression are reliant on the availability of public funds. Thus much of the power to improve earnings is not in the hands of the employee

(limiting earning autonomy). Pharmacists are aware that this is different in the private sector.

If an employee has placed a high value on a reward (in this case climbing salary notches) and makes a great effort to improve their earnings via performance, only to be deflated by the increase in salary, they may not be motivated to make such a great effort the second time around (Spector, 2000). This demotivation may lead to either an employee with a sluggish attitude towards work or employee turnover.

Much of the problem lies in not educating the employee on what is required to improve remuneration. Once again, most employees felt information was not transparent. Transparency greatly influences trust and may affect the way the employee perceives the employing organisation.

Since the number of years experience required to enter a supervisory position has been reduced, pharmacists in supervisory posts fear job security. All supervisory pharmacists complain that the work-load and responsibility in this position is overwhelming. Most feel that they will make a change once they reach their “pay-ceiling”. Some would like an opportunity to negotiate responsibility or salary but fear this is impossible due to the popularity of the job. Many pharmacists in this position may therefore be secretly unhappy.

What the employer must consider is the value of replacing employees that may leave the position or seek demotion. The cost of losing and replacing a pharmacist not only has financial ramifications but affects every part of the organisation (Holdford, 2012). If the employee has proven their capability to fulfill the key requirement for the position, it will not be in the organisations’ interest to lose or replace the employee.

If OSD is too rigid to allow employee negotiation on an individual level in the area of remuneration, intrinsic factors (Herzberg, 2003) must be considered in negotiation in order to keep the employee happy. One of the biggest problems is

the work-load burden. Can the public sector afford to improve their employee-patient ratio? Extra employees to spread the work-load may cost more at first but less in the long run by preventing employee turnover. Showing interest in improving the situation for individuals and groups within an organisation may also improve the image of the organisation as one that cares for its employees.

7.4.4 Reflexive conclusion: OSD and retention

In the light of Herzberg's Two-Factor Theory (Campbell & Pritchard, 1983), OSD is attracting pharmacists by ensuring that the extrinsic factors of "pay" and "security" are fulfilled and will ensure that pharmacists will not necessarily be dissatisfied with work. However, in order to retain pharmacists, the "intrinsic" factors or "motivators" will need to be addressed such as achievement, recognition, promotion, growth and the work itself.

Although OSD may be improving junior pharmacists perception of the public sector, once employed for a number of years, ODS's potential to remain a positive influence may wane. Other career areas and a long term improved reward strategy may need to be developed in order to retain senior pharmacists.

7.5 SECTION 4: THEMES RELATED TO CURRENT NEGOTIATIONS

In Figure 22, a section map illustrates themes discussed relating to current negotiations (sub-section 7.5.1, 7.5.3 and 7.5.5). After each theme, a short reflexive conclusion has been included (sub-section 7.5.2, 7.5.4 and 7.5.6).

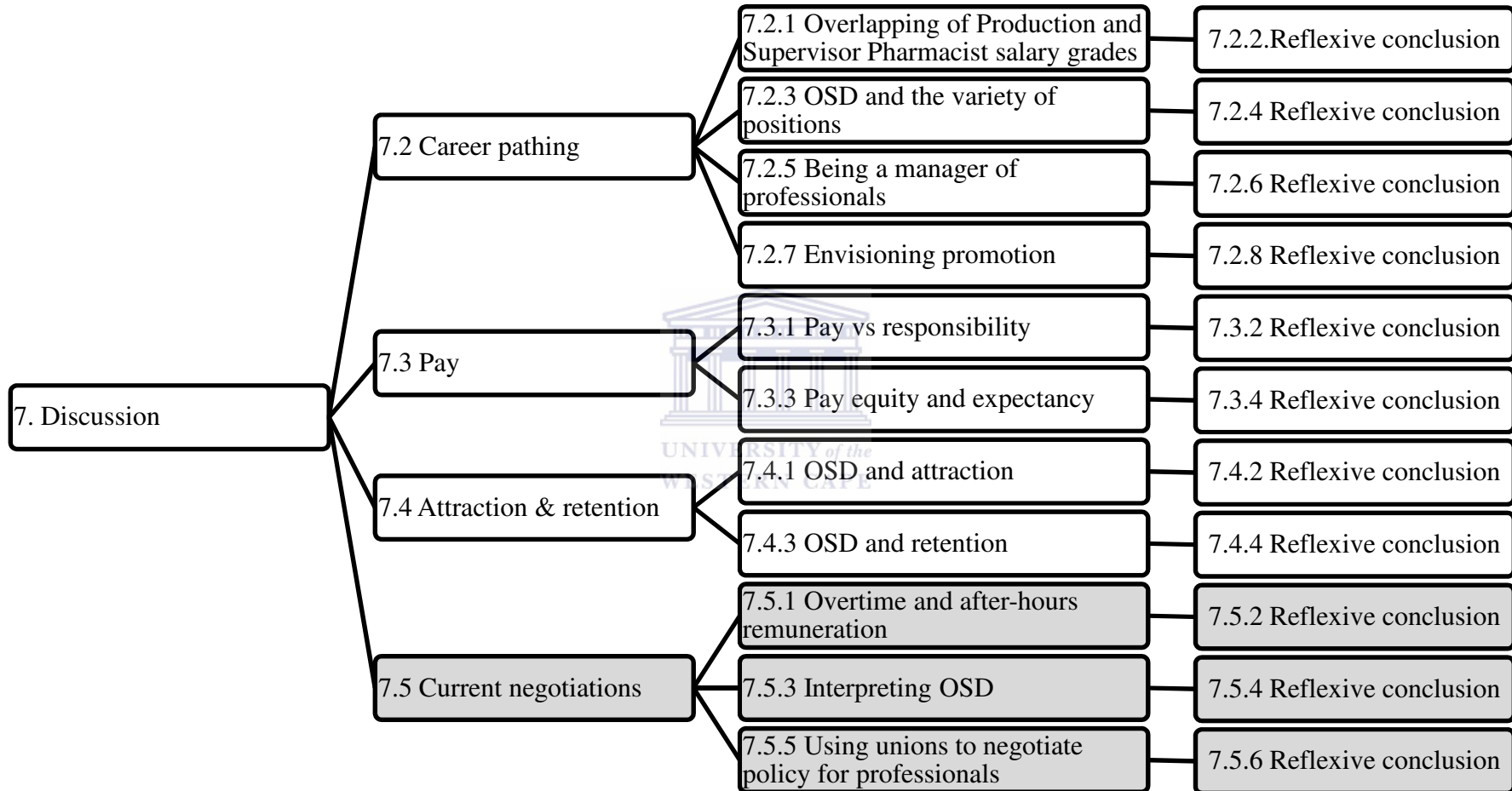


Figure 22: Section map of themes related to current negotiations (shaded in grey)

7.5.1 Theme: Over-time and after-hours remuneration

Human resource and career perspectives disapprove of the current over-time rate. According to Adams (Campbell & Pritchard, 1983), “inputs” such as effort, experience and education are weighed against remunerative “outcomes”. Pharmacists will therefore be less likely to compare the level of work done after standard working hours with remuneration but will be focused rather on the effort made to remain at work beyond standard working hours (which may be encroaching on valuable personal time). The skill required for this level of work may be generic to all pharmacists but they still feel a connection to their level of expertise, especially when employed in a supervisory or management role. Supervisors or managers may compare their “input/outcomes” ratio in this regard to production pharmacists (acting as the comparative “other”).

Another comparative “other” may be those employed in the private sector. Over-time in this sector is always rewarded as 1.5 times or double the rate per hour. Since the public sector over-time rate is below the salary of production level 1, over-time may be perceived as punishment in comparison to private rates. Adams’ Equity Theory would predict that the effort made or “inputs” during over-time will decrease or some arrangement will be made to improve the “outcomes” in order to bring balance in the perception of the employee. This prediction is fulfilled as pharmacists confess that their managers give them time off from work as compensation or claim their over-time at agency fee rates (locum rates). Both methods of compensation are not permitted in the public sector.

The poor over-time rate has therefore forced management to use methods to retain staff that are similar to those used before the introduction of OSD which is counter-productive to the foundational purpose of the remuneration structure. These methods of remuneration are deceptive and corrupt.

Although some management is not adhering, the causative fault lies in policy. As a solution, over-time rates must be renegotiated or other forms of compensation i.e. allowing time off from work, must be written into policy. To avoid abuse of

over-time claims, a limit may be placed on the amount of over-time a facility may claim and arrangement can be made that the balance of the owing over-time may be taken as time off from work.

Another problem may arise that staffing models at the some facilities do not allow for staff to take time off from work. This reinforces the fact that over-time rates must be made attractive. In some cases there has been no budget to allow for over-time claims or the employment of locum staff. In this case the eventual outcome may be the increase in staff turnover which inevitably affects the staffing budget. Would it not be better to seek funds for over-time before losing a staff member?

It is inevitable that more patients will become reliant on the public sector for services especially with the advent of National Health Insurance (NHI). It is therefore important to plan staffing models and budgets ahead of time in order to avoid damage control. Flexi-time contracts have been suggested and implemented in some facilities to alleviate the need for over-time claims. However, only some facilities can implement flexi-time policy.

Flexi-time policy can be advantageous but only if:

1. The facility has enough staff. Staffing models need to be assessed
2. The contract is offered to the employee from the outset. It is very strenuous for an employee to renegotiate an employment contract once already in employment (the new contract must show some benefit to the employee)
3. Flexi-time must be administered fairly and requires a good manager to ensure all employees see the benefit.

If contracts are abruptly changed, the “security” needs (Maslow, 1943) of the employee may be disrupted on a psychological, economic and physical level. This may lead the employee to search for other employment that will offer to fulfill those original needs. Management also needs to ensure that employees don’t perceive unfair administration of the flexi-time schedule (Collins, 2009). Open

discussions and negotiations therefore need to be encouraged when there are disagreements about staff work schedules.

Professionals must either be remunerated well or be offered flexible working hours. Management may be desperate to retain professional employees and may therefore contravene policy. These options should therefore be official and properly consolidated as part of OSD-related policy. This will allow for better personnel planning and budget control.

7.5.2 Reflexive conclusion: Over-time and after-hours remuneration

Changes in the over-time rate must be made in order to motivate pharmacists to work beyond normal hours. Over-time pay at the current rate will always be viewed in a negative light since it is well below standard pay for all levels of pharmacists. Those already in, or those considering a supervisory or management career may be discouraged to continue in, or apply for such positions as a consequence of the aforementioned problems.

7.5.3 Theme: Interpreting OSD

Due to discrepancies in the interpretation of OSD policy between provinces, many pharmacists in other provinces were translated into a higher pay grade despite their experience. Prior to the implementation of OSD, other provinces were already erroneously paying their pharmacists higher salaries than in the Western Cape. The Western Cape may therefore find it more difficult to attract pharmacists from other provinces.

In the light of Maslow's Hierarchy of Needs, pharmacists may choose to stay in the province that is going to fulfill their more pre-potent need of "safety" in the form of economic security. However, "safety" also includes psychological and physical (Ramlall, 2004). Some pharmacists may move to the Western Cape for better working conditions or location. Since these needs compete on the same level of the hierarchy, the pharmacists may be motivated to take a drop in salary in order to have the other "safety" needs met.

Translation from the old pay structure to OSD did cause problems. Many of these were resolved in the negotiation stages of the policy. Some translated positions were initially not recognised as supervisory or management posts. Fortunately, one detail was consolidated, i.e. that responsible pharmacists were graded as supervisory pharmacists despite the number of other pharmacy staff employed under them.

However, since responsible tasks vary so much between the types of facilities and different districts, how can we be sure that pharmacists are recognised appropriately? Have the parameters for supervisors been well designed? Are some production pharmacists perhaps not fulfilling the roles of supervisor? How many other staff should you be overseeing and what types of responsibilities and tasks would determine whether a pharmacist should perhaps be considered as a supervisor?

It will be the task of the employee and higher management to recognise these potential positions and appeal for renegotiation. It may require persistent determination.

7.5.4 Reflexive conclusion: Interpreting OSD

Key-informants may be concerned that inter-provincial discrepancies in pay are seen as inequitable, thus negatively affecting the perception of public sector employment in the Western Cape. However, according to Maslow, pharmacists may be motivated to transfer to the Western Cape despite pay differences in order to have other “security” needs met (Maslow, 1943).

7.5.5 Theme: Using unions to negotiate policy for professionals

This theme is closely related to the previous theme in that answers the question of how pharmacists can renegotiate their posts if they feel they operate at a higher level of decision-making.

Although professionals are generally autonomous, negotiating policy for professional careers is complicated. There is no other way to negotiate policy but via the Bargaining Council Chamber. It is evident that public sector pharmacists rely on unions to assist them since they do not have the technical proficiency for labour negotiations and are a minority group amongst other professional groups in the public sector (e.g. nurses and doctors).

It is also evident that they rely on higher levels of employed pharmacists in government (policy specialists) and professional societies to combine professional and extra-professional knowledge and experience to bring changes to policy. Pharmacists in facilities at all levels must strive to show interest in issues being addressed by policy specialists, to avoid future repercussions.

7.5.6 Reflexive conclusion: Using unions to negotiate policy for professionals

If a position has not been negotiated and recognised appropriately, the employee may not have hygiene (or extrinsic) needs fulfilled leading to immediate dissatisfaction (Campbell & Pritchard, 1983). Production pharmacists performing unusual tasks or in unusual circumstances who are satisfied with their work, but do not feel financially recognised, must have their work and position assessed by higher management to determine whether renegotiation of such positions should be considered.

7.6 DISCUSSION SUMMARY

7.6.1 Perceptions of public sector employment (PSE)

According to Table 14 in Chapter 6 (Section 6.4), themes related to pay, attraction and retention and current negotiations are connected to PSE. This section concludes the positive and negative perceptions regarding PSE as a summary of this discussion.

7.6.2 Positive perceptions of PSE

Occupational Specific Dispensation (OSD) has provided an opportunity for young pharmacists to earn more by reducing the number of years experience required to enter supervisory positions. OSD has also positively influenced the perception of entry level employment for pharmacists in the public sector. This is influenced by a market-aligned salary offer for production level 1 pharmacists and has indirectly lead to a better calibre of pharmacists being attracted to the public sector.

OSD has also improved the number of posts on offer to pharmacists in the public sector as compared with the previous post structure. More pharmacists are now considering positions that were not previously popular, such as those in rural situations and entry level supervisory positions. It appears that entry level supervisory positions have become more popular among junior pharmacists than prior to OSD.

Pharmacists may still, however, be attracted to the public sector due to its traditional employment image, i.e. employment security and stimulating work. Not all pharmacists seek employment based solely on the remuneration structure in place.

Flexi-time contracts are now being considered as a solution to the poor over-time rates offered in the public sector and may be a successful option to eliminate pay dissatisfaction in this area of concern.

7.6.3 Negative perceptions of PSE

Remuneration packages for pharmacists have improved in flexibility in that they offer the employee options regarding cash payout and remuneration related benefits. However, pharmacists do not perceive that the public sector offers much flexibility to improve total annual or monthly earnings.

With regards to remuneration as a retention strategy, many feel that long-term retention for employees that reach the “pay-ceiling” has not been considered, especially in the case of senior production pharmacists. In addition, OSD’s pay progression, in some cases, may be perceived as a negative retention strategy, in that it may encourage retention of non-ambitious employees.

Some aspects of the traditional image of the public sector are negative and cannot always be rectified by new strategies. Issues as work load versus staffing levels in the public sector works against the goals of OSD.

Since the introduction of OSD, supervisory pharmacists perceive their position to be in demand. Popularity may threaten feelings of job security. Supervisors may therefore not feel confident enough to negotiate rewards leading to an unhealthy concealment of dissatisfaction.

Although flexi-time contracts are a possible solution for poor after-hours remuneration, problems may arise if management does not appropriately oversee staffing arrangements or existing public sector pharmacists are required to alter their contracts. Inter-provincial discrepancies in the interpretation of OSD-associated policy may make it difficult to attract pharmacists from other provinces.

7.6.4 Perceptions of career advancement (CA)

According to Table 14 in Chapter 6 (Section 6.4), themes related to career pathing, pay, and current negotiations are connected to CA. This section

concludes the positive and negative perceptions regarding CA as a summary of this discussion.

7.6.5 Positive perceptions of CA

Overlapping of production and supervisor salary grades has provided career path choice. The career pathing structure has also offered a greater variety of positions. The inclusion of experience requirements has encouraged suitable pharmacists and in some cases, junior pharmacists, to apply for management positions. Younger management may potentially introduce new ideas to improve how the public sector is managed. Some feel that those employed at higher decision-making levels are now recognised by improved remuneration, even though some pay grades of different career paths overlap.

7.6.6 Negative perceptions of CA

Overlapping of production and supervisor salary grades may not encourage senior production pharmacists to pursue career development via promotion while pharmacists already employed in supervisory positions may feel cheated. Since career progression is limited by the availability of funds to create posts, pharmacists do not perceive that there is much opportunity for promotion despite the new career structure. Potential promotion is also hindered due to lack of information or understanding of career pathing.

It is in some pharmacists' opinions that changes made to experience requirements (reduced years) for management has encouraged immature pharmacists to enter supervisory positions. OSD does also not cater for senior production pharmacists that will remain in their position, either by default or by choice. Reasons may be that salary bands do not appear to be long enough and the rewards are not considered satisfactory. The choice to seek promotion among these pharmacists may be limited by lack of exposure to other career paths.

In opposition to the positive perception, some pharmacists do not think they are recognised according to their decision-making level, due to grade overlapping.

Supervisors are frustrated that they carry more responsibility but get paid the same or less than their production counter-parts. Supervisory pharmacists at Community Health Centers (CHCs) have a unique burden of responsibility but are remunerated the same as supervisors at other facilities that do not face the same level of challenges. Since experience is measured as a time unit, pharmacists that do not work full days (5/8th and 6/8ths) are not recognised even though their task completion may be on par with full day pharmacists.

Over-time rates in the public sector are currently not attractive and need to be renegotiated. Interpretation of OSD-associated policy may still have disadvantaged some positions after being translated from the old structure to the new structure. Some production pharmacists in unusual work circumstances may still need to be recognised as supervisors.

7.7 CONCLUSION

All eleven major themes have been discussed and connections between these themes and research questions have been described in term of the foundational theory for this research viz. Human Resource and Work Motivation Theory. The final conclusion (Chapter 8) will attempt to summarise these “thickly” described (Merriam, 2009) connections to propose simple answers to the stated research questions in Chapter 3.

CHAPTER 8

CONCLUSION

8.1 INTRODUCTION

This final chapter aims to reconcile the findings of the dissertation with the research questions and subsequent objectives. In addition, recommendations for adjustment to human resource policy related to OSD and further studies will be suggested based on concluded findings.

The image of public sector employment (PSE) and the ambitions of career advancement (CA) are addressed separately in this chapter to establish answers to the two constructed research questions in Chapter 3 (Theoretical Framework).

8.2 SUMMARY OF FINDINGS

8.2.1 Perceptions of public sector employment (PSE)

How do pharmacists perceive public sector employment? Have their perceptions shifted and if so, are they influenced by OSD?

The evidence presented in this thesis demonstrates that OSD has shifted the perceptions of pharmacists regarding public sector employment. Pharmacists employed in the public sector perceive some positive and some negative aspects of the public sector which are connected to OSD and associated policy.

The major positive shifts in perceptions are as follows:

- The perception of entry level posts has improved
- Public sector is perceived to offer opportunities for junior pharmacists to enter management careers
- Offering flexi-time contracts has improved work-life balance and honoured after-hours remuneration.

The major negative shifts in perception or perceptions that have not shifted:

- The public sector does not offer enough to those seeking a long-standing career along a single career path, i.e. production pharmacists that are focused on reaching senior levels
- There are perceptions of lack of flexibility in earning potential to fulfill individual employee needs
- Pay progression is perceived as inadequate
- The public sector does not offer opportunity to negotiate salary or “perks” as a supervisor
- Flexi-time policy may be negative if not soundly implemented by management
- Specific production pharmacists, who should be recognised as supervisors, are not
- Traditional factors of public sector employment, such as high work-load, have not changed.

Negative shifts in perceptions or stagnant perceptions produce an image that fails to care for individual employee needs and tarnishes the image of public sector employment.

8.2.2 The affect of OSD on career advancement (CA)

How do production and supervisory pharmacists perceive career advancement and the promotional structure of OSD?

The findings of this thesis indicate that OSD has changed the perception of pharmacists with regard to the career structure in the public sector and career advancement. Positive perceptions have indicated that OSD has the potential to retain pharmacists. Negative perceptions of career advancement indicate areas where OSD does not influence pharmacist retention or may even stimulate employee loss.

Positive perceptions of career advancement which will lead to staff retention are:

- Dual career paths are perceived to offer career path choice and a greater variety of positions
- There is a perception that more positions are offered
- The management career path is perceived as more specific and accessible especially to junior pharmacists.

Negative perceptions of career advancement which have a negative effect on retention:

- Overlapping is perceived to discourage promotion of senior pharmacists
- Overlapping is perceived not to recognise positions of responsibility (i.e. supervisors)
- Offering career pathing without available funds for positions is perceived as deceptive
- OSD does not recognise variation of responsibility within career paths (i.e. supervisors at different facilities)
- Experience requirements are not appropriate for first time employees in the public sector and those employed in half-day positions
- OSD is perceived to encourage immature pharmacists to take supervisory positions
- Overtime rates are poor and level of expertise is not considered.

Since the perception of career mobility is related to organisational commitment and retention, negative perceptions of career advancement may result in apprehension to develop via promotion or career path change. This can lead to employee boredom, complacency or frustration of career ambitions and eventual loss of an employee.

8.3 RECOMMENDATIONS TO IMPROVE PERCEPTIONS OF PUBLIC SECTOR EMPLOYMENT (PSE)

These recommendations are a basis to improve public sector image. Some recommendations suggest improvement in policy. However, existing policy may

already include a means to implement suggestions, but these are not apparent to employees and therefore need to become transparent. Some ideas can be implemented at facility level while others require intervention at higher levels of policy from policy-makers. Some of these recommendations come directly from research participants.

Recommendations:

- Provide transparent information on how to improve earning potential. This could be done via internal staff meetings, management training, and workshops
- Offer potential to earn more. Be creative to provide earning flexibility such as offering inter-facility work beyond standard hours. Over-time rates would still need to improve
- Review Staff Performance Management Systems (SPMS). Consider linking SPMS to non-remunerative and non-promotional “motivators” (achievement, non-financial recognition, responsibility, growth and the work itself). Ensure financial recognition is fair, consistent and substantial
- Renegotiate the current over-time rate or improve policy in other areas to include compensation in the form of time off from work
- Flexi-time is a positive option for the public sector but should be developed well and implemented with caution
- When attracting professionals from other provinces, allow the offer to include the other advantages of living in the Western Cape (i.e. perceived low crime rate and a better family life-style)
- Management may need to reassess all production and supervisory positions and especially those in rural facilities or unusual circumstances. If assessment indicated unrecognised responsibilities, management and employees must approach labour experts or unions to consider renegotiation of such positions
- Develop a specific system of recognition for half day pharmacists (5/8ths and 6/8ths positions)
- Consider and approve comprehensive staffing models per facility. Employing one more pharmacists may spread the work a little, ensure happy and healthier

employees and ensure work-life balance. This may improve staff turnover figures and save the organisations' finances over a long period.

8.4 RECOMMENDATIONS TO IMPROVE PERCEPTIONS OF CAREER ADVANCEMENT (CA)

These recommendations may be used as a foundation to improve the image of career mobility/advancement in the public sector to ensure the retention of pharmacists with potential at basic production and supervisory levels. Many require policy changes which may not be possible to produce. Other recommendations may be used as “think-tanks” for policy specialists and management and subsequent program development and implementation.

Recommendations:

- Overlapping of grade at supervisory and production level be altered or removed
- If career overlapping cannot be altered, develop non-financial incentives for positions of responsibility
- Consider longer career bands such as five extra notches on the production career path i.e. 10 notches on production level 3 with an overlap with Supervisory level 1 on the second set of 5 notches. Limit acceleration on these 5 notches
- Pharmacists' jobs are currently being re-designed by changes in other areas of the profession (advent of other professionals which infringe on pharmacists roles). Active re-design must be considered to control the long-term outcome of pharmacist's scope and career
- Provide clear and easily available information on career paths, employment posts, training and development opportunities, experience requirements for positions and reports on progress of career path development
- Develop a mentorship program to expose junior pharmacists to management tasks. The mentorship program can also be a tool of intra-career path mentorship, e.g. senior production pharmacists connecting with junior production pharmacists

- Develop a program to expose pharmacists to projects in other career paths such as clinical pharmacy, policy development and management
- Develop specific staffing models for community health centers
- Consider a special allowance for pharmacists at community health centres that supply services to large patient loads.

8.5 DISSEMINATION OF FINDINGS

An executive summary of the findings and recommendations of this research will be sent to the Head of Health, Western Cape and to the participants of the research. Some of these participants are at policy level and the idea is to affect those at policy-making level to consider further investigation and changes to OSD-related policy.

The other goal is publish the findings in a peer-review journal to ensure the findings are accessible to other interested researchers. National and international journals focused on public health policy or human resources will be considered.

8.6 LIMITATIONS

The findings of this research can only inform policy within limits. The sample of informants and participants were limited geographically to Western Cape Metropolitan areas. The sample only comprised of 4 levels of participants (production pharmacists, supervisory pharmacists, management and policy specialists). The findings, therefore, do not provide answers or propose recommendations for national or international level, or for the situation of pharmacists employed in rural districts.

It should also be noted that the style of the research does not allow for extrapolation to the full population of public sector pharmacists in South Africa. This is influenced by the qualitative nature of the methods and analysis style, being in the interpretive paradigm.

Sample limitations were also influenced by time and financial constraints of the researcher.

8.7 RECOMMENDATIONS FOR FUTURE RESEARCH

Recommendations:

- Similar research in other metropolitan areas in South Africa to check for consensus with or deviations from these findings
- Research in rural districts which offer professionals inferior infrastructure and work environments
- Studies to ascertain an external perception of the public sector, viz. the perspective of ex-public sector employees
- A large scale review of pharmacist employment statistics since 2010 in the public sector
- A study to establishing a correlation between public sector employment statistics and aspects of OSD.

8.8 CLOSING REMARKS

It is my hope that this dissertation motivates small adjustments to OSD-related policy and thereby improves the perception of public sector employment in the eyes of individual pharmacists with the affect of long-term retention of those already employed in public sector and those who are considering a career in public health.

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WESTERN CAPE

APPENDICES

APPENDIX A: ETHICS APPROVAL – SENATE RESEARCH COMMITTEE, UNIVERSITY OF THE WESTERN CAPE.



UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

20 December 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Prof N Butler (School of Pharmacy)

Research Project: Pharmacists' perception of occupational specific dispensation (OSD): an exploratory study of career and human resource perspective.

Registration no: 12/10/75

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink that reads 'Josias'.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge

APPENDIX B: APPROVAL TO ACCESS SITES IN THE EASTERN/KHAYELITSHA SUB-DISTRICT



STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House., 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 175/2012
ENQUIRIES: Ms Charlene Roderick

Postnet Suite 88
Private bag X15
Somerset West
7129

For attention: **Michelle Theunissen**

Re: Pharmacists' perceptions of occupational specific dispensation (OSD): exploratory study of career and human resource perspectives

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Karl Bremer	Dr L Naude	Contact No. 021 918 1222
Westfleur Hospital	Dr J Gqodwana	Contact No. 021 571 8040
False Bay	Dr W Warrington	Contact No. 021 782 1121
GF Jooste	Dr R Chunga	Contact No. 021 690 1117
Eerste River Hospital	Dr M Moodley	Contact No. 021 902 8014
Khayelistsha	Dr A Kharwa	Contact No. 021 360 4479
Kellinvlei CHC	Mr J Lucas	Contact No. 021 904 3421
Gastrouw CHC	Ms Salie	Contact No. 021 845 5180
Macassar CHC	Ms C Alexander	Contact No. 021 857 2330
Strand CHC	Ms L. Lubbe	Contact No. 021 853 3380
Nolungile CHC	Mrs Mqikela	Contact No. 021 387 1107
Michael M CHC	Ms J N Matiyela	Contact No. 021 361 3353
Mfuleni CHC	Mr J Lucas	Contact No. 021 909 2755

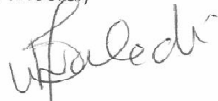
Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely



DR NT Naledi

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 22/7/17

CC

DR A HAWLRIDGE

DIRECTOR: EASTERN/KAHYELITSHA



UNIVERSITY *of the*
WESTERN CAPE

APPENDIX C: PERMISSION TO ACCESS STAFF AT TYGERBERG HOSPITAL



Tygerberg Hospital

REFERENCE: Research Projects
ENQUIRIES: Dr M A Mukosi

REGISTRATION NO: 12/10/75 (UNIVERSITY OF THE WESTERN CAPE)

Pharmacists' perception of occupational specific dispensation (OSD): An exploratory study of career and human resource perspective.

Dear Ms M Theunissen

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research at Tygerberg Hospital.

Yours sincerely



A handwritten signature in black ink, appearing to be "M. A. Mukosi".

CHIEF EXECUTIVE OFFICER: TYGERBERG HOSPITAL

Date: 24 July 2013

Administration Building, Francie van Zijl Avenue, Parow, 7500
tel: +27 21 938-5966 fax: +27 21 938-6698

Private Bag X3, Tygerberg, 7505
www.capegateway.gov.za

APPENDIX D: PERMISSION TO ACCESS STAFF AT GROOTE SCHUUR HOSPITAL



GROOTE SCHUUR HOSPITAL

Enquiries: Dr Bhavna Patel
E-mail : Bhavna.Patel@westerncape.gov.za

Ms Michelle Theunissen
Master's Student
University of Western Cape
School of Pharmacy
Private Bag X17
BELLVILLE
7535

E-mail: mich.theunissen@gmail.com / michelle@reform.co.za

Dear Ms Theunissen

RESEARCH: Pharmacists' Perception of Occupational Specific Dispensation (OSD): An Exploratory Study of Career and Human Resource Perspective

Your recent letter to the hospital refers.

You are hereby granted permission to proceed with your research.

Please note the following: **UNIVERSITY of the**

- a) Your research may not interfere with normal patient care
- b) Hospital staff may not be asked to assist with the research.
- c) No hospital consumables and stationary may be used.
- d) **No patient folders may be removed from the premises or be inaccessible.**
- e) Please introduce yourself to the person in charge of an area before commencing.
- f) Confidentiality must be maintained at all times.

I would like to wish you every success with the project.

Yours sincerely

A handwritten signature in cursive script that reads "B Patel".

DR BHAVNA PATEL
SENIOR MANAGER: MEDICAL SERVICES
Date: 21st June 2013

CC Mrs V. Naicker
Mr L. Naidoo

G-46 Management Suite, Old Main Building,
Observatory 7925

Tel: +27 21 404 6288 fax: +27 21 404 6125

Private Bag X,
Observatory, 7935

www.capegateway.gov.za

APPENDIX E: RESEARCH INFORMATION SHEET FOR ONE-ON-ONE INTERVIEWS



FACULTY OF NATURAL SCIENCES

Private Bag X17 Bellville 7535

Telephone +27 21 9593190

Fax +27 21 9591588

RESEARCH INFORMATION SHEET (ONE-ON-ONE INTERVIEWS)

Pharmacists' perceptions of occupational specific dispensation (OSD): exploratory study of career and human resource perspectives.

Dear Pharmacist

I am conducting research on pharmacists' opinions of occupational specific dispensation (OSD). If you will recall, in 2006 and 2007, the South African government set about developing a new pay system for professionals (doctors, pharmacists, dentists, etc) working in the public sector. Their goals were to keep professionals employed in the government, to improve their earning potential and to build a career structure that was specific to each profession. The details of the study and your possible role as a participant follow.

Information about the research

A little more about the study

How did you, as a pharmacist, view your earnings and careers before OSD and how do you perceive them now? If you weren't employed in the public sector before OSD it doesn't mean that I will exclude you from the study – all opinions are important. I intend conducting a series of one-on-one interviews and your participation will be appreciated. We'll also discuss topics such as:

- What motivates and satisfies you in your career?
- Have you ever thought of leaving?
- What do you think of the government's reward system?
- Are there career opportunities for you in the state sector?

What would be required of you if you desire to participate?

- You will be asked to be interviewed face-to-face.
- The interview will be more like an informal discussion based on some focus questions.
- The interview will be a maximum of 1 hour 30 minutes (one and a half hours).
- The interview will not occur during working hours. It will be scheduled, for your convenience, either for an early evening (after work) or a Saturday morning.
- I will provide a snack and something to drink a half an hour before the interview commences (and will consider your religious dietary requirements).

- I will try to ensure that the interview will be at a comfortable venue that is convenient for you.
- The interview will take place in June, July or September 2013 which we will schedule well in advance.
- This research is being conducted for the purposes of a Master's Thesis.
- The interview will be sound recorded but all your potential concerns will be discussed in the following section and you are always welcome to call or contact me with any concerns or questions.

Declaration to the participant

Confidential and Anonymous

- All sound recordings will not be accessible to anyone but me (the researcher). Recordings will be password protected and stored on storage devices that are only accessible to me. Your name will be replaced by a pseudonym and all hard copies of the interview will not be accessible to others.
- Sound recordings and hard copies thereof may be viewed at any stage if you request it. I, however, will not allow copies to leave my possession in order to protect your confidentiality and anonymity.
- I will ensure that anything that can identify you will not be included in my writing. If I use any direct quotations they will not have identifying traits.
- You can request a copy of my research findings and discussion at any time.
- You are allowed to withdraw from the study at any stage. You have the right not to answer or discuss any topic at the interview. You have the right to ask me to withdraw anything you have said during the interview from my research data.
- I would like to create a safe interview environment free from judgment.
- The final thesis will be accessible at the University of the Western Cape, once it has been published. I will also present a summary of my findings to policy developers and specialists (these will be some of the pharmacists you know at head office, pharmacy services, PGWC). Another copy will go to the office of the Head of Health, PGWC.

Anticipated Risks

There do not seem to be any foreseeable risks in this research topic. However, social and psychological discomforts may be experienced during discussions and for that reason I want to make it clear that, as the participant, you can decide not to participate in the discussion at any stage. You will be free to leave or to return at any point in the interview. I also encourage you to discuss (via email, phone or in person) any discomforts experienced or concerns you have about the interview.

Anticipated Benefits

This may provide you with an opportunity to look at your career, find out whether you are satisfied/ dissatisfied with your job and pay. It's an opportunity to look at the future of your employment and to celebrate your past achievements.

Yours sincerely,
Michelle Theunissen

Contact details:
Mobile: 083 578 7644
Email address 1: 2418771@myuwc.co.za
Email address 2: michelle@reformed.co.za

APPENDIX F: RESEARCH INFORMATION SHEET FOR FOCUS GROUP INTERVIEWS



FACULTY OF NATURAL SCIENCES
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RESEARCH INFORMATION SHEET (GROUP INTERVIEWS)

Pharmacists' perceptions of occupational specific dispensation (OSD): exploratory study of career and human resource perspectives.

Dear Pharmacist

I am conducting research on pharmacists' opinions of occupational specific dispensation (OSD). If you will recall, in 2006 and 2007, the South African government set about developing a new pay system for professionals (doctors, pharmacists, dentists, etc) working in the public sector. Their goals were to keep professionals employed in the government, to improve their earning potential and to build a career structure that was specific to each profession. The details of the study and your possible role as a participant follow.

Information about the research

A little more about the study

How did you, as a pharmacist, view your earnings and careers before OSD and how do you perceive them now? If you weren't employed in the public sector before OSD it doesn't mean that I will exclude you from the study – all opinions are important. I intend conducting a series of focus group discussions and your participation will be appreciated. We'll also discuss topics such as:

- What motivates and satisfies you in your career?
- Have you ever thought of leaving?
- What do you think of the government's reward system?
- Are there career opportunities for you in the state sector?

What would be required of you if you desire to participate?

- You will be asked to attend a group interview.
- The interview will be more like a discussion with colleagues based on some focus questions I will ask.
- The interview will be a maximum of 2 hours.
- The interview will not occur during working hours. It will be scheduled either for an early evening (after work) or a Saturday morning according to what is convenient for the majority.
- Some of your colleagues will be there and I will let you know who will be at your session before you attend.
- I am only group interviewing production and supervisory pharmacists for this part of the research.

- I will provide a snack and something to drink a half an hour before the interview commences (and will consider your religious dietary requirements).
- I will try to ensure that the meeting will be at a comfortable venue that is convenient for you.
- Group interviews will take place in February and March 2014.
- This research is being conducted for the purposes of a Master's Thesis
- Group interviews will be sound recorded but all your potential concerns will be discussed in the following section and you are always welcome to call or contact me with any concerns or questions.

Declaration to the participants

Confidential and Anonymous

- All sound recordings will not be accessible to anyone but me (the researcher). Recordings will be password protected and stored on storage devices that are only accessible to me. Your name will be replaced with pseudonyms and all hard copies of the interviews will not be accessible to others.
- Sound recordings and hard copies thereof may be viewed at any stage if you request it. I, however, will not allow copies to leave my possession in order to protect other participant's confidentiality and anonymity.
- I will ensure that anything that can identify you will not be included in my writing. If I use any direct quotations they will not have identifying traits.
- You can request a copy of my research findings and discussion at any time.
- You are allowed to withdraw from the study at any stage. You have the right not to answer or discuss any topic at group interviews. You have the right to ask me to withdraw anything you have said during interviews from my research data.
- Everyone will be asked to agree to a question of confidentiality posed to them before participating in group discussions to ensure that no information may be divulged to others outside of the meeting.
- At the beginning of the session I will ask all to agree to allow an environment of freedom and non-judgment.
- The final thesis will be accessible at the University of the Western Cape, once it has been published. I will also present a summary of my findings to policy developers and specialists (these will be some of the pharmacists you know at head office, pharmacy services, PGWC). Another copy will go to the office of the Head of Health, PGWC.

Anticipated Risks

There do not seem to be any foreseeable risks in this research topic. However, social and psychological discomforts may be experienced during discussions and for that reason I want to make it clear that, as the participant, you can decide not to participate in the discussion at any stage. You will be free to leave or to return at any point in the interview. I also encourage you to discuss (via email, phone or in person) any discomforts experienced or concerns you have about the interview.

Anticipated Benefits

Your participation may provide you with an opportunity to look at your career, find out whether you are satisfied/ dissatisfied with your job and pay. It's an opportunity to look at the future of your employment and discover other pharmacist's ideas on pharmacy as a career in public service.

Yours sincerely,
Michelle Theunissen

Contact details
Mobile: 083 578 7644
Email address 1: 2418771@myuwc.co.za
Email address 2: michelle@reformed.co.za

APPENDIX G: INFORMED CONSENT FORM FOR ONE-ON-ONE INTERVIEWEE PARTICIPANTS



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Fax +27 21 9591588

INFORMED CONSENT FORM (ONE-ON-ONE INTERVIEWS)

Pharmacists' perceptions of occupational specific dispensation (OSD): exploratory study of career and human resource perspectives.

This study and the related procedures have been explained to me to my satisfaction. I have received a copy of the participant information sheet and have been given the opportunity to ask questions which have been answered to my satisfaction.

I understand that the confidentiality of information disclosed during one-on-one interview sessions, whether observed live, recorded, or collected in any other form, will be maintained. "Confidential Information" shall mean information or material obtained or observed while participating in a one-on-one interview session conducted by or for the benefit of the researcher. Confidential Information thus includes, without limitation, any information about any participant that is not currently in the public domain or readily available to the public. It also includes any participant's identifiable information which may reveal the person's identity.

I freely give my consent to take part in this study and agree to be interviewed either in a group interview or one-on-one and that the verbal content of that interview will be used as data in this research.

I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form and the information sheet to take with me.

Signature of Participant

Date

Printed Name of Participant

Signature of Researcher

Date

Printed Name of Researcher

APPENDIX H: INFORMED CONSENT FORM FOR FOCUS GROUP INTERVIEWEE PARTICIPANTS



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Private Bag X17 Bellville 7535
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Fax +27 21 9591588

INFORMED CONSENT FORM (GROUP INTERVIEWS)

Pharmacists' perceptions of occupational specific dispensation (OSD): exploratory study of career and human resource perspectives.

This study and the related procedures have been explained to me to my satisfaction. I have received a copy of the participant information sheet and have been given the opportunity to ask questions which have been answered to my satisfaction.

I understand that the confidentiality of information disclosed during group interview sessions, whether observed live, recorded, or collected in any other form, will be maintained. I therefore agree not to disclose any information that was discussed during the group interviews. "Confidential Information" shall mean information or material obtained or observed while attending a group interview session conducted by or for the benefit of the researcher. Confidential Information thus includes, without limitation, any information about a participant that is not currently in the public domain or readily available to the public. It also includes any participant's identifiable information which may reveal the person's identity.

I freely give my consent to take part in this study and agree to be interviewed either in a group interview or one-on-one and that the verbal content of that interview will be used as data in this research.

I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form and the information sheet to take with me.

Signature of Participant

Date

Printed Name of Participant

Signature of Researcher

Date

Printed Name of Researcher

APPENDIX I: INTERVIEW GUIDE FOR KEY INFORMANTS (ONE-ON-ONE)

1. In your opinion, what was the purpose of OSD?
2. Why did it become necessary to implement OSD?
3. Talk a bit about **your involvement** in OSD.
4. Explain any **concerns before, during** its development and implementation.
5. What were the **benefits** of its implementation, in your opinion?
6. If there is space for improvement, what would you propose to be improved?
(this deals with current concerns)
7. One of OSD goals was to eliminate **inter-provincial discrepancies**. Are you aware if that has materialised?
8. Were pharmacists' **values**, and if so, **what values** were **considered** when the OSD structure was developed? *(Does the structure suite pharmacist's values and will it fulfill our expectations?).*
9. Is there anything notable in the structure for production and supervisory pharmacists? *(I.e. characteristics of the structure that you would take note of if you were employed in those roles BOTH POSITIVE AND NEGATIVE).*
10. Is salary and **career progression transparent** and easily **accessible** for pharmacists *(both in supervisory roles and management, i.e. can career progression be envisioned?).*
11. What about the proposed career path for **clinical** pharmacists? Do you have any information of the requirements and the creation of that position?
12. In your opinion: is the policy reaching its intended goals?
13. What are your future plans for involvement? Is there anyone else that you know that is involved and has important information concerning the policy?

APPENDIX J: INTERVIEW GUIDE FOR PRODUCTION PHARMACISTS (GROUP INTERVIEWS)

Intro Questions

1. Name - how long you been at GSH - how long in government - where before government?

Transition Questions

2. **Why** did you choose **public sector**?
3. Do you think **public sector is popular** or not? Why?
4. What are the aspects that make you stay?
5. Why would you go? (**no judgement**)

Key Questions (GIVE TIME TO LOOK AT THE ANNEXURE AND ASK QUESTIONS)

CAREER

6. Goals for career: **stay production or climb the ladder**? Would you want to be a manager/supervisor? **Why/why not**?
7. **What about other career paths**? Clinical? Policy specialist? (What do you know about these?). Why or why not?

MONEY (LOOK AT TRANSLATION TABLES)

8. Is the **money enough**? Are the increases good? Reasons. (IS IT BETTER?)
9. What do you think of **grade overlapping** (Prod 3 and Supervisor 1)?
10. Do you think you **getting paid fairly** for what you do? Would you prefer more? Why?

Probes: When you compare to others (here or elsewhere, is it fair?)

11. Do you feel **utilized**?

Ending Questions

12. Discuss a summary of the main issues mentioned and agreed on.
13. Did we leave anything out?

APPENDIX K: INTERVIEW GUIDE FOR SUPERVISORY PHARMACISTS (GROUP INTERVIEWS)

Intro Questions

1. Name – how long you been at GSH? Where were you before?

Transition Questions

2. **Why** did you choose the **public sector**?
3. Is **public sector popular** at the moment or not? Why?
4. What are the aspects that make you **stay**?
5. Why would you **go**? (**no judgment**)
6. **What is your understanding of OSD (intro if needed)?**

Key Questions (GIVE TIME TO LOOK AT THE ANNEXURE AND ASK QUESTIONS)

CAREER

7. Goals for career: **stay supervisor/assistant manager or climb the ladder?**
Would you want to be a deputy manager? **Why/why not?**
8. What about **other career paths?** Clinical? Policy specialist? (What do you know about these?). Why or why not?

MONEY

9. Is the **money enough?** Are the increases good? Is it better?
Reasons.(SPMS/RETIREMENT)
10. Do you think you **getting paid fairly** for what you do? Would you prefer more?
Why?
Probes: When you compare to others (here or elsewhere, is it fair?)
e.g. Production level 3, Supervisors in a different post, proof of experience.

Ending Questions

11. Discuss a summary of the main issues mentioned and agreed on.
12. Did we leave anything out?

APPENDIX L: CONVERSATION STIMULATOR FOR GROUP INTERVIEWS (PRODUCTION)

Production pharmacists' sayings

I am confident I will make a good supervisor; you only need 3 years experience in the government.

I plan to be a supervisor as part of my career goals. / There is no way I want to be a supervisor!

What does my supervisor do all day? We need their help with dispensing and they are always busy with something else!

I wish the older pharmacists would help me more. / The older pharmacists have been such great mentors.

That pharmacist is so stuck in their ways.

These younger/new pharmacists are not learning fast enough; they are always playing on their cell phones and they don't realise how much work there is to be done. / These younger/new pharmacists are so keen and energetic; I think they should consider a supervisory position.

I am often bored/ I am often mentally stimulated by my work.

We claim overtime at our facility without any problems! / We work flexi-time.

APPENDIX M: CONVERSATION STIMULATOR FOR GROUP INTERVIEWS (SUPERVISORY)

Supervisor pharmacists' sayings

Ag, it's easy to become a supervisor/manager nowadays, you only need 3 years in the government.

I planned to be a supervisor as part of my career goals.

If I knew then what I know now, I would do it again/I would think twice!

I had adequate skills when I entered this position. /I didn't have adequate skills when I entered this position but now I'm on top of it.

I am finding/using opportunities to improve my understanding and skills for my position.

I feel like I am losing touch with some areas of pharmacy (within public sector).

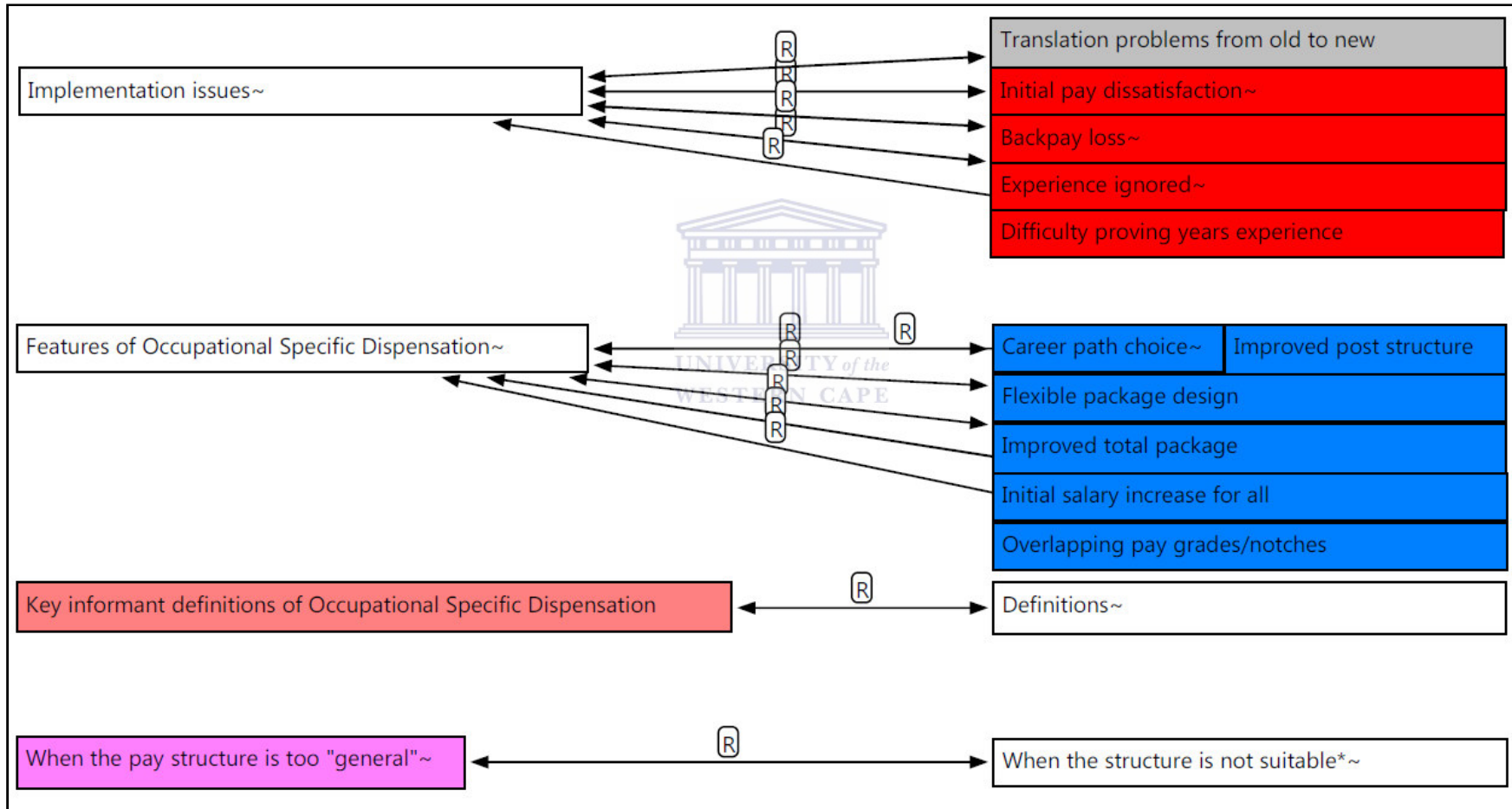
I am often bored/ I am often mentally stimulated by my work.

I don't know why a fellow supervisor is moaning, to be a supervisor is to be a supervisor, no matter where you work.

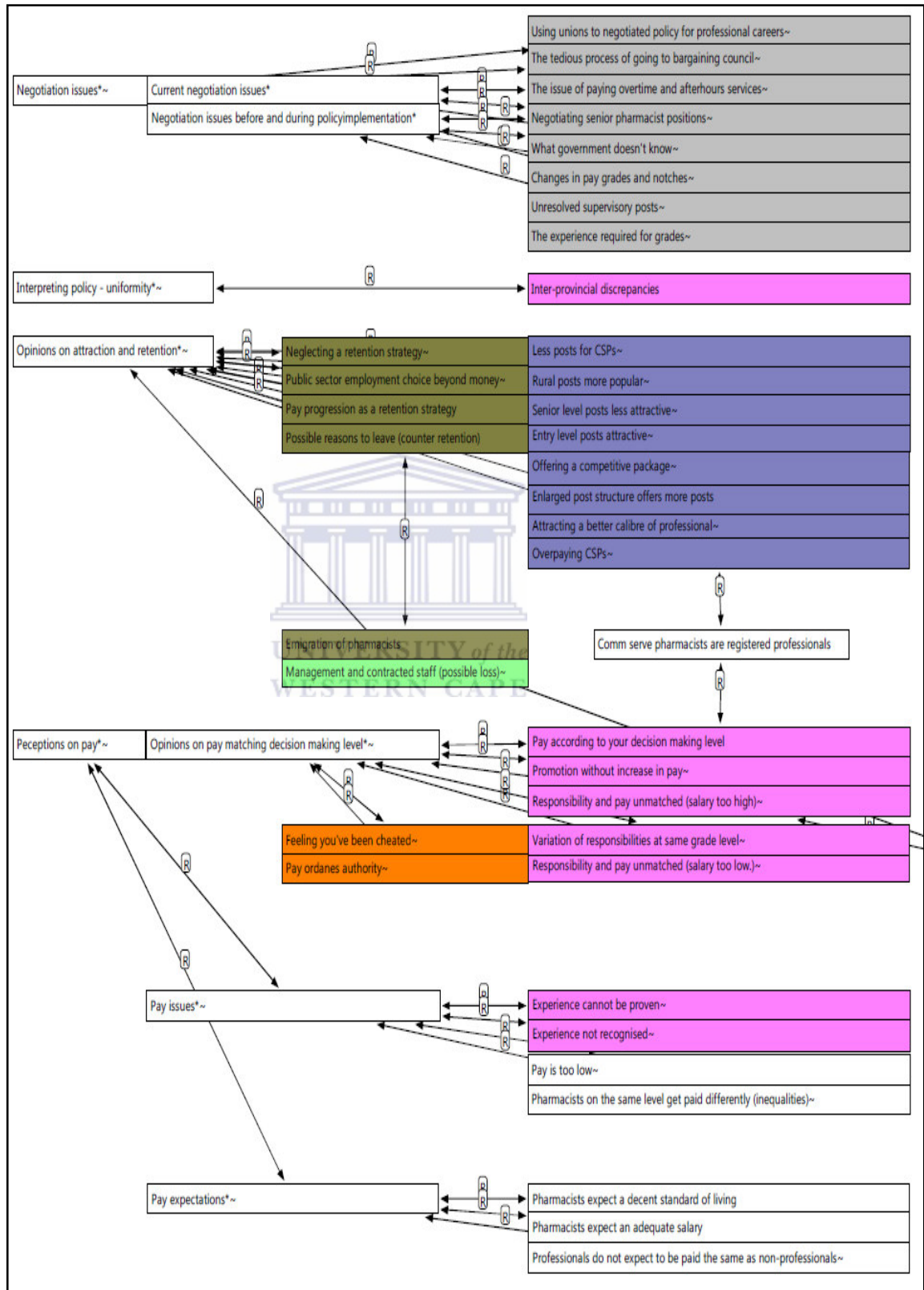
It's easy to manage others! I have managed assistants and production pharmacists without a problem.

We claim overtime at our facility without any problems! / We work flexi-time.

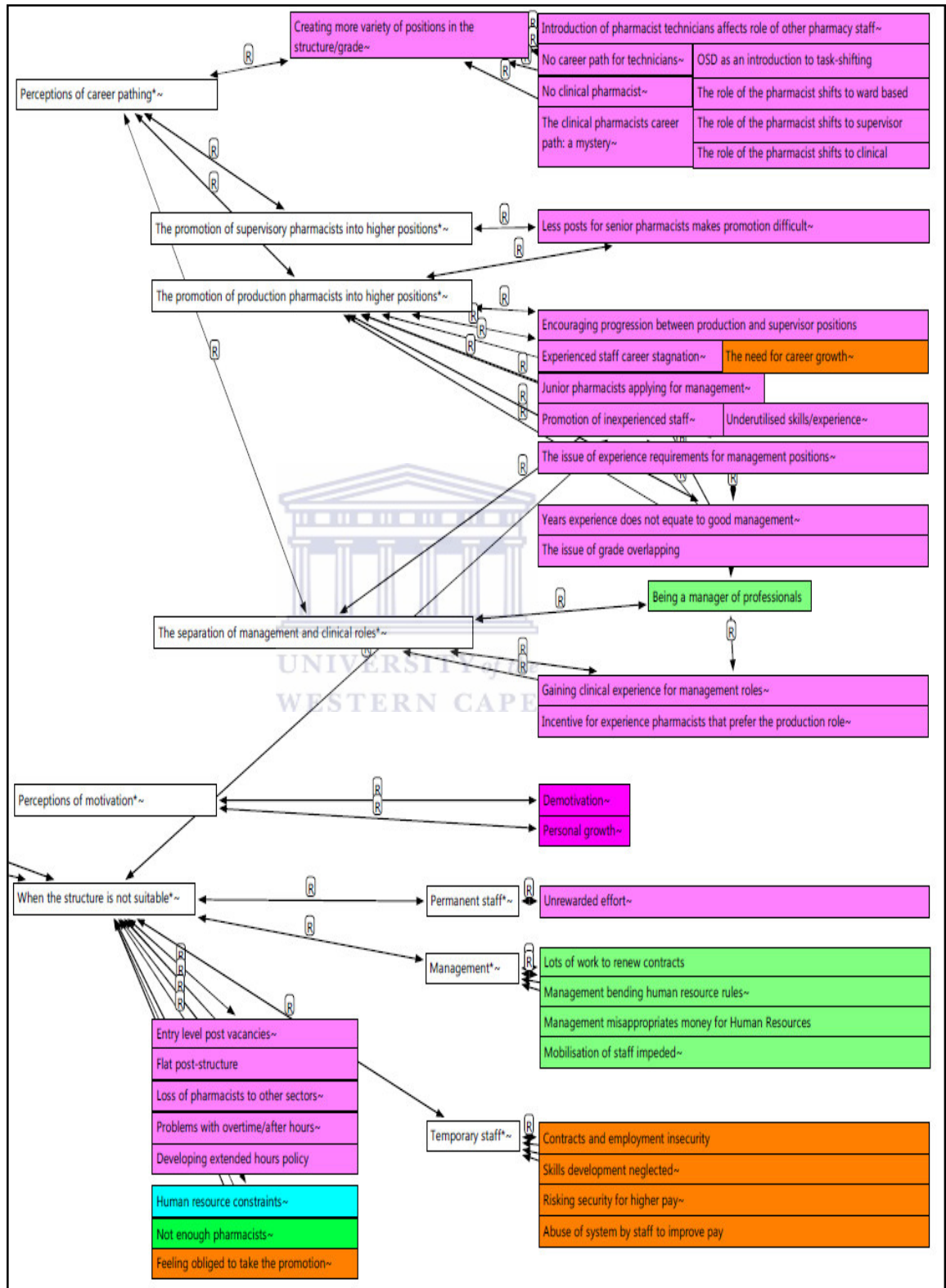
APPENDIX N: CODE LIST FOR PERIPHERAL CODES



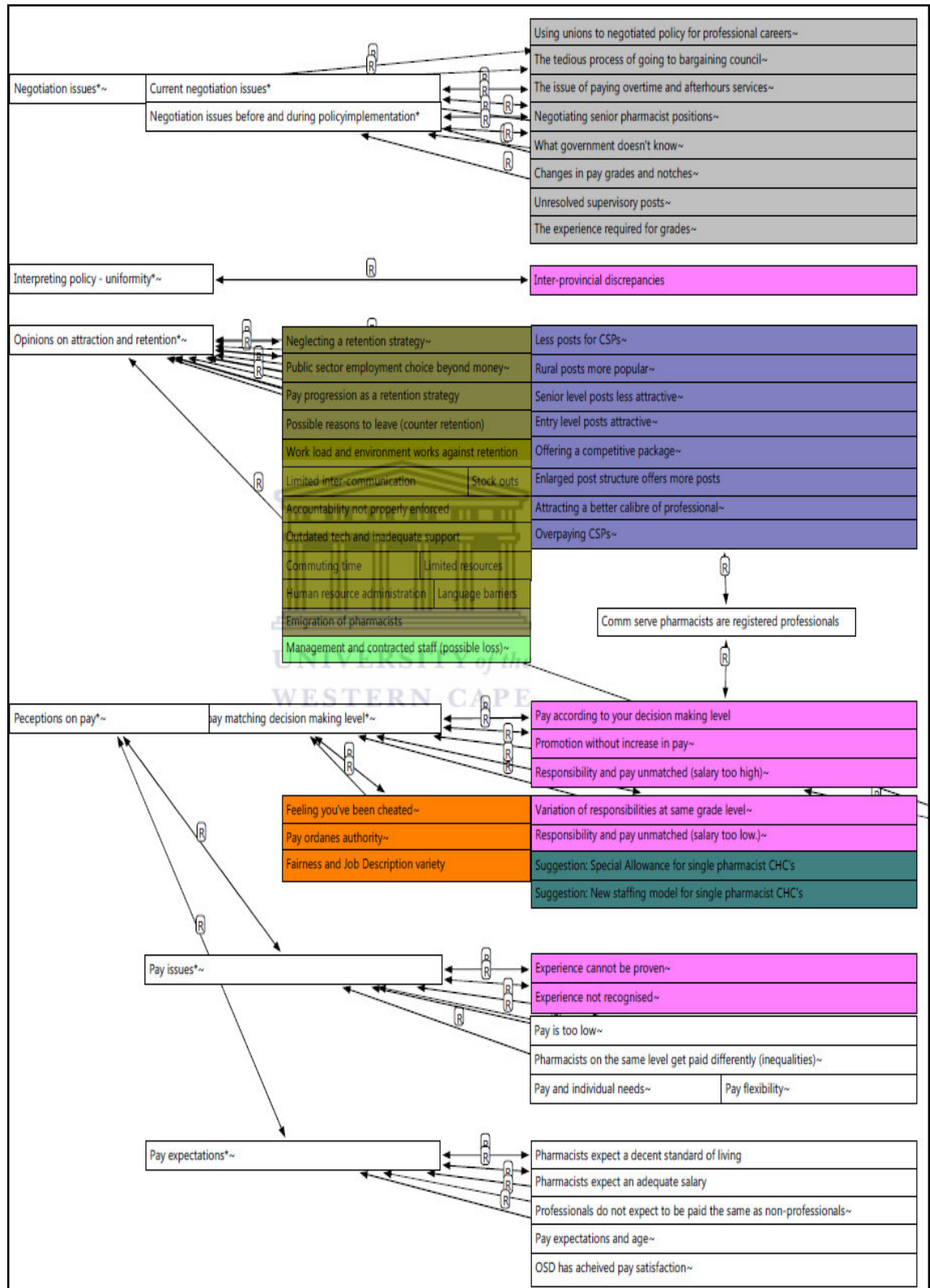
APPENDIX O: CODE LIST FOR SUPER AND CORE CODES BEFORE GROUP INTERVIEWS – APRIORI FRAMEWORK (PART 1)



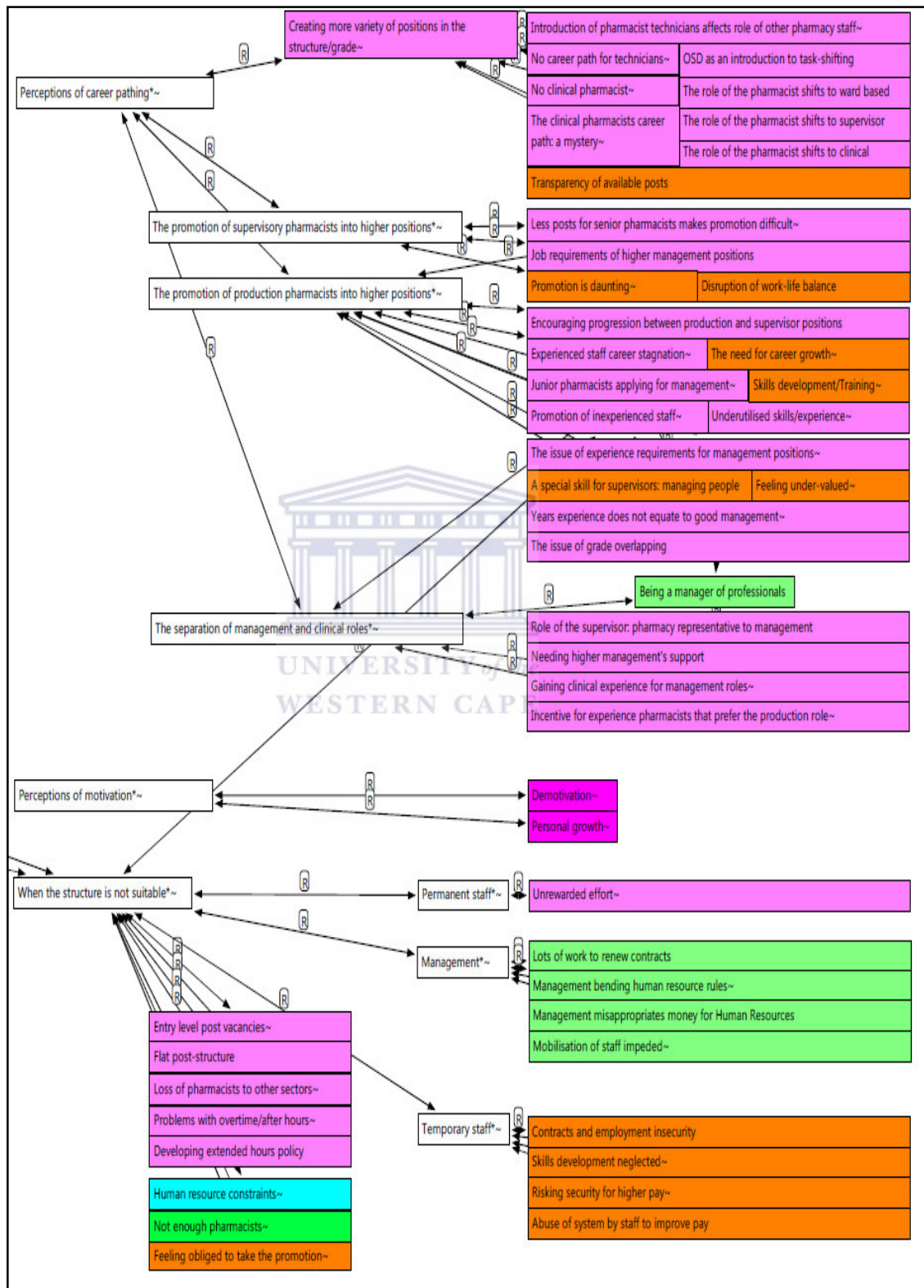
APPENDIX P: CODE LIST FOR SUPER AND CORE CODES BEFORE GROUP INTERVIEWS – APRIORI FRAMEWORK (PART 2)



APPENDIX Q: CODE LIST FOR SUPER AND CORE CODES AFTER GROUP INTERVIEWS (PART 1)



APPENDIX R: CODE LIST FOR SUPER AND CORE CODES AFTER GROUP INTERVIEWS (PART 2)



APPENDIX S: TRANSCRIPT FROM INTERVIEW WITH KEY INFORMANT “KP”

PART 1

Michelle: Okay, your understanding of OSD. Remember we spoke about this in the past, and we were talking about... when you started...talking about structure. What was the idea behind it?

KP: Well, my understanding of OSD, um, was that it was going to look at appropriate remuneration for pharmacists... and it was going to develop a... sort of put in place, a career path for pharmacists in the public sector. Those were the key, um, issues out of OSD.

Michelle: Ya...so those are the big things, ya?

KP: Career progression and, ya.

Michelle: Ya, and I do remember that as well. Remember we spoke about, um, that up until that point it hadn't really been , uh... there wasn't something appropriate in place, am I right to say that?

KP: yes, ya. Because the remuneration would be linked to, um, the retention of staff, recruitment and retention of staff.

Michelle: Fantastic, that is exactly what I recall from it, okay. So you were saying that it was necessary at that point in time, um , before that did you, what I mean, you said it was necessary for retention, so do you think we were losing people?

KP: [00:01:29]We were definitely losing people. I mean, um, sort of people that you could, um, attract for normal pharmacists posts were, other people that were retired. You couldn't see very well what they were dispensing, sorry, but, um, it wasn't the kind of staff that we wanted, and it was really very difficult to address (unclear)

Michelle: Ya, so it was basically, we were in need at that stage.

KP: and the more staff you lose, the more difficult it becomes, the more staff leaves, so... actually, you know, we were in sort of a crisis, I'd say. Um,... also what happened, because of this, um, in some areas people would... sort of put in ... (unclear), how would you say,... they would divert from... normal policy and put in their own, sort of ways of, um, attracting staff, so they would remunerate people on different levels, put um, ... I am not sure how to put it in words but, but (unclear), um, to kinda find ways of recruiting staff,... so you will have staff paid for the same work on different levels because one area can get away with it, where as another facility cannot get away with it. You know?

Michelle: Mmm, that's very interesting, hey. So, I didn't realise that, so you were actually, we were aware that there were, there were managers that we kinda trying to get people in... by maybe just doing it on their own. They didn't have any set format. Is that what you are saying?

KP: yes, if you had, if you work in an environment where you're now really desperate and you have your managers maybe being open to finding a way to, to get staff into the facility, um, they would for instance, if you're the supervisor and you get paid at a certain level, they would employ another pharmacist at that same level and they wouldn't be doing the same work, or you would also find they would pay them in a different way, for instance, we had a lot of, when I worked at (facility name) at the time, we had a lot of pharmacists that were, um... paid as locums or through an agency, and the agency would negotiate then, the rates, and because you're paying them through an agency, you're not paying them as a permanent staff member, you could use a different salary structure.

Michelle: Ah, that's interesting, ya.

- KP: So they would also end up, um, earning more than the permanent staff...with less responsibility, because you have to come back every day, they can walk out when they want. So, so that kind of... all that contributed to decrease in morale... and, you know. And even when managers in, like, also when I was at (facility name), there was a... okay, I don't know how you're going to report this, but, there were sort of, our finance manager tried to find a way to at least get us on par to the agency staff at (facility name), but he was blocked all the way. So there was no way that he actually, um, ... kind of...reward us...
- Michelle: ... get you salaries on the same level...
- KP: ...ya, ya.
- Michelle: ... as the agency staff. So in other words, am I right to say, that there's a lot of finances going out...uh, to agencies.
- KP: Yes.
- Michelle: And so your budget, for your permanent staff, was that now becoming a problem? Because you wouldn't have access to money. Well, also, I suppose you couldn't...
- KP: It can be seen as waste!
- Michelle: Ya
- KP: Kind of wasteful expenditure, because that person doesn't take that responsibility, they don't have the same job description but, but you need the staff member, you know. So it was really, it was really difficult because... people would then sometimes resign and come back through an agency.
- Michelle: Oh, my word.
- KP: You know what I mean?
- Michelle: Ya, this is the things we don't know about.
- KP: Ya, and part of that salary goes...to the agency.Obviously... so, for me, really, it was a real wasteful expenditure. Um, but I think because there was nothing in place, there was no other way for, um, sort of managers, When I say managers, I mean, managers of hospitals and so, to approach it any other way.
- Michelle: Ya. And also, (participant's name) now, talking about this, you were saying that... um...can you see, OSD'd like, it's a big policy. So this must have been happening in other sectors as well, I mean, do you know, or did you hear anything about that, or were they just saying, we gonna do it for everyone, because there is certain... Do you think it was a , a general...
- KP: I think it was happening were it was needed, I mean, they would only do such things when it was, sort of crisis situation or critical. So I think, I think it happened in other, you mean non-pharmacy areas...
- Michelle: Ya, like in other words, um, other professions, like Doctors and I suppose Nurses and... that's why they brought OSD into their... their field as well.
- KP: And I think in other provinces, it was actually far worse as well.
- Michelle: Western Cape kind of does, uh , do a bit better generally...I don't want to...be opinionated.
- KP: Ya, also, we... our situation was not as bad as you would find in other provinces, in other provinces, they would, uh, pay pharmacists on chief pharmacist levels, you know..you know what...I think it was far worse in other provinces.
- Michelle: Ya. But do you think it's because the salary wasn't good enough, on just... the normal levels as pharmacists? That they had to kinda beef everything up and take people up to chief pharmacist level? or is it because pharmacists were getting greedy and putting pressure on the system?
- KP: No,...I, I think, you know there should... there should be a salary, that is satisfactory. And for the amount of studying that you have done, and the type of living that you expect...and I don't think any pharmacists expect mansions

- and overseas trips and stuff like that. What pharmacists basically expect is to be able to afford a house...to buy a decent car,
- Michelle: I agree
- KP: [00:07:38]... and the salary that they were earning at the time did not provide that. You could earn the same salary...um, when we, we saw an admin persons earning that type of salaries, um...you now, I mean,.. if I think back now,...I don't know if you should put this in, but, out our admin person is on level 7... and a pharmacist was paid on a 7. And then we had a senior on a 8 and a principal on 9. And I mean... um, I think our, our salaries were out, out of line.
- Michelle: Were, were just too small...basically.
- KP: It was.
- Michelle: See, the thing is, this is the reason why... you're so important for information, because you've been there a long time, (participant's name), and you have seen the stages. And I think the thing is that, for me, I have no idea how bad it was. i think...
- KP: Yes
- Michelle: ... this is, this is the reality of it so... anyway. So to move on. The previous structure... what was that again? What was the name, firstly, I mean, what did we call it? Was it just a general hierarchy? Was the hierarchy kind of?...
- KP: I think, I think, we were part of...
- Michelle: I remember something about PAS?
- KP: Ya, there was PAS and the came the CORE...
- Michelle: That's it! CORE, that it, I remember that.
- KP: Which means that everyone was kind of... fell into this...
- Michelle: Hmm...one structure.
- KP: One structure, yes...
- Michelle: That's how I remember it as well.
- KP: Professionals, non-professionals and whatever, and you had to be paid... on a level within that CORE. And, because, I think... at a certain level you paid... um, deputy directors or assistant directors whatever, it was difficult to,... get a pharmacist's salary above that.
- Michelle: So...your middle management guys, and the senior management guys...
- KP: In other areas...
- Michelle: Ya...other areas, would basically would block the pharmacists from getting a salary higher than a certain amount?...
- KP: Yes
- Michelle: Because they're not managers, as...
- KP: because then we won't be falling into this CORE structure.
- Michelle: That's the thing, okay, that's I wanted to know. So what I came in I remember doing my community service on level 8, I think it was?, does that sound right?
- KP: Yes, so...
- Michelle: I mean this is now
- KP: Was it 8 or 7? Wasn't it 7?
- Michelle: Could have been a 7?
- KP: 7.
- Michelle: Or the internships might have been on the 7.
- KP: Ya, I can confirm for you, but I think the interns were on 6...
- Michelle: ya, that's possible, yeah
- KP: That is possible and community service were on 7, and pharmacist was on an 8, and I know...
- Michelle: The senior pharmacist on 9...
- KP: 9
- Michelle: ...management on 10? Am I right, or 10, 11? I'm not sure?

- KP: Ya, because a chief, I know, was 10.
- Michelle: Okay...
- KP: Principal was 9...
- Michelle: Okay... let me see, so chief 10.
- KP: Senior was 8... a pharmacist was 7. That's how bad it was...
- Michelle: I remember when my salary was really...it was okay. I am not complaining, for a start. But I know it wasn't, wow.
- KP: Yes, because as a community service pharmacist, right. Because we... we saw, community service pharmacist, as a pharmacist.
- Michelle: Ya, I know that, and that was really nice about it.
- KP: but the bad thing was that when you then eventually become permanent after that, you still have the same salary.
- Michelle: [00:10:55] Yeah.
- KP: And that means no difference.
- Michelle: So in other words, you could lose community service pharmacists instead of keeping them, they were kind of leaking out again.
- KP: Ya, because they feel now...they need to earn more. but...I think it wasn't fair to pay them on an 8, because they weren't interns anymore... and and and, their responsibilities were the same as a pharmacist.
- Michelle: Ya, that's right. because at the end of the day, you had to dispense, you were your own person. if I recall.
- KP: Yes... ya
- Michelle: Um, also talking about that, um... I remember as well, the community service guys could drop their benefits in lieu for a percentage, if I am right, hey? and then, which means when you became permanent staff, you'd have to take the benefits package. Am I right? So you would actually have cash out less? Does that make sense?
- KP: Yes... yes.
- Michelle: So that was a big thing as well, hey?
- KP: Ya, we... um... if you are on a contract, a permanent contract basis, you had the choice. You could either take the benefits, or you could, um, take a percentage... in lieu of the benefits. Um, most of our community pharmacists decided to take the money. Not the benefits...and then when you you become permanent, it was... how do you say, obligatory, it was, you had to take... compulsory.
- Michelle: Compulsory benefits on
- KP: You have to take it
- Michelle: ...pension, I think, and then there was something else as well...
- KP: pension, medical aid,
- Michelle: Oh okay.
- KP: well not medical aid, necessarily, if you don' t have a medical aid but pensions.. and stuff like that. So you actually end up with less.
- Michelle: Hmm. That's... now you see...
- KP: There is 37% extra, hey.
- Michelle: That's right... ya
- KP: 37%... so if you don't join a medical aid, you don't get the benefit, you don't get the money.
- Michelle: Ya. ...And now we've got to remember, because I want to come back to that, because now... I am not sure... how the system has changed since OSD has been implemented. Is there a still a change?
- KP: Yes.

- Michelle: I mean, you do, you do, because you got, you got your interns at the top, now I wanted to say, (participant's name), what I have done, was I... summarised that organogram.
- KP: Okay, one of the biggest things that we fought for, for OSD, and it was my... that was one of the thing that I was really passionate about, because... when I looked at our pharmacists, more than, at the time before OSD, just prior to OSD being implemented... more than 50% of our staff, decided to take out contracts. So they would sign one year contracts, 6 month contract with the department...just because, they wanted then an extra, um, 37%.
- Michelle: That's it. I remember that, ya.
- KP: Right, um... which made it, um... employment very, not employment... like, like skills development and all the things you want to do with them, you don't know if the manager is actually going to renew the contract next year and everything depends on this while process and sometimes the posts are frozen...and then this, and money is frozen. So you have this uncertainty all the time to deal with. But the pharmacists obviously went for the, for the contracts. So we used that as a motivation to change the structure, of the, of the salaries. And we proved to them that if you are not going to change the structure,...then you have to actually pay these people on that level, so that they come out the same as they come out... at the point prior to OSD...Because... after OSD there wasn't going to be any contracts allowed like that. When you look at that...contracts... that you won't have contracts that freely available...
- Michelle: No
- KP: ... you have to motivate, ya.
- Michelle: That's right.
- KP: Which means, more than 50% of our staff had to earn at least a salary more than what they are earning now.
- Michelle: Yah. In order to keep them basically, ya.
- KP: So I think with that, they realised that the package was better option. That's what I assume because that the motivation we put in ...that I'm very grateful for, because a lot of our pharmacists, they are on their husband's or partners medical aids,
- Michelle: Ya... what's with that?
- KP: they don't have a house... they don't. So, if you don't have all that, you actually don't benefit from the benefits.
- Michelle: Absolutely. I agree. So, the option shouldn't be there, basically, from the start.
- KP: Yes
- Michelle: And like you say, if you're in a contract, the development side of you career, falls flat. Because you don't have any progression, or way of earning better, or seeing that and then wanting to stay because of that, you've got that constant...
- KP: And the amount of work for the pharmacy manager involved every time to renew...these contracts...
- Michelle: And also, if they lose the person, the contract is not renewed... to get in a new person, if I from my sides opinion, I suppose it is a lot of work, because they need to recruit someone again?
- KP: Yes...yes
- Michelle: It's a mission, advertise, interview, select the right person, make sure they know everything...mmm
- KP: So the first time the, the, what do you say, the kind of, the first draft, or something of the OSD, that came out... it wasn't, um, we weren't offered, what we call now, a package.
- Michelle: Ya

- KP: We had too...
- Michelle: You had to fight for that package to basically be...added
- KP: Ya, so then we submitted this information.
- Michelle: Not included but added on what they offered, I suppose?
- KP: Ya, and obviously you have to add it on and, I mean, they realised that would cost them money, so it was better just to say, there's your package, do with it what you want.
- Michelle: That's it. Ya, I can see that happening.
- KP: So, I mean, you don't have to put this in, but at least after that, I could join whichever medical aid that I wanted too.
- Michelle: Ya, I won't put it in but...
- KP: ... because you had to, you were forced to... well maybe you can!... with this option, they can actually whichever medical aid that they wanted to...
- Michelle: Yes
- KP: because i wasn't happy with GEMS at that time
- Michelle: Yes, ya, and it depends on what...
- KP: (Unclear), ya
- Michelle: And it depends on what you needing, I mean each medical aid has got something specific...
- KP: I don't like their benefits.
- Michelle: That's what it comes down to, and should have freedom of choice
- KP: I didn't like their benefits, I wanted a plain hospital plan, they didn't have one.
- Michelle: That's it. Ya, I mean, why would you, say for instance, like, I was thinking as well, if I am 30 or 25 and I am coming into a job why would I want to take the top plan?
- KP: Yes!
- Michelle: So I want to be able to go, okay, if I am taking a hospital plan, what's the best priced hospital plan with the same benefits? Doesn't that make sense?
- KP: Yes. And I mean I, I wanted just a hospital plan. I did not want this out of hospital, because there's always issues with it. I would rather keep that money and...
- Michelle: Save it and use it when you have to.
- KP: ... when I have to. Um... so there were various proposals that were put forward.
- Michelle: Yes
- KP: Um... our initial proposal was 2 levels above what we were, I mean... and people said that was... not... not reasonable. But when I showed them, again you are being paid on contract, if you add that in, and if you add that in... And I think it is basically what, what most pharmacists got. The only place where they kind of lost out, is the pharmacist that were kind of new in the- service, depending on where you fell in your number of years, you would get a bigger... increase...then somebody that been...longer in the service that's already on a higher scale. Because when they changed everything, there were like levels and everyone was brought in at the same level.
- Michelle: That's right.
- KP: For instance I was at (facility name) for... I think 6 years,...and there were some people there for 1 year...and we were all at the same level.
- Michelle: Ya, because you would've been, what were you at, were you put in (level name) 2 probably?
- KP: We were put in grade 2 because of our years of service.
- Michelle: Correct. So someone who has just come into 2, and you on the end of that 5 notches...
- KP: Ya

- Michelle: (sigh)...Your salary become one?
 KP: All the same, ya.
 Michelle: Yoh, that a bit of a thing.
 KP: REMOVED (confidentiality)
 Michelle: (Laugh), ya, at least no one can point fingers at you any more, hey?
 KP: Ya, so I think it caused some dissatisfaction because it didn't just happen, it would happen, it would happen at all the levels. So, so some pharmacists would lose out, didn't get such a big increase. Others would get a fantastic increase and others would have people now on the same level as they are when they had much more experience. But unfortunately, um, something needed to be done. But I think it was also done in that way in order to make things simpler for implementation.
- Michelle: Ya, because...you have to have an HR kind of boundary, hey.
 KP: It probably just saves some money...So I think that do save in that way.
 Michelle: Ya...ya, because then they kind of have to give a couple people the larger salaries and maybe the majority takes a bit of dip or, or a smaller salary, so they even it out, hey?
- KP: So, so when people say..."what was your percentage increase?" It wasn't that easy...to say that I got a 5%, I got a 20% because on depending on, exactly on where were, you would have a different percentage increase.
- Michelle: Okay, ya, so its individually...
 KP: Some people would have 30%, and some people end up with a 10% and if you look at it, ya.
- Michelle: Hmm...not so easy.
 KP: Ya, but I think the majority kind of got... a better salary. No body got anything less.
- Michelle: Ya, I don't know, you'll know better. If there were any cases...where, human resources had to, kind of, sort out a lot of nonsense for one individual, that...
 KP: Ya... there were cases where, um, either if you could not find your, you could not prove your years of service...I know we had people working overseas and then coming back and... or people working, um, somewhere, where a company closed. Or a pharmacy closed and now they, they don't have proof of that employment. Um, so they sort of lost out, in that way.
- Michelle: Ya...ya. That could make sense, hey.
 KP: Ya, so if you ask about an increase, there, it wasn't a, where you could say, oopsie, it was a 20% increase for everyone or a 30%, because everyone...
- Michelle: Ya...No. I remember they did do a, did they have a single sort of increase, there was one, oh, it was because we had a delay of the OSD. I remember there was, it was supposed to be implemented... and then it wasn't and we were a couple of months behind and I remember they gave 5%...
 KP: Okay was supposed to be implemented, I can't remember the exact date...
 Michelle: Ya, this is the thing....
 KP: ... at a certain time...
 Michelle: It doesn't matter about the exact date...
 KP: ... and then it wasn't because nothing was finalised.
 Michelle: I have the exact date somewhere, but
 KP: And then what they said instead of giving back pay, from that day onwards, they are just going to give everyone a lump sum and they are gonna start from there
- Michelle: Yes, that's correct. And that makes sense, because you're going to back pay, I am sure it would've been way more.
 KP: I would've been a wonderful, wonderful, it would've been wonderful.
 Michelle: (laugh) a fabulous thing!

- KP: (laugh)
- Michelle: It would have been fantastic for us but I think the government might of felt like they were nipping...
- KP: ..out of pocket...
- Michelle: ...and where would they have found that budget, that money in the budget, actually.
- KP: Ya
- Michelle: I mean, they could probably have moved it from some somewhere else but we don't know that, hey.
- KP: Yes, um,
- Michelle: So you would say, that it's,...um, the previous structure, okay, where there any positive things about it at all?
- KP: (Pause)
- Michelle: I mean, as far as grading, it was on levels. Was there any specific, because now this was the other difference as well...
- KP: Look...
- Michelle: ...was there anything, 'cause now it works on years of experience, there wasn't anything like list of skills that you had to have on the last, on the last structure, or anything like that? Was it very similar to this structure in that way?
- KP: Ya, I mean, the previous one, (pause), I mean, the only thing that I, I could maybe say (sigh), that a little bit different to this, where here they defined, your years of experience, when you go into these levels...
- Michelle: Yes
- KP: ... where as before, it wasn't this clearly defined. so if you wanted to be a (level name), you didn't need so many years of experience.
- Michelle: Ya, they didn't say for sure how many years, I think? Did they specify what skills you need to have. I don't know, this is the thing I don't know.
- KP: Because, that is what, what also caused the problem for us, because, um, your, your higher levels, you could get paid the same amount for taking less responsibility. so, you are not going to apply for a post with more responsibility or whatever. So, what happened was that people, like very um, I don't want to call them inexperienced because, we are all pharmacists, what would be a, um, with, with less years of working experience, for them it would be a jump to go to, maybe a supervisors post. For them it would be something...something great, so they would, would apply for it. So we land up with a situation where you would get younger pharmacists becoming the supervisors and the older pharmacists, just, coming to work.
- Michelle: Ya, because they're in production roles but on, in well paid production roles.
- KP: So...well paid... yes.
- Michelle: Like in grade 3, or whatever.
- KP: So, they would not be interested in supervisor pharmacist. so that was another negative from the first ones. For instance also, in other provinces, not so much in our province, but the other provinces, the head of these positions would be, um, occupied by pharmacists that did not go through a process before they got there. So, they don't understand some of the HR issues, some of the pharmacy issues, because... the people with the experience that should do that job, they weren't interested because there was very little difference in salary.
- Michelle: Mmm
- KP: So you have these... inexperienced or, or less experienced people being in positions of...
- Michelle: Decision making importance, hey?
- KP: Yes
- Michelle: And they need to know?...

- KP: Policy and stuff like that.
- Michelle: And they don't know anything, I suppose? Or... far less?
- KP: so that is what it created in, other provinces, like I said...not so much in the Western Cape.
- Michelle: Ya
- KP: Um
- Michelle: [00:25:30] So, Um. Now I am just thinking about what you said then... but ya, I don't there is anything that you haven't highlighted properly. Okay, now, you were saying about the overlapping. Because I remember there's overlapping. Is there still?
- KP: Yes.
- Michelle: Production and supervisory overlap of salary? There is about 5...
- KP: 5, 5...
- Michelle: ...notches, hey?
- KP: Ya, Um, sort of, a previous proposal they had before this, they had 10 notches overlapping.
- Michelle: That's right. I remember you said that, And they reduced that, because that's a big thing.
- KP: Ya... they then made it 5, ya. Ya because that was now really ridiculous. Why would you then apply for the supervisor manager post and their reason was that, um, some pharmacists are interested in clinical stuff, other pharmacists are interested in management.
- Michelle: Yes
- KP: So you can go both streams, and you can be remunerated, but I think in reality, it doesn't work!
- Michelle: No, okay that's what I was wondering .
- KP: Because, because if you work for me and I earn the same, and I've got to give you instructions and whatever, you're going to not...
- Michelle: You're going to clash in the work environment...
- KP: Yes, you don't see the person as a manager.
- Michelle: yes...yes, perhaps the respect thing becomes a problem?
- KP: Or...I don't know...yes. I mean, I just saw that, I don't know if it's reality...
- Michelle: I've also seen that...ya.
- KP: ...but I've seen that happen. And I've seen people say, "why must I take on that responsibility?"
- Michelle: That's the other thing, like, there's a lot of really experienced pharmacists in that level 3 productions, now.
- KP: and they won't move!
- Michelle: And I am thinking, there is some supervisory pharmacists that are going to retire soon or move out. Now, the perfect person, wouldn't that be that production pharmacist grade 3?
- KP: Yes
- Michelle: But I, but I know they won't move, And why, because...?
- KP: There's no benefit.
- Michelle: Ya, and supervisory come with a lot more responsibility.
- KP: Lot more responsibility, lot more responsibility, lot more work and it's very difficult to manage staff. It's not easy. And, and also what also they don't realise, even though you're a manager, you need the skills and the experience, to know when something is wrong, to know what systems to put in place so you need that experience...you can't just say, "okay, well, I do a management thing, you do a clinical stuff." You need the clinical knowledge. So for me, it was more of an obstacle to creating a proper career path where you can get the right person into the right post. It actually created, a, the reverse, Because the

people that would find that post attractive...would be pharmacist's on a lower salary level.

Michelle: yes, because they are thinking "well, I can just skip all the years of experience and get the better salary"... and that makes sense to me

KP: Yes.

Michelle: Tjoe.

KP: And I think that, I think that, you know a lot of pharmacists, for me, I feel that if, you do a certain job, you get paid for it. And then at a certain point you reach experience where... that additional experience, contributes minimal, and I think that where they put a cap on your, on your salary. Right, so now from there on, there needs to be, to be a... be something where your next level, which will force you to go into the next level.

Michelle: Ya. so in other words, um, yes...

KP: That they didn't create that.

Michelle: Ya, because what you want, like you said, is that your most experienced senior pharmacists to kind of, now...they are forced...they've gotta take that. The other thing is, (participant's name), what if the person isn't really management material?

KP: Then, that is what they do. And... and they are being paid for what they do. so, even if I am here 30 years, I am still, doing this. And at a certain point, you do develop...your additional experience that you develop...I would say, it is minimal...

Michelle: But, do you think naturally if you're in a higher, normal, normal production post, that naturally all those years, will allow you to have... some, idea of interaction with other staff and...management...

KP: Yes, that is why you move up

Michelle: That's why you should, though, at least.

KP: There's, there is clearly a difference between an experienced pharmacist and one without experience.

Michelle: Ya

PART 2

KP: [00:00:01] they tend to work faster, they pick up things quickly, they, they are definitely better.

Michelle: I am just quickly checking this 'cause it does it in... it's perfect! It does it in half hour segments.

KP: So experience contributes! There is no argument about that. But you want that experience then, to become also a mentorship. And when do you become like that? When you become a manager. You know. um...and I am sure that if that people don't want to become, managers, there will be enough posts for them to remain where they are but you must remunerate the person that takes that responsibility.honestly, I feel that, um...I think a lot of young pharmacists wanted the difference in pay. A lot of older pharmacists wanted. um... they were happy with it overlapping. They prefer the overlapping.

Michelle: Ya, obviously and like we've now been talking about, it's because of this issue that those pharmacists think that, you know like I am 5 years from retirement, why would I want to go into a supervisory role now.

KP: Yes... ya

Michelle: It's going to be very stressful, and then obviously the younger ones would want that to be able to make that just fast in life and actually be on a better earning level.

KP: I mean, I don't know if it is important, but I fe... the only way we can negotiate our salaries is through the unions. And, they don't have much experience,

dealing with unions, and unions and unions don't have much experience of our...work and what we see as appropriate. And, and if I've found it's sometimes difficult to explain, why this is different and why this is a different calibre of person...and, and that union member must, go and talk for you in the bargain chamber. So he needs to be adequately informed and I feel there was no process and it was left up to us, to find our unions and deal with them and inform them and make sure they - you know, which I think was a, was not really a, a (unclear) process.

Michelle: maybe not fair, a fair process.

KP: Ya, the doctors, because they were a bigger group and they had, I think they more structure, and they had more support,

Michelle: Mmmm

KP: ... they had a lot more support and, and so they could manage this process better. You get smaller groups like, EMS, or, EMS was it. Didn't get out of it so badly but you know, radiography and obviously those groups... they, they don't have

Michelle: ya, they are small groups

KP: Ya, they're smaller groups

Michelle: And not recognised, maybe, as well

KP: So for me, is this really the right way to, to maybe negotiate?... yes?

Michelle: To handle professional... it's a very good question.

KP: So for me, that, that was, like really sad to see that, and, and you, you at no point... almost could give input. On, a... management level, how do you say, what was what. Um, ...the managers... well I dunno how this is going to come out but, the managers very often didn't want to get involved, because they said it's between HR and the unions.

Michelle: And it can't be because you need the people with expertise

KP: So whatever happens at national, where somebody's got to allow the voice, or whatever with... and and I just felt there should've been... if management was more interested in, retaining their staff, there should've been a greater interest in, is the proper career path for pharmacists. Not for us to convince a union. That this is a proper... I, I just felt there was a link missing there. Because, when they developed the structure, there were all these things that we brought up and we said, this is going to be a problem and that is going to be a problem and this is going to be a problem, but there was nowhere to take it except for through the union.

Michelle: Yeah, and that is, ya I was actually going to ask you about, about your personal feelings, or you personal opinion about that implementation process, and that process when, when you were designing. You're actually giving it to me. This was a big thing, hey?

KP: It, it was, it was a... ya,

Michelle: The negotiation process.

KP: Hmm, I mean we had to organise ourselves, we had to get pharmacists together and say, "look, what do you want?" There was...

Michelle: And, this clinical, who suggested the clinical...?

KP: pharmacist...

Michelle: Ya

KP: I mean that was always on the books.

Michelle: Ya, so it was something that was spoken about among all the, the kinda manager pharmacists

KP: Ya... the chief pharmacists...ya

Michelle: Um, as a question now, 'coz now I am very dumb on this, this is why I need your, your ideas. Who sits in these management roles. Is this our,

- um...(pointing to the organogram), it says assistant manager, pharmaceutical services?
- KP: Okay
- Michelle: And you deputy manager pharmaceutical services, and your manager pharmaceutical services.
- KP: Yes
- Michelle: And your senior manager, who are these guys. I don't even know who they are?
- KP: Okay, an assistant manager... they have decided, because, when they also, before they could introduce this they wanted job descriptions...and I think Western Cape contributed a lot, because we, we really took our pharmacy services seriously. We went out there, we saw what people needed, what the need were, what kind of structure was then needed in place, um so...
- Michelle: So, the job description was for all the, all the...?
- KP: All the levels.
- Michelle: Oh. oh wow
- KP: Right
- Michelle: Okay, so, so for everyone.
- KP: Ya... so we had to, sort of a generic one for uh, uh pharmacists grade 1, 2, 3, then your supervisor, one of the additional roles and an assistant manager. So, an assistant manager would be.. a...a manager of a, ...regional hospital or sp...special(trail off). It was regional but some of the hospitals became district hospitals. So we still kept them assistant managers. So if you're in a hospital, you're an assistant manager. We also wrote in that, bigger pharmacies, like Mitchell's Plain for instance...should have an assistant manager. Because... their budgets are as big as, could be Eerster River, I, can't say definitely but there are some of the district hospitals...depending on the patient load and whatever, so we felt that it was not acceptable. So, so assistant managers, sort of, the manager from hospital, I'll put...Deputy manager, is, sort of, uh...
- Michelle: That's the deputy, is that the deputy director? So your...not yet, hey?
- KP: It... the deputy director, all that fell away. They still sometimes call them... Deputy Directors. What they, they all became managers.
- Michelle: Senior manager...not
- KP: Manager
- Michelle: Just normal manager, okay
- KP: Of pharmaceutical services. So, they're the district pharmacists' managers.
- Michelle: Okay. You see this is the thing, I am trying to figure out where these people... these people, people are using titles, when we talk in pharmacy...
- KP: Okay
- Michelle: we use titles that don't fit into this structure and that's where my problem always comes in, you know?
- KP: Okay... so a deputy manager... was, sort of, a, a DD, and let's not talk about a DD.
- Michelle: Yes
- KP: here were 2 levels in the old, um, structure
- Michelle: Yes
- KP: It was a, a 11 and a 12,.
- Michelle: Yes
- KP: So all our district managers, and our managers of tertiary hospitals, became... the 12
- Michelle: Yes, 12's?
- KP: All the 12's became managers. And all the 11's became deputy managers. So the only deputy managers we have in the province, is at (facility name),

because they're a smaller tertiary hospital. And I think there was a post at the (facility name). And I am not sure if they kept the post. Uh, there were 3, I don't know where the 3rd one was, but there were very very very few. I think there were about 3, I don't know where the 3rd one was. So, so this is your hospital managers (pointing to organogram). They were the chief pharmacists and ten level... 10's.

Michelle: Okay... yes.

KP: It's like, it's like I almost wanna write that there.

Michelle: Chief pharmacists on level 10. You can write it! Please do.

KP: So this was the old chief pharmacists

Michelle: Ya... here's another one. Try that one (handing over new pen). That's why I've got a back-up.

KP: This was the... the chief pharmacists and they were level 10. Then the deputy was level 11, and they were called like, deputy directors level 11. Then you have a deputy director... level 12.

Michelle: Ya. Level 12, you see this is the thing it's...

KP: Right...And then , the senior manager. Now this...we don't have that post. This is, what in other provinces, is like a director level. Kind of, but I think it is even more, you are actually basically more than a director level.

Michelle: So we don't have them in the Western Cape? We don't have anyone on that...

KP: We do have, um... so when they initially did the negotiations with the OSD, that wasn't on. And that was another thing we motivated for...Because we felt that... um, in other provinces they had a director of pharmacy services. At the time of the OSD [00:09:36] we didn't have a director. I don't know if you can remember, we have a director now. We didn't have one.

Michelle: I know you have one now, but I wasn't sure... you said, I know you said something about that but, ya.

KP: So, so in other provinces there were director pharmacy services, um...and, and, that was supposed to fall in there...and...um...so...some believe that is what you call senior management and that is not part of the OSD.

Michelle: Okay, so someone, they believe, they, they're out of the pharmacy, kind of, role...

KP: And then I think that, I don't know if this did it, or if they just decided to change their minds, but, um... there was a week that I acted for (name)...(laugh), and I wrote to national...And I explained to them what is the role of, this person and even though, we don't have one but, but as a director of pharm services this is your role, whatever and whatever, and then they included it last minute.

Michelle: Okay. Wow.

KP: Right, but... because it was so last minute, there wasn't time to, to comment on it and fix it. So, basically, what is said that, was that, if you are already in that position, you can...you can, translate

Michelle: Keep it, ya... translate it, okay

KP: If you don't have the position, it's up to the province [00:11:03]...so we still didn't have one and we eventually with, whatever, whatever, we now have one.

Michelle: Yes

KP: But I think the OSD document says that this person should be a pharmacist...for you to fit into, or not or, to fall into the OSD, you need to be, registered with a professional, you need to, to require registration with a professional body such as the pharmacy Council...in order to occupy your post. Ya... So if you don't need that for a post then you're not part of pharmacy.

- Michelle: Exactly
- KP: And I think we, we also said that this person, because this person, will fight for us at pharmacy council, will do this and this and this, they must be a pharmacist, they must be registered with pharmacy council, because there's no point being a pharmacist and you're not registered, which means you're not really accountable.
- Michelle: I agree, ya, 'cause how can, how can that person do any, um, communication or or whatever for you if they don't actually understand the nitty-gritty of what's happening within the structure or be a, ya
- KP: Yes... so eventually after the OSD they decided that,... just a bit of history. We used to be a directorate with the, depo and pharmacy services. Then they decided, nooo, we don't need this anymore. They took the depo away. They put it under supply chain. And they took us and put us under professional support, so we lost our director... (unclear)...Now they've decided, that wasn't right, let's bring it back.
- Michelle: Okay
- KP: So now they have put the depo back in and the CDU and whatever and now we're a directorate, again.
- Michelle: So when they separated the two, where did your director go?
- KP: Our director had a choice to go to... professional support, because there wasn't a director there, because they put medical-legal, radiography, laboratory services, pharmacy, all these professional services with a director. Okay, or forensic services. Forensic services was a new service that health took over...which I think was under the police before or something?
- Michelle: Yes, that's correct, ya
- KP: it was a new service. So our director, was a pharmacist, chose forensics. And we went under, 'cause there were these two people who could chose, because they were now the additional people.
- Michelle: Yes
- KP: DELETED (Confidentiality)
- Michelle: DELETED (Confidentiality)
- KP: DELETED (Confidentiality)
- Michelle: Its so...technical as well, you know
- P: So now, ya, then they separated these two out again, professional support services there and they took us out and made us a directorate again
- Michelle: Yes
- KP: ...she could choose, whether she want to stay at professional support or whether she wanted pharmacy, and she chose pharmacy.
- Michelle: So is that who your director is now?
- KP: (Yes Nod)
- Michelle: Okay, I see, so this is the thing.
SECTION DELETED (confidentiality)
- Michelle: But it is important for me to get a feeling of how you guys are feeling as a group.
- KP: Yes... ya... so I feel this is part of the OSD and part of implementation.
- Michelle: It is, because this is the most senior position on that side of the OSD besides this position here under policy specialists your, that is the other important, the senior pharmaceutical policy specialists. Am I right, this very last position?
- KP: Yes
- Michelle: Who falls in that?
- KP: This level, is exactly the same as that level.
- Michelle: Is it.

- KP: Sorry not that one, this one (pointing to organogram), okay, those are the same levels. And the way I initially first interpreted it was, that, um, senior manager pharmacy, oh it's, no it's, senior manager pharmaceutical....
- Michelle: Senior pharmaceutical pharmacy specialist.
- KP: Okay, ya. So, so I saw this as a manager of the policy specialists. Which would probably be, like, you know (Name) was now our manager. So now I would see her as that person. But she's got that title (pointing to position).
- Michelle: So it actually is a, It's a bit different
- KP: So I saw these managers as being out there in the services and this being the manager of that...
- Michelle: I also thought that
- KP: And then that as being the director.
- Michelle: ...and that's the director of everyone, basically as well.
- KP: Yes, but, but they have made, that is a manager. So, so the senior pharmaceutical policy specialist, I don't know what, what that is at the moment. We don't have such a post. There's no post like that in the Western Cape. No post in Western Cape (writing).
- Michelle: Okay, so it's on the list but it's not here, basically.
- KP: Ya, so, I mean sometimes they would talk of, okay now, if you were a pharmacist policy specialist with more experience, that people referred to, maybe you can be the senior, ya. But it's not yet defined, and there is no post and I think...
- Michelle: So most of you guys on, policy specialists are sit in grade 2 at the moment.
- KP: Ya, we are all, ya
- SECTION DELETED (confidentiality)
- Michelle: Shame. What's your schedule like, [name]?
- KP: 3...
- Michelle: 3 o'clock?
- KP: Is 3 fine?
- Michelle: 3's fine, so then we need to move quickly.
- KP: Ya
- Michelle: Okay, so, okay when we implemented this, we, now on the reward side of things, 'cause this is all about remuneration, hey? Okay? So did we think, how did, we structured the package but the package is very just kind of financially driven. Do you know if there's another side to it as well? Like, um, values side, Like what pharmacists wanted? An example would be, I know that we're supposed to have a...um, yearly, what's it, SPMS, so with the SPMS, how linked is that to this?
- KP: I think in terms of the Job descriptions, it's linked, in terms of your output and what you're supposed to be like, that. I mean in terms of values, pharmacists that work in public sector, I think... they want an adequate salary... but then they are there for other reasons. They are there for the hours. Uhhh, they are there because of... the exposure, they are there because you can get, you, it's a different environment to the...some of them feel that, they learn more there. If they can get involved in projects and stuff like that, so I think pharmacists that actually come to the state, they want more than just, just
- Michelle: Yes, more than just money
- KP: ... and dispensing
- Michelle: Ya, money and dispensing. So you think, the position is challenging, well the position for pharmacists in the state is challenging, I think. Am I right to say that? Do you agree with me?... or is there some positions that are not so challenging...and...

- KP: I think since the OSD, things have improved significantly. Um, I've had calls now from pharmacists saying they are struggling to get back into, into the state and the people that have left, and they're struggling to get back into the state. I've seen us recruit very good pharmacist now. I've seen us recruit passionate pharmacists, um, and they, they appreciate what they've got. I've seen a lot of the pharmacists that have left that's come back..You know, you know, so it has, it had an impact. Um, ya, and and, but I think that, that other things are important as well
- Michelle: Yeah, I think so as well, so
- KP: but the basic thing was to get the money right... and then we can look at all the other stuff
- Michelle: Yes... yes
- KP: That was for them the most critical part of everything... ya.
- Michelle: Ya, and I agree with that as well, that's ya, I just, um, the nitty-gritty was always the problem for me so, because in order for to have , to get a promotion, you would have to have the number of years experience but I suppose...
- KP: in honest
- Michelle: Ya, and um, but you couldn't just, you can't just hop over promotion with just number of years of experience, I suppose you have to have skills as well? to meet the requirements...
- KP: Well, obviously they will obviously do that through and interview and a CV
- Michelle: So it would be formally done
- KP: The initial, even after the implementation of the OSD, the initial, document said you must have 5 years. They've now reduces it to 3 years.
- Michelle: Yes
- KP: And they have done it so... blanket 3 years that even to become that (points) or that (points), is 3 years. You see, so everybody is 3 years, so you could have 3 years. Now they start changing it to appropriate experience or whatever, whatever...
- Michelle: So they are trying to change the wording a little bit in order to make it easier
- KP: ...to find someone with appropriate experience and then they will ask for management experience. But I think, that because of the fact that, uh, pharmacists had to wait so long to , to be able to apply, they've made it 3 years. So they've reduced that, um, I think that if there are exceptions, you can write a motivation if there's nobody else that applies or something like that, um, but in most cases they do get people. And um...
- Michelle: Ya, that's perfect. Okay, let me just think about that, think about where we are at. Okay, so where do you think we need improvement still? In the structure, in your opinion?
- KP: I think that, in the career progression, um, in terms of... I think that overlapping must just be re-looked at. I know there people that, that, that feel that, you know I've got the same experience as a new manager, we fall on the same, but I think that to wait another few years to actually earn more when you're going to manage that person [00:27:45], and I know maybe the experience counts for a lot, but I think managing staff, is one of the most difficult jobs...that you will ever have.
- Michelle: Yes... it is the number one challenge...as a pharmacist
- KP: You need to know your stuff, you need to know you clinical stuff, you need to, you need to know everything. Unless you want to be a manager that doesn't know anything, and let your pharmacists do everything and you just...fill in rosters and stuff, which I don't think we want our managers to be. So I think that is one area.

- Michelle: So you're saying, okay, when it comes to management positions, the most important, well, there is so many things but, just to summarise what you are saying, besides having management skills, you need to be an excellent pharmacist.
- KP: You need to know your stuff... you need to know the stuff that you are going to...
- Michelle: So if policy, if something happens in your office and gets handed down, who's the first person in the pharmacy, the manager. And the manager must be conveying that, not the other way around.
- KP: Yes, yes. And the manager signs off your work, so must know the work as well. You now, must know it's correct, must be confident...
- Michelle: Yes, yes. It's quite a challenging position
- KP: It is, yes!
- Michelle: This is the thing of being a professional and a manager at the same time
- KP: Yes. You need to know you stuff. Because if, if I've got a problem I need to be able to come to you. Um, and you need to know when I do something wrong.
- Michelle: Ya... absolutely
- KP: You know
- Michelle: To say, woah, woah, woah, you're on the wrong path here.
- KP: So, so number one, it's the overlapping, I think for me, is a problem. And then I think, It must be structured in such a way, that will encourage people to actually move through the stages. Because then they've got a longer career path. And, not a well, this level is the same is that level so when I've reached that level, there's nowhere else I wanna go so I won't be interested to become a policy specialist. So that person might be interested to jump there (pointing)
- Michelle: Uhhh, I see what you're saying, yes.
- KP: So, but you want that person to come or you want that person to come (points), because they come with that experience.
- Michelle: Yes
- KP: So it must be structured in such a way so it actually encourages, moving through the levels and not wanting to jump levels. People think you can pick-up these things very quickly but you actually make bad policy if you don't understand. I've seen really bad policy out of there and then I think...

PART 3

- KP: [00:00:00]...and tell them that this is wrong, whatever, then, uh, no you're obstructive and no you must try new things but
- Michelle: It's not actually how it works, hey
- KP: Yes, so you can develop really bad policy and I think policy specialists, they guide...they should know what they're doing. They should have experience, personal experience.
- Michelle: So if you, just a suggestion, if you were going to come into policy specialists, do you think that person should have been in a management position in a facility at least
- KP: Definitely, because...
- Michelle: Ya, because then they've dealt with all the most important things
- KP: Yes...ya
- Michelle: ...that are going to be addressed in the policies
- KP: ...there's disciplinary action you've dealt with. If there's how to recruit staff, how to appoint staff, you've dealt with it. If it's how to manage late coming, you've dealt with it, you know what I mean.
- Michelle: Absolutely

- KP: if there's a mistake or an accident or there's difficult Doctor, or there's a whatever, you've dealt with it
- Michelle: ... you've dealt with that
- KP: ...on a personal level, and then, and, and, it just makes you, know there's something to, to work towards,
- Michelle: Yes, absolutely. Ya, you are inspiring the thoughts and this is the thing, and I need to know these things, okay. So,um...okay you've already explained to me how you can move between the career paths...in a way, so that's not a problem, okay. You've told me who's kind of in the positions that I need to know. Right. (long pause). Okay so, now for, because you know I'm going to go to the, the people I really wanna hear from is the production and supervisory pharmacists, because the rest of the people, yes, and that can be another task at another time, because they are very important. Those management, those middle management, everyone needs to be heard. But, I think the thing for me is, when you're in a production, and especially if you're a junior, sometimes you don't know where your life is going. You don't, in a sense of career life. You have no idea.
- KP: What you want from it.
- Michelle: Ya, you're not even sure, at at uh,... do you think, do you think junior pharmacists have a really, can they actually visualise this? I don't know?
- KP: I think you've got different, you can have different interests at different times in your life. I mean, I never wanted to sit in an office. It was just not me, you know. When I was younger. I liked the mixing and the seeing of patients and meeting doctors and, that was me. Please don't put me in an office. Um, and, and, as you grow older and, and you realise, you want to this or you want to change that...
- Michelle: Uhhh, something more or, different, hey
- KP: You actually become, in that job you feel there is nothing more you can contribute. You know?
- Michelle: Yes
- KP: Uh, then I thought I would take a chance at (facility) and see. And initially it was frustrating because, things take so long to happen. But afterwards you realise that, whoa, I know this so I make good input here, or I know that, so actually made good input here. These people that sit here, they, they don't know. You know? So, So you, um...so I think...
- Michelle: You personally learning something
- KP: ...you develop all the time...
- Michelle: And you're helping also develop, helping with the development of others that are in other areas...
- KP: Yes
- Michelle: so it's very fulfilling
- KP: you develop the pharmacy services in the province...
- Michelle: Ya
- KP: ... and you can say what you like, but I can tell you that, pharmacists will always look for something that will...
- Michelle: Something more
- KP: If you make, look, if you stop people from growing, they are going to become miserable.
- Michelle: Ya
- KP: They are going to become, what's the word...
- Michelle: complacent...or what's the word.... bitter

- KP: they become complacent and and they become, niggly and they become, you know, but they can complain, if they like. Oh, this new and what whatever, but if that new things come
- Michelle: ...doesn't come...
- KP: And also develop me and and moving somewhere, then it's a different ball game, um...
- Michelle: and do you think the supervisory role, um, in big hospital is vastly different to the supervisory role in the community health centres?
- KP: I think, it's not vastly different, But I think, some people say it's easier...
- Michelle: to be where? In the hospital?
- KP: In the hospitals, um, when it's in the community health centre, you're kind of, you've gotta look after your facility, um,
- Michelle: ... more widespread...
- KP: ... talk to council, do, do lots of other things, like more responsible stuff, whereas in a hospital, you maybe supervisory for your pharmacists, and that's it, but all the other really, um, serious managerial issues are seen to by, an assistant manager, or deputy manager, you know what I mean?
- Michelle: Someone else that's in the hospital that take responsibility...
- KP: Ya, that takes that responsibility
- Michelle: Whereas I ya, so you, are you saying the, the pharmacist in the community health centres are really more in-touch with what's happening in the whole facility?
- KP: In the whole facility, yes.
- Michelle: ya, as opposed to to just being in their corner in their pharmacy.
- KP: Ya, I I think they have more experience, like if, if, something is broken, they must get it fixed. If council comes to do an inspection, they must, it's their responsibility to sort it out ...to register their learners, it's...
- Michelle: It's a lot more in that sense
- KP: It's a lot more. In the hospital, I think you, your role is maybe, just a little bit more, maybe a bit more technical, or clinical or whatever.[00:05:29] Um, um , I am scared to say that it's, it's easier, because I think the pharmacists will probably kill me in the hospitals...I think they...
- Michelle: We will ask the, the supervisors their opinions... because I think that they must say...
- KP: I think that... there is more responsibility attached to a,..
- Michelle: I was just asking for, just for the sake of getting an idea of, if you are a production pharmacist, say for instance you want to go into a supervisory role, now you've got your options so what will people choose...
- KP: Where would you go?
- Michelle: Ya, this is the thing. Availability, I suppose would be the first factor because not every position is always available, I mean, There is not many of them, so...
- KP: I, ya, I think that the hospital one would be easier.
- Michelle: Ya, probably, maybe, probably, hey?
- KP: Probably would be more problematic, but some people want to be their own bosses.
- Michelle: That's the other thing as well.
- KP: They might prefer that freedom
- Michelle: Yes... yes.
- KP: ... you know, of, I can do what I like, and I can sort this place out. You know it's a lot more freedom. which it's nice.
- Michelle: It is, yes. so, you, um, 'cause, I think what I found from personal experience is that if I've got, it you've got a good manager in your facility, you have , you, that person helps you to have a vision for you career. But if you've got a really

lousy manager, you can't really envision this. I mean I couldn't see that there were other options for me, because I had a really hard time. Not mentioning any people, but I, I do remember that there was a time that I thought, am I going to stay on production level 1 for the rest of my life and just be thrown at the window and just deal with the quantities, or will there be some other stimulation. Because I think, as you were saying, pharmacists need stimulation and change. I think it's something in our character...

KP: I think any person basically, you know, um, I, okay now I am going off the point again...

KP: DELETED (CONFIDENTIALITY)

KP: Because I think it's gonna make you miserable, Where are you going to go, what are you going to do...

Michelle: (laugh)

KP: ...because I want someone that's motivated here, and you're going to become miserable, so what do you want?

Michelle: Ya, have some goals, hey?

KP: Yes, so, I mean the one guy that now studying and whatever, because I want them to move on. I think that what any anybody needs to do, and that is why I would really like to see a career path that is just, that allows, fl...

Michelle: A little bit more, a...

KP: It's quite a flat structure, in a way... ya.

Michelle: Ya, okay. Ya. And this clinical (pointing), remember we were talking about clinical. Do we have anyone in any of those positions yet?

KP: Um...

Michelle: Still not really, hey?

KP: Not, not yet. I know (facility name) once mentioned to me, about a week or two ago, that they have created a clinical pharmacist post.

Michelle: Yes

KP: Now I don't know what that means and what they've done and they will probably be interviewing soon. And, um, and obviously you must have a certain qualification to, to apply.

Michelle: Yes, yes and I suppose we have to wait for, for the academics to get to the level where they've opened up... there has I know with Rhodes they've got their degree. And I know that UWC, is con..., is, is talking about how they would structure this course and who would be the person to run it, because that's the other thing, the person that comes in there, needs to have clinical skills of a very good degree...in order to, in order to teach other to be clinical pharmacists and then also, you would need to have probably, the clinical pharmacist will need to have, like a number of years, like it's on there (pointing) in a normal post before they can move over... plus the qualification. Or is it...?

KP: I mean that, that, I must have admit I haven't given it much thought.

Michelle: I haven't either

KP: But the clinical pharmacist, I think, I think a lot of, I see more pharmacists doing MPH's and stuff like that, because I think there are more opportunities in that way, um, and, and they' see less opportunities as clinical pharmacists.

Michelle: ya

KP: ...and I think that's the only reason why they don't train like that because where do you go from here, and, and

Michelle: ...because there is nothing, really, at this stage, that's...

KP: Ya. So I think, I think it depends, I have not seen the job description, but I think it depends what you are actually going to do. Because if you are going to be involved only on the wards and giving advice... it ,it doesn't say , I don't

- know, it doesn't say anything here about experience, does it? Minimum of 5 years appropriate experience after registration with pharmacy council.
- Michelle: Uhhh, you see it's appropriate again...
- KP: ... and clinical
- Michelle: you see so we're talking about this word appropriate...
- KP: So that means, that means you must have a... so even if you are qualified as a clinical pharmacist, you can't go into the post, like I said all these 5 year's (pointing) were changed to 3 years, so this thing is a bit outdated...
- Michelle: [00:10:02] ya, this was one that I took from a while back, ya. So it will be, it should be amended
- KP: (unclear)
- Michelle M: it's based on, it's based on the 2010 one, you see?
- KP: Hmm
- Michelle: based on annexure A2, resolution 1 of 2010.
- KP: So we must actually look, or maybe you can check what is the entry requirements... of that
- Michelle: Of the clinical...
- KP: Do they actually want some experience, but...
- Michelle: I know, I think, I suppose someone that might have... (Name) might have information...
- KP: Hmm
- Michelle: ...on that post, I don't know.
- KP: Because, um... I mean I know pharmacists that work a little bit and then they go back and they study...but somebody might decide study straight and then they're a clinical pharmacist, do you employ them?
- Michelle: and, then, ya, this is the thing. Do you employ them first as a normal pharmacist, or straight into clinical?
- KP: Ya that, that I don't know. I can try and find out.
- Michelle: Ya, ya, so. Okay, then ,um... so let's, let's actually just, I think we, we basically got what we need. I will, when I run through this interview again, if there's any questions (Name), I am going to ask you via email, just to clarify one or two things. Um, but in your opinion do you think that our goal to actually recruit people and keep them...And, could we use this as a motivational structure as well? I mean it's supposed to be, because that what you said about the path.Or motivate people to get their goals done so they can move into new positions. Do you think it could be a motivational tool as well?
- KP: Yes
- Michelle: Ya, I mean the organogram as such, you know. Not the organogram, the fact that there are positions there. Would you consider it motivational or is it really just recruitment and retention? Because I mean there is promotional...
- KP: Look I, I, there's a lot more opportunities here, then there was in the past, um, and all the, all the different levels. But then if you look at the number of all those posts compared to the total number of posts in the province, um, I don't know if this was...
- Michelle: Ya, that's not the post number, ya
- KP: Salary notches, ya. I think if you look, if you go and look at, how many posts there are for these people (pointing) there are few, compared to our number of pharmacists.
- Michelle: So...
- KP: So in a way....
- Michelle: And that's for management kinda...
- KP: if you say motivational for... there are only so many posts, okay.

- Michelle: So if you're in a production role, you need to be motivated by something else, not necessarily just be motivation. Am I right to say that? I mean is not, this is only a small contributor to all other things, the salary, like you said...
- KP: The OSD... I am quite sure what you are asking?
- Michelle: In a sense that OSD is a, a promotion structure as well, in a way, It's kind of a foundation for where you are going, because it's a career path thing.
- KP: Yes
- Michelle: I know you won't use this...
- KP: But I, I don't think it's an ideal.
- Michelle: No
- KP: It's not, not ideal, it has its value but I think there is still a lot lacking because if you look at the number of posts that's available for promotion, it's, um... there are few
- Michelle: It's really all sitting top heavy...
- KP: Ya
- Michelle: Oh, Oh well, bottom heavy, I mean
- KP: Bottom heavy, and so if you're already there (pointing) then whatever
- Michelle: Ya
- KP: And I think there is a a looong, like, a really loooong stretch of notches, 16 years, 13 years and then you kinda done after 13 years, then you have another 5 years.
- Michelle: So it would be 20 years before you kind of can move into anything
- KP: I think it, it has improved
- Michelle: Uhm
- KP: and it...has its value but I think it can be improved further
- Michelle: Definitely
- KP: to put it like that. Um, the policy specialist post, I feel, really can be looked at, because, um, (CONFIDENTIAL) and then I think there are other posts such as, I don't know if you know (Name)?
- Michelle: Yes, I do know (Name), yes.
- KP: She does...
- Michelle: I have heard of her name, so, I'm just trying
- KP: DELETED (CONFIDENTIALITY)
- Michelle: Yes, that's right, yes.
- KP: Ya, so she does that, and she's been (CONFIDENTIAL)
- Michelle: that's right
- KP: Um. and then there's, um, the (position), (Name), from the (division), I mean policy specialist.
- Michelle: yes, that right.
- KP: There was a post now recently for a cold chain manager post, that they've left at a pharmacist's level. Which I was thinking shouldn't that be another, another policy specialist, because then you looking at vaccine, vaccination, vaccines across the province. I mean ARV's, vaccines, what's the difference.
- Michelle: Yes, they are all in the same
- KP: it's across the province...
- Michelle: If the one is a policy specialist, why not the other?
- KP: Why the other, ya?
- KP: But they left it...
- Michelle: So there is actually some more post out there besides (CONFIDENTIAL). There's other ones, other people?
- KP: There are other ones and I think this is an area where you can look at, you maybe want pharmacists that... this is an area where you can also improve in your structure, to look and see, do I want a pharmacist that just looks at

- auditing, and monitoring and evaluation...In the province for pharmacy. And manages that, you know.
- Michelle: Yeah, and that would be maybe a lot, because I mean (CONFIDENTIAL)...
- KP: So the work is getting more and more and more...
- Michelle: DELETED (CONFIDENTIALITY)
- KP: so this has created some kind of opportunity there.
- Michelle: Ya... okay, well... so you, you generally, you are quite happy with the structure except for the things you've said and you feel like it's really achieving more than what was previously there...
- KP: I think it's a big difference. It is... It is really significant, um. I wasn't, I wasn't...I didn't think it was ideal but I wasn't unhappy when it came around, it was... I th..., I thought we were going to get worse.
- Michelle: Yeah, ya.
- KP: You know.
- Michelle: Ya, I suppose at the beginning of the mention, of mention that this was going to happen, I am sure you guys panicked?
- KP: I mean the first proposal was ridiculous! It was really, really outright ridiculous, and, and we've moved on since then, so. The other problem, and I don't know if it's related to the OSD but um, somewhere in one of the resolutions that was signed but also with the unions, and that we find extremely difficult to change at the moment, but it says that if you do overtime work, the maximum you can be paid at is a level 8.
- Michelle: That's right, I do know about that...
- KP: Notch 1.
- Michelle: Ya, that's it. [00:16:38]
- KP: so, after hour work, you earn way less then what you earn normal hours work. So that is... (unclear)
- Michelle: I have experienced that personally (Laugh).
- KP: Oh you have!
- Michelle: I remember being remunerated and working hard...
- KP: (unclear)
- Michelle: and thinking this is really not worth it. so when we run over... with patients, you feel a bit grudgingly...
- KP: Yes
- Michelle: You know...
- KP: And I can't understand why that can't be changed because if you're a pharmacist...
- Michelle: And we couldn't take hours off.
- KP: ...you're still OSD, you still whatever... and then they keep on referring. So that's what I am saying, something is written incorrectly, if it suites them, they will change it. If it doesn't suite them then they will say, no you've gotta change it. So that is a big issue for pharmacists at the moment. And at the moment, again we are using that route of, of going through agents and doing whatever to (unclear), so you actually waste money again
- Michelle: Ya, 'cause you gotta do the whole process of bring forth you....
- KP: Because you can't say, okay, you work late, I've gotta now get you through an agency or get somebody else. Which is an outsider that doesn't understand...so that, that was not, almost seems not to have been addressed in this OSD.
- Michelle: Hm. Ya, I do remember that. I remember that a lot of pharmacists have complained...
- KP: So your, after your, on-call work, all that...ridiculous...Their thing was that any after hour work you do on production pharmacist level, you're not doing a manager's work.

- Michelle: Ya
- KP: So they maximise that
- Michelle: How could they say that, because it might be a manager..., I mean what if you're a full staffing that's staying afterwards?
- KP: It could be?
- Michelle: Everyone doing their, their thing still?
- KP: Yes, yes, ya.
- Michelle: I mean the manager...
- KP: So if you as a supervisor, works late, you earn even less. You will earn the same as, your production pharmacist's earn.
- Michelle: it would be interesting to find out if nurses have the same thing? You know, because some of them are facility managers, if they work overtime, do they get remunerated on their first level.
- KP: The nurses have shifts.
- Michelle: Oh, ya, so their hours are...
- KP: So theirs is different. The doctors have commuted overtime. So they don't have that problem.
- Michelle: Ya, so we're actually the only people that got problems.
- KP: Ya, and, and the thing is um, I mean there was a suggestion, why don't we look at commuted overtime. But we don't have that many hours that we need too...
- Michelle: Ya, because we don't work extensively, it might be an hour over here or an hour over there or two, you know. And that's that or sometimes I see some of the facility are running weekend hours...
- KP: Ya...Yes... extended hours. Ya, so that is something we are trying to take up at the moment because we are working out what the, quantity is and the value would be and trying to (unclear)...
- Michelle: Good, that's good. Ok, so we will end off. So I think my, my thing is, If you will allow me to contact you if there is anything I'm not sure about in the interview and um, just as a summary... I have a good idea of what is happening there in the middle management (pointing). I can see what is happening here now that you've explained to me with the, with your posts and also that fact that you said the flow, between the overlapping, you know, the over lapping of the two, and that promotion flow to come in, is not, not quite dealt with.
- KP: It would be nice that if you apply for something that you would get a different level of pay.
- Michelle (laugh)
- KP: laugh) Ya, I got a promotion but ya!
- Michelle: Ya exactly
- KP: Yes
- Michelle: Ya, um and then ya, if you're happy, is there anything you want to?... you know your summary on it... I mean you've already said, what, what you feel. So I don't think there is anything else we need to talk about. If there is anything you know that you left out today and you wanna mention it, you are welcome to email me , and say, you know what there is something we didn't talk about that,
- KP: Um, no I think we have basically covered everything.
- END

APPENDIX T: TRANSCRIPT FROM INTERVIEW WITH KEY INFORMANT “KQ”

PART 1

Michelle: [00:00:07] Okay, so let's just quickly start off with just two basic questions, Um, if you could explain to me in words what the idea behind OSD was, what was the purpose of us introducing this, new...?

KQ: Prior to the introduction of OSD we were really struggling to recruit and retain pharmacists, and that for many years it was a challenge, we sat with vacant posts and I think OSD, part of it, that was the strategy, to try and improve the salaries of pharmacists and make state sector more attractive to pharmacists, so, to at least retain people we had but more important, recruit people into the public sector. Our biggest problem was filling our entry level posts and that was one of the challenges.

Michelle: So entry level, okay, interesting

KQ: Yes

Michelle: Um, so... you've answered the second question, why did it become necessary to implement OSD and like you said, we didn't have enough people, um... were people leaking out or would, or were we losing people or was it just that we...?

KQ: it was a combination of, of both. Firstly we couldn't actually attract them, because the private sector was more competitive, and also at that stage there was quite a tendency for pharmacists to emigrate, 'cause the were quite nice packages offered by the overseas countries, so we were losing pharmacists to other, private sector or to overseas. And then pharmacist's that were with us, you know after you worked for the state for a certain amount of time, there was no, the progression wasn't attractive enough for you to remain in the state, whereas the private sector could offer better packages.

Michelle: Ya, that makes sense to me, ya. Okay, so and let's talk a little bit, maybe you can tell me a little bit about your involvement with OSD. What have you been doing from your side, because I know, I have heard you're involved.

KQ: Well, I think we were quite involved in giving input into the, the documents that were put forward by national in terms of the suggestions that were put forward or the guidelines that were laid out, the requirements for the positions. But looking to see if what national was actually putting out would make a difference in pharmacy. If it was really going to address the problems that we knew were in the state sector. And I think we did a lot in terms of writing mandates, giving inputs, speaking to the unions, um, sending representatives up to the national meetings, meeting with national when they were in the Western Cape. To give what we thought were the problems the OSD as they put it forward.

Michelle: Okay, so you had people from here, from this facility actually going, um, as representatives for, Western Cape, am I right?

KQ: Well the one that went actually represented pharmacists in general.

Michelle: Okay, that's fantastic. right, Um, so, when it was being developed, and the proposals were being made, what were your feelings at that stage? Was there anything important that stood out to you? Did you feel good, did you feel bad? what?

KQ: I think it was good that there was a move being made to address the problems, however our concern was that there were things in the document that we knew were going to be a problem. And we felt at that time that we were not being heard. That our concerns were not really being listened to and that's why we

had to push via the unions side, to get the unions to actually... take us forward to the national meetings. So, unfortunately that was the bigger problem with OSD. From the department side I felt that they were not listening enough to what the concerns of the pharmacists were and there were real concerns about the document was put out. We had to go and fight the battle via the unions. Whereas it should be... as government, this is what our pharmacists are saying and we put forward a document to address that. We had to go almost a side route by involving the unions to go that route.

Michelle: Okay, so did, um, government, um... from our side, Department of Health, actually have some sort of foundational idea of how they think it should be structured? Did they bring that to you and then you said, "these need to be changed". Or did you have to from fresh, did us, our policy specialists from fresh and involving you, the top guys, come together and say, "this is what we'd like" and present that to national?

KQ: No. National already had a document out. So national came to us to say, "this is the document, this is what we're proposing".

Michelle: Ah, okay. So that's where the concerns came out, okay.

KQ: Yes. No, it wasn't, we didn't start the document. The document was, sort of 80 percent done by national, and they were just coming to the province to listen to input, and that was really the first time we saw the document.

Michelle: And their, so their proposal was obviously, was quite unacceptable? In your eyes?

KQ: No, I think a lot of it was acceptable, but there were, there were portions of it, that we were not satisfied with.

Michelle: Okay, that's, that's great. Okay, um so... how do you feel now, in retrospect after these number of years that we've been going with OSD, what's your current feeling about this?

KQ: I think definitely, OSD has addressed one concern, which was recruiting staff. It has made the entry level extremely attractive. So we're able now to recruit staff. I think, my concern is, it's still didn't address the more senior levels in pharmacy. So the career progression, that part of it, wasn't, it didn't do justice to that part. So I think we, we more in a way for one thing. We managed to attract people to the service, but then if you've been in the service for a while, if you've gotten to a certain level, it's no longer attractive. And that's the gap [00:06:13] for OSD.

Michelle: Yes, okay. No I am glad you, you've stated that. Okay, so um, was there any major things, now you're talking about there were certain section in that, um, initial document that you guys weren't happy with. Would you be able to highlight some of them for me? Or...or explain to me what were the big concerns? The specific ones. I mean, I know I am asking you about things now that are current and before.

KQ: And maybe I should have quickly looked at the document before, Um...

Michelle: But I mean anything, I know some people have said, I can't remember now. What were the big things that I had heard? Um... overlapping, I remember something about that?

KQ: I think, part of it was, if you look at, I'm talking now career pathing, so... it moved... okay, one things we felt was the community service salaries, were moved quite high as well, and that's in a way, not the purpose, because you're forced to do community service so why... why give that incentive, you could rather spend the money on the other levels.

Michelle: Absolutely

KQ: Um, there's quite a bit of overlap, if you look at pharmacists' Grade one, two and three, and then we've got pharmacy supervisors. A supervisor takes a lot

of responsibility in an area and so do the assistant managers but there's quite a small difference between a pharmacist Grade 3 and supervisor. So really why do you want to be a supervisor. There's no financial benefit, but you get all the added responsibilities. And that was one of our problems with the document. We felt you were not encouraging people to take on positions of responsibility. Because it's just all the challenges and no benefit, so, it's often you ask, people will say, "but why must I apply for the post, because the salary, it's such a small difference but it's all the challenges that come with position". So that was the problem between pharmacist Grade 3 and pharmacy supervisor. We also felt it didn't, if we look at the province as such, the structure in the province, it didn't recognise that, um... your manager, the head of pharmacy services, has a lot more responsibility, than [name] for instance, that person is on the same level as [name], who's in charge of [facility name]. It doesn't make sense. We felt that, that person, should be recognised at a higher level. And that still hasn't been addressed. So it's those kind of things. I think our other big problem was that we, OSD in a way should have addressed the inequalities between the various provinces. When it was difficult filling posts, lot's of provinces took an independent decision to move people up a level. Whereas the Western province refused to do that.

Michelle: So you stuck to the structure that was in place.

KQ: Exactly, but with OSD, instead of correcting it, as we'd hoped it would, people that were now on a higher level, still went on a higher level. So our pharmacists were still disadvantaged, yes.

Michelle: Yes, okay. And currently, is there still those inequalities? There are then, hey?

KQ: Yes

Michelle: There are people in positions in other provinces...?

KQ: That are slightly higher level than we are.

Michelle: Okay

KQ: So it's just that they will still be, in a supervisor position, but they should have been a pharmacist. But with the translation, when they got translated, then they got translated into the higher position.

Michelle: That's interesting. That's actually not right.

KQ: Mmmm

Michelle: Because I suppose also, um, what should have happened, you were talking about job description, you were obviously very involved in, in laying out the key performance areas for each, or the structure of position...

KQ: Well that was the other biggest challenge, that national said that these positions come with job descriptions, and to date, we've never seen them.

Michelle: Hmmm. Okay, so, so there's no document to actually say what our supervisors, or our...?

KQ: No. And that's why we, it was such a battle for us, because we had to fight to recognise our pharmacist's in supervisory positions. I think the biggest battle for the province, was getting the pharmacy supervisors recognised, and even to date there's some people that in certain positions, they wouldn't recognise it as a supervisor, so we've had to [00:10:27] push and sh...

Michelle: So they've had to stay on other levels

KQ: Yes

Michelle: ... these are the problems, I see. Okay.

KQ: And I don't know to what extent you looking at, there's also a huge gap of pharmacists assistants in terms of OSD. Are you looking at that?

Michelle: We're not really looking at that... not really, but that, okay, that is interesting that you do mention, I mean.

- KQ: I think that that was our other problem with the document, that, remember, pharmacist assistants, the history behind it, is people initially didn't have qualifications, so you just from where ever... Matric or Std. 8 and you started working.[00:11:03]
- Michelle: You trained under a Pharmacist?
- KQ: You trained under a pharmacist, but you worked as a post basic for many years before this requirement from Pharmacy Council came along that you had to be registered, but OSD only recognises the assistant post-registration. So we're still battling that registration, that recognition of experience prior to registration.
- Michelle: That's terrible. Because that's, they obviously won't just accept a document from the pharmacist to say that this person...
- KQ: Well, I mean if you've got their job description that says, that hasn't changed and that says they were dispensing prior to registration, it's legal, because it wasn't a requirement that they be registered, so why can't you accept that.
- Michelle: Exactly, so they would have had a number of hours or months or years experience at dispensing.
- KQ: Years
- Michelle: That is problematic. Well, okay, you've already given me some of the benefits, alright of what's happened, with its implementation, so just too... summarise what we are currently chatting about. Space for improvement? Where do we need improvement still? Are there things we need to still be taking forward?
- KQ: I think for us the strong one is still the recognition, career pathing, that there must be a clear financial benefit to a person in a management position. So whether it's the pharmacy supervisor, that's in charge of one or two pharm... okay. The other problem we had with the document while I remember is it is a requirement that a pharmacy supervisor must have at least one pharmacist under them. But that's not always the case and therefore there's some position that never got recognised.
- Michelle: Ya, because sometimes like I know, in the clinics the pharmacists there might not even have a pharmacist and they're a singular pharmacist managing, and I suppose...
- KQ: But if you look at the load the clinic has and the number of assistants they have...
- Michelle: And the, and the requirement of that pharmacist, if you look at the documentation...
- KQ: If you are a responsible pharmacist, yes
- Michelle: Exactly. That makes sense, yes.
- KQ: So the gap for me, is the career pathing that I feel that there needs to be given recognition, not just for seniority, but if you're occupying a position of responsibility, so that, that's an incentive to people to take on those positions, because there's recognition of it. And maybe then we do need to look at, there's Grade 1,2 and 3 but if you want pharmacists to stay longer, there needs to be something beyond Grade 3, maybe. Because pharmacy is a career where, I think when you've gotten to Grade 3, and if you're in a facility, then, I think, you're unlikely to move from there. You know it's just the nature of the individual. So you get people now at Grade 3 after 13 years, and they've still got quite a while to go in their career, and then what happens then? So, you know, maybe, a different kind of incentive system.
- Michelle: Yes, that makes sense. In other words, what you're saying is some people don't really want to be in supervisory positions not only because of the money, thing...

- KQ: But just, "I don't like responsibility", you know, "I love my job, and I want to be clinical", so I think that's the other thing. I want to be clinical...
- Michelle: And do you think that's a valid reason for, for pharmacists not moving up into the supervisory?
- KQ: Yes, there are actually. There's quite a few that, because you know, as you get more senior in terms of management, you get less operational in terms of clinical.
- Michelle: And then they'll miss out on those interactions with the patients and actually the medicines...
- KQ: Exactly, and some people love that part of pharmacy. That clinical part of pharmacy. So they not a clinical pharmacist in that they, they not responsible for training pharmacists in clinical pharmacy etc., but they, they love doing clinical work. So, I know a few pharmacists that will never consider a management position, just from that point of view, they don't want to [00:15:05] deal with all the admin...
- Michelle: You were talking about the inter-provincial discrepancies and I was going to ask you about that so you have already covered that. Just your opinion. When we structured this whole thing, I suppose OSD is part of a full, it's basically a full package and what comes in the package. It's all your benefits, it's a career pathing, its how much you're going to get paid. Do you think it's appealing to the values of pharmacists? I mean, we're professionals and we don't only, in my opinion, work for money alone. So, do you think the, government actually considered our values? Before implementing?
- KQ: Not really. I mean, I think this was, it was just a strategy to address the financial part of it. And really, that's all I see OSD has done. It hasn't done anything to address all the other challenges that we face, you know. So all they did was look at, "is there is a problem in recruiting and retaining". Whether it's nursing, whether it's doctors, whether it's pharmacy, and that package was mainly...
- Michelle: Just for that, basically...
- KQ: That's all the benefit I have seen after all these years.
- Michelle: But we haven't really had anything else implemented to make our work more satisfying, besides this.
- KQ: No, and I think that's where the institutions come. It's been, if anything is done to make the work more satisfying, it's been...
- Michelle: It happening internally...
- KQ: It hasn't been, the other mechanism could have been, you know, we recognise that for instance, pharmacies specifically, it's always been a shortage of posts. But there is so much for pharmacists to do! But they just get stuck in the pharmacy dispensing, because that all that you have the hands to do. [00:17:01] so they could have said, with OSD we create special kind of posts and we fund you for those. It's fine creating the posts, that's not an issue, but we need funding for the post. And then you've got, you can give opportunities to pharmacists. So they didn't give added opportunities. They didn't add value in that terms, that you could expand the scope of pharmacists, look at what you can do differently.
- Michelle: Yes, so there wasn't a lot of creative though put into...?
- KQ: No, it was, more financially. This was the issue that's been raised; this is how we sort it out.
- Michelle: Very difficult, I think for us to get to the next level.
- KQ: Yes, I think lots of people have ideas, how you could, these are the kind of, types of, specialties you could create for pharmacy, so that's missing.

Michelle: That's true. Now, since I will be interviewing the supervisory and the production pharmacists, and you have, spoken about the overlapping, or basically, the fact that there's no incentive for moving up, is there anything else [00:18:10]...

KQ: [DELETED - INTERRUPTION][00:19:15]

Michelle: Okay, besides, that sort of negative thing of not having the push between production and supervisory roles, is there anything else specific, you think applies in OSD to production and supervisory positions, anything negative, anything positive, anything for them, specific to them.

KQ: I think, one of the other things is, the proof of experience. I can understand from an administration point of view that you need that proof but the pharmacist will probably feel, that sometimes it's unfair because they don't always easily have the proof of experience. And maybe it's something we haven't advertised enough, to pharmacists as a profession, "please", it's something we've never had to do before, get certificates of service. So now you apply for a job at [facility name], and you've worked for 10 years somewhere, but that company closed down. And you never thought to get a certificate before they closed down, and you get here, and I can't recognise 10 years of service. So it's that maybe, that's the only thing I can think...that they maybe unhappy with, It's quite an effort to get their recognition. Their proof of experience. Especially for people that have worked at multiple jobs. Then they need to get that proof. The other big thing, and it would be unfair if I didn't speak about this one, is 5/8th's pharmacists. So, if you're employed as a 5/8th's pharmacist, you only work for 5 hours in the day. To move from Grade 1 to Grade 2, you've got to have 13 years experience. So if you've worked for 5 hours, they will not grant you 13[00:21:06] hours, you've got to work that 8 hours.

Michelle: So it's a tally of hours...

KQ: It's a tally of hours versus a tally of experience and maybe that's unfair. Because if you look at the 5/8th's pharmacist, true they only do 5/8th's but you've practiced as a pharmacist for that day, and then you should be given recognition for that experience. So I think that's a big bone of contention that we had with OSD that's still hasn't been sorted out. It shouldn't be worked on the number of hours, but for how long have you been employed as a pharmacist in that... I can understand if you work 3 hours a day. That's different, but if you've worked for 5 hours there, that's a significant portion of your day.

Michelle: You're basically past lunch, if you can say that.

KQ: So that's probably a big issue for certain production pharmacists

Michelle: I am sure it is an issue, you're right. Also, concerning that, do you think, when a pharmacist comes into an entry level post, say for instance in production level 1 or 2 depending on how much experience they come in, do they have an idea of what else there is out there beyond production/supervisory? Like, management roles? Do pharmacists even know what is happening? Where the positions are, in your opinion? Do they, have you seen if they've been able to look at things and say , "you know I would really like to eventually be there...", or do you think pharmacists just come in and just work?

KQ: I think it's changed, maybe, in the last few years. Initially you had that kind of thinking where pharmacists just came in and worked. But now you find people coming, for instance, for internship or community service and they have an idea, "I am here for my community service but this is not really my interest. I want to be in industry. Or I really want to be in retail." So I think now there's a much broader awareness, of what the scope of pharmacy is. You do get those

that still come and say, “You know, I’ll just figure it out as I go along”. But I find a lot more people are aware of what’s out there. They’re planning, they’re looking for jobs. They are looking at senior positions, and in some cases looking also looking at how they’ll develop themselves for those positions. So that thinking has shifted.

Michelle: And do you think, there’s more opportunity for production pharmacists to actually skip into roles now concerning, particularly looking at the amount of years required before you can apply for another position on a different level. Like, what I noticed is, you only need 3 years to go into a supervisory role. So do think there’s, have you noticed some people are trying to skip?

KQ: Oh, definitely, I mean, I have community pharmacists that apply for management positions. So, I think...

Michelle: Do they get it?

KQ: No, obviously the requirement there is the 3 year, so they don’t. But you’ll get a pharmacist that’s worked for 3 years as a production, will apply for an assistant manager post.

Michelle: Do they get that? Do they get that position? I don’t know, I am just... have you seen anyone actually, after 3 years in production going into...?

KQ: I’ve seen more junior pharmacists appointed than previously, maybe. So maybe not the exactly 3 years, but I think that if you looked at, maybe, 10 years ago in pharmacy, it was progression of years. You had to do your years to get to a senior position. And that’s no longer it. So I think it may not be the 3 years but definitely people, more junior people, are getting more senior roles. It’s now more a recognition of your skills and ability, than how many years you’ve done.

Michelle: Do you think that’s a good thing or a bad thing?

KQ: I think it’s a good thing. I always think it’s a good thing to recognise years, but, years of experience doesn’t necessarily equate to being able to do the job. And that was probably the problem with the past, that, “I had 10 years, you gave me a management position but I couldn’t do the job”. Whereas now I could have been only working for 5 years but I have the skills to be in the management position. So I think from that point of view, it’s good. It’s brought in new ideas, new blood, but also new ways of thinking. Sometimes the problems in the past was, you know, “I’ve only known this way of working. And now you put me in the management position”, and it carries on exactly the same way, with the same problems. Whereas if you put someone with new ideas, a new way of thinking, from the private sector, or from wherever, industry, they’ve got different ways of things, they’ve done things differently and that helps rejuvenate the process somehow. So I think it’s good. As long as you’ve got the skills, for me, it’s about the skills.

Michelle: And hopefully in the interview that’s something that gets...

KQ: Yes, so you’ve got to be very careful with designing you’re interview questions to ensure that you actually pick that up.

Michelle: Ya. Right. What about these clinical pharmacists that band, that specific position. Do you know anything about that? Has there come any developments?

KQ: No, there’s been no developments. Okay, there’s been, that’ll be wrong. So, in private sector, people have been appointed as clinical pharmacists without formal training. Whereas in the state sector, posts haven’t been created as yet.

Michelle: So although the structure is there, in OSD for it, we don’t have any post available yet?

KQ: And it comes down to funding. We don’t, I think [facility name] is trying at the moment to get a clinical pharmacist post, but it’s an issue of funding. If we

didn't have funds for the before, it means you got to take a production post and convert it to a clinical pharmacist post. The responsibilities, or the role, I would see of that person is different, which means you then lose a pair of hands.

Michelle: What is their role exactly? Do you know kind of what their job description is?

KQ: I don't know what their job description is. I think my idea I have of a clinical pharmacist is, in a way our role as pharmacists, are quite limited to the pharmacy at the moment, but for instance we have pharmacists that go to the wards. And because of the other pressures, they only have an hour in the wards. So for me, the clinical pharmacist, that shift will happen that your focus will be more your wards, and less the patients in the outpatient waiting area. So you'll spend more time looking at the medicines, looking at the doses, the drug interactions, liaising with the nursing staff, seeing to, "how do the drugs get mixed, how do they get administered", renal function. We've also got a big antibiotic stewardship program now, so I see the clinical pharmacists being quite involved in antibiotic stewardship. So, and just interacting with the doctors, you know, bridging that gap. So for me the role of the clinical pharmacist is more out of the pharmacy, and into the wards.

Michelle: That's exactly what I thought in my mind as well, but it hasn't been very clear, so I just wanted to clarify although you're saying this is what you have an idea...

KQ: So that's my idea, because there isn't a standard job description but that's how I see the role, of the clinical pharmacist. [00:29:05]

Michelle: That's fantastic. We don't really need to talk about much more. I just wanted to ask you, so, as a summary, do you think OSD is achieving its goals? What it was set out to, to do?

KQ: I think it's definitely achieved its goal of attraction of pharmacists to the public sector...

Michelle: But not progression, is that what you're saying?

KQ: To a degree, but you know, we find, so if you come into the service, you probably here for 3 years, and it's that, "beyond the 3 years", that OSD hasn't...

Michelle: Kind of addressed?

KQ: Yes, maybe 3 is cutting it short. I would say 5 years. So you move to Grade 2 and then do you really want to stay here for 13 years before you move to the next Grade. You know that kind of thing.

Michelle: That's Great. And your future plans for involvement. Is there still something you're busy with, that you're trying to...

PART 2

KQ: [00:00:00] Giving input, every time there is a request for input, we give our input, but at the moment there is nothing actively been done in terms of OSD, because there hasn't, there's no forums that I am aware of...

Michelle: So no one's come forward and said, "We'd like to change something or anything"...

KQ: Or you know, "there's now an opportunity to give input", so I think about maybe a year ago there was a request from HR, after you've implemented for this amount of time, what are the challenges. Give you input, so...give input. But there is nothing active at the moment, as far as I am aware of.

Michelle: Alright, and, I do, I know that someone else has mentioned to me that there's a problem with our top position somewhere?

KQ: That's the manager position that I was talking about.

Michelle: Yes, okay. So is that a director of services?

KQ: No... Okay it depends what problem you are talking about. So...

Michelle: Ya, I am not sure myself as well, I know that, you said okay, there was a difference, there wasn't much of a difference in money between, ... I think the director level and...

KQ: Okay so, the way the structure works is that there's us who are managers, so I manage [facility name], there's [facility name], there's [facility name], and above us, you've got [position], and above that you've got [position name]. So, our feeling is that, that manager, pharmacy services, should be the director pharmacy services. And, OSD puts it out that way, so the document is not a problem. It's the implementation in the province that's an issue.

Michelle: So, in other words, that's why you were saying, that manager that's now in place at the moment, is actually kind of getting the same salary as you guys.

KQ: Yes, but with a, such a broad scope of responsibility.

Michelle: And is there anyone in the top, the position above that?

KQ: Yes

Michelle: There is. As far as I know not a pharmacist?

KQ: Not a pharmacist, ya.

Michelle: And that's also another problem. Does the OSD document say it has to be a pharmacist?

KQ: Yes

Michelle: Okay. So that's something that obviously needs to be addressed, hey?

KQ: [Nod]

Michelle: Alright, that is it! Thank-you so much.

KQ: No problem.

END



APPENDIX U: TRANSCRIPT FROM INTERVIEW WITH KEY INFORMANT “KR”

PART 1

Michelle: So to just analyse the distance from there...alright so it's very simple, very simple questions. Okay so in your opinion, or from what you can remember, when OSD was introduced, what was the whole idea, what was the purpose, why did we have to?

KR: Yes, one of the key aspects was that that the structure as it was, that the public sector lost a lot of people because there was not significant recognition for experience, so you either had to go for promotion or you had to move out somewhere else to...there wasn't...the initial idea was that you could actually grow in your occupation, so the OSD created levels...service, additional salary levels to recognise experience but also to retain the people and the other issue was that there was certain career and pharmacy career categories that were not catered or recognised and also I suppose the translation and the movement from the one to the other one, its better regulated but also, it made specific...created specific places for clinical people as well as policy specialists to retain them because that was the idea that, how it was at that stage, you had to go into management.

Michelle: So there was nothing available before this, for policy specialists and kind of clinical....

KR: Ja you were like at a certain rank and then if you wanted to move on you either you had to be a manager of a big hospital or pharmacy or...

Michelle: Ja, I didn't know that so...

KR: And there were people that were, they were quite happy to do what they do, but they were...most of them reached a maximum and they were not...wasn't competitive to what they would get somewhere else and this whole thing do not take into account work circumstances. This is just remuneration, at that stage it was something and I think that the backlash now is that there has been a lot of development in other spheres of pharmacy, chain pharmacies...became popular but they opened quite a lot of them, but I am deviating from OSD but the key thing now is that, that it is not OSD that also attracted people, it was the working hours, cause although they got more previously they were willing to sacrifice the extended working hours. Now up till recently you could stay in a, for example, work as a pharmacist in a facility and at a competitive salary and work comfortable hours and I see that is one of the attractions of people are still coming back.

Michelle: So you are saying money isn't everything, it's got to do with the fact that we have got cushier hours than working in private...

KR: Yes.

Michelle: ...but are we limited now because of the structure of OSD, or do you think it's much better than it used to be?

KR: It depends on if you have a look at individual career paths, if you...and recently we, you know people that were quite welcome about it, they not interested in promotion as long they can make...you know, get remunerated and their experience be recognised in a suitable way, then there is the people that have a career path in mind, although they go through these ranks, they'll see but now they was only a supervisor but they, there is people working in the same pharmacy that is on level 3 of the pharmacists...of the grade 3 of the pharmacist level whatever and earning more than, but that is, I mean that is a choice you make, it's a career path, so there is career pathing with more

options, previously it was quite a flat structure and you got rank promoted although you didn't necessarily get the experience. Now you could move from a pharmacist to a principal pharmacist doing the same job, now you need to have appropriate experience so....so in that way it's better because for the service it's better because they getting people in higher ranks with more appropriate experience and for the...you get people....there is a...not just a progression scale, it is a...

Michelle: A word...you must speak Afrikaans if it helps you cause...

KR: Ja, no it's fine...

Michelle: I am also not sure of the technical words...

KR: The terminology...the terminology...

Michelle: The technical terms...

KR: Okay, so ja but then because the...for the service the problem was that you had people in a fairly high rank that didn't...

Michelle: Didn't have the...

KR: Willing to take responsibility...

Michelle: Responsibility...

KR: Now there is riders to it, you can be a supervisor if you are a responsible pharmacist with council...so that changes the whole thing.

Michelle: You were saying...I am always you know, looking at that structure there and you were talking about appropriate experience, how do we know what appropriate experience is? Is that something that is determined in the interview when that person is being interviewed for the position or is there a guideline of some sort now?

KR: There is a...each one of these, there were supposed to be job description with key result areas, KRA's, so I don't know if you know... have experience of the interview process?

Michelle: I've never had to no, because I have come in straight in from community service and was lucky enough...

KR: So what happens is, well the post gets advertised or it is, there is a block ad out for a year or so...let's say it's a entry level post or any other promotional post gets advertised.

Michelle: Yes.

KR: So there is a job description for that specific post.

Michelle: Yes.

KR: Certain key result areas for example, good pharmacy practice, financial management, medicine supply management, quality pharmaceutical care that deals with stuff like waiting times and HR, HRD and data management is also part of it.

Michelle: Yes.

KR: So when you apply, they obviously if you need three years to become a supervisor and interesting for pharmacists it's three years including the Comm Serve year.

Michelle: I didn't know that, so it would be two in production and one in Comm Serve.

KR: Ja, we tested it.

Michelle: Yes.

KR: Especially in [facility name] with what happened there you know, because there was a fairly young pharmacist that was capable...so, because unlike doctors, your first year you have the same responsibility and the same accountability to the pharmacy council where I believe medical community service, they...

Michelle: They don't have...

KR: There is still a, have a tutor or mentor or something.

- Michelle: They are not a registrar or they are a registrar and but not a medical officer or something like that...I know they have the rankings.
- KR: It's a lot of terminology.
- Michelle: I don't know either.
- KR: So then, then according to your CV, first of all you have experience, then they say okay, do you demonstrate any experience of financial management, so I were responsible for...for instance you can say I have to give feedback to the hospital management about the medicine budget.
- Michelle: The budget.
- KR: Or you can say...I were involved...I supplied work information for the PTC or I was a tutor for assistant or I did the pharmacy roster, the leave roster, the afterhours, so it comes out in that and that's why the people when you, I mean that's the (unclear 10:39.2), the people just send in CV "I work two years for [business name], five years for [facility name] six years for [facility name]", it was actually...if they...
- Michelle: They watch what you did in those...
- KR: And your achievements...
- Michelle: Yes.
- KR: So with that you can easily determine if you have experience.
- Michelle: Yes.
- KR: Appropriate experience and then obviously there is an interview process that is also structured according to the KRA's...
- Michelle: Yes.
- KR: So they ask, okay financial management and give you a set of data...okay, what is the projection now for the pharmacy are you within budget or not?
- Michelle: Yes. Simple kind of questions but...
- KR: You can ask the pharmacy assistant post basic, what is this person allowed to do, so they can...
- Michelle: Stuff in practise and see if you know what...
- KR: So it's about competency and then obviously before that you see what experience they have. So hopefully the supervisor, now, won't be there because there were five principal pharmacists and everybody left and it's only me that is remaining and you know...
- Michelle: Like it's been in history, basically...where we've had problems. So these key result areas have been actually drawn up...
- KR: Yes.
- Michelle: ...for interview purposes, at this stage...
- KR: No, but also for SPMS...that's how you manage the SPMS, purposes and process and also when the same thing with evidence and then also it's on your job description in that way.
- Michelle: So now we relating key result areas to job description and so you saying there is job descriptions...
- KR: Yes.
- Michelle: But previously you said that you weren't sure or there weren't job descriptions, am I right?
- KR: There were job descriptions previously...
- Michelle: Yes.
- KR: But the...I don't think it was linked to your SPMS and the job description, I don't...that's before my time, I don't know if it was the basis of selection.
- Michelle: Okay I see. Whereas now it is all been linked...
- KR: It's integrated and if appropriately managed you can most probably...because it is not about just seeing if somebody doing their work but let's say the substructure management has certain focus areas...

- Michelle: Yes.
- KR: Then you can direct people...
- Michelle: To fulfil the focus areas...
- KR: We want to reduce child mortality, the diarrhoea season they working there vaccinations so to reach the organisations goals...
- Michelle: Goals, ja, I get that. We're down here but there is the goals up there and at the....
- KR: Ja it's the outcome...so, and then obviously if you want to reduce waiting times, all of a sudden it becomes then everybody's job description...
- Michelle: Yes, I can imagine.
- KR: So you can go on. I think that is the thing that we doing it that way now, unfortunately this thing...when it...when this process became part of this...
- Michelle: Yes.
- KR: We had people...sorry, the problem was when the supervisor posts, but that wasn't the national problem, it was a problem in the province. They didn't have the idea that the supervisor need to be the responsible pharmacist. So we had people that were pharmacists, principle pharmacists that were responsible pharmacists and with a stroke of a pen all of them became...
- Michelle: Production or...
- KR: Ja, they were production pharmacists then they became supervisors. That is good, giving recognition but there was no...they should have...I mean, we were against it but in retrospect people should have applied for the post.
- Michelle: Absolutely, because now you don't know, you've got perhaps a supervisor in a post and you are not sure if they have the appropriate experience so there might not be a match. So your involvement [name], what have you actually...have you been involved with the process right from the beginning?
- KR: No, I started working in my current capacity in 2009. I was for four years, I worked in the States from 2005 to 2009.
- Michelle: So you came back into the system in 2009 which is post-OSD's implementation. It was kind of on the border, I remember it was when we were doing payments for the first time...paying out at that stage.
- KR: Ja, I know I was still appointed as whatever in the old thing and then three months later it was like that but with that came the challenges of recognizing people that was responsible pharmacists because everybody was just translated to production pharmacists with translated according to years and not necessarily according to the responsibilities. With time it was correct...
- Michelle: So it took some work.
- KR: Ja, and that was....
- Michelle: So you had to obviously – some of your work was obviously doing – making sure the administration was being done on that, am I right?
- KR: Ja, [name] had a little task team and we were part of that because we had to convince the provincial HRM people that there is a category of grade 1 to 3 pharmacists that actually need to be supervisors.
- Michelle: I agree. And I suppose...what further did you want to?
- KR: Then as you know there is a gap.
- Michelle: Yes.
- KR: A supervisor at [facility name] Hospital and at [facility name] Hospital has got a different responsibility, in two ways, than a supervisor of [facility name] or a supervisor of [facility name] CHC. The weight...
- Michelle: Yes , so your CHC and your district hospitals key result or job description is slightly different right?
- KR: It is different and this larger CHC especially the 24 hour CHC,[facility name] and [facility name] and so on, they have about a budget two or three times

bigger than a district hospital and the problem is that that's not only specific to pharmacy. The medical superintendent or the CEO of [facility name] at the moment is probably at the same rank as the CEO of Khayelitsha Hospital that's twice the size.

Michelle: And that doesn't make sense at all then. So it should be weighted differently. Do they get paid the same salaries then [name]? Say for instance supervisory pharmacists of, I mean they all...

KR: [facility name], they all the same and that is – I don't know how you do that, I suppose there is a HR, a refined mechanism where when it get higher up the ladder, when [facility name] Hospital opened there was a work study and it was identified as an assistant manager.

Michelle: Yes, I have seen assistant managers and that makes sense.

KR: [name] is an assistant manager and the same at [facility name] Hospital, [name], so at least that was corrected. The bigger ones was, they were put on higher ranks before OSD so they just translated you know, [facility name], [facility name] and so on and [facility name].

Michelle: So they're basically standard manager and then a normal manager and then you will get your assistant manager and then your supervisory pharmacist and then your production.

KR: And fortunately we could fix it with [facility name] as well because we need the structure so it's no use having an assistant manager so they created a supervisor as well so [name] is a supervisor.

Michelle: That is fantastic. That makes sense.

KR: Now I think [facility name] didn't go that way yet, especially the bigger... [facility name] has got two assistant managers and a supervisor, there is a hole...so at least and previously, prior to this, everybody was like grade 3 and there was no you know – a nice rotation thing perhaps going but people would I mean would just say I am not getting recognised because everybody is not having the same responsibility.

Michelle: And who answers at the end of the day as well because the responsible person needs to answer, that makes sense.

KR: Although...you know there is always...there will always, you won't get the perfect thing but at least that is, it helps, it helped a lot with that and I know post-OSD supervisor posts categories and so on were created at [facility name] and [facility name], in a bigger pharmacy. So this obviously it's assisted to create not only a career path but a post structure, a slightly bigger post structure than...

Michelle: Than what was previously there, cause we were very...in a very generic structure am I right cause we used first the CORE, it was CORE structure?

KR: Ja.

Michelle: It was CORE structure? And then I wanted to ask you [name], 'cause I think you might have some information on this. We hear a lot about that there is interprovincial discrepancies in our positions and I am not sure exactly where that problem is but I suppose it's higher up in the post higher up in the management post or perhaps with the translations when OSD was introduced?

KR: Between the provinces?

Michelle: Between provinces in other words, I know as Western Cape we stuck rigidly to our old structure and so when we were translated, I think we didn't get a very good deal whereas some of the other provinces seem to have people in higher posts and they are not supposed to be there.

KR: It would be interesting to compare figures. I think what (unclear 22:23:1) is that it, before OSD it was to give...they call it bi-office, so they gave people to retain them; they gave them not a level increase but a post increase.

- Michelle: Yes that is right.
- KR: A principal pharmacist were given a chief pharmacist's salary.
- Michelle: I remember that.
- KR: And very often the responsibility of that person is much less than the people in management and so on and I know where recently a lady transferred to [facility name]. She was in a higher rank and she worked in a much smaller setup so I don't know how you address that. Our problem is as soon as we comparing posts how do you quantify what you are doing and I think that is going to be difficult.
- Michelle: So we can't really – I think the problem for me envisioning what the issue might be is that we can't attract people easily from other provinces perhaps.
- KR: We do because of work environment and circumstances.
- Michelle: So we have other pulls to the Western Cape.
- KR: Yes. I don't know, what we discussed, I don't know what is the extent of it. It's not that there is so many pharmacists out there to start off unfortunately and then the other issue is that they, the people recently that came to, it was about work experience, work environment and so on, we are perhaps getting slightly better management, we don't have all the stock outs and with JAC we got some technology and we go...oh ok, that will nice. And we have a CDU and stuff like that that makes it a little bit more easier. Where what I hear from [name], the previous director here, he is now a director in the [area] district so there is a pharmacy with a few pharmacists and thirty assistants in [area]. They do not have a referral system like we have so everything gets done centrally so people wait for three days outside the hospital to get their medicine, that kind of story.
- Michelle: Sounds a bit outdated like.
- KR: Ja, so it's also about systems and if we, it gets a little bit difficult to compare the things because the systems is not in place yet. The country is now going for a national CDU tender, I don't think they sorted out the referral process yet but this is something we've been doing for twenty years now and the patient didn't have to go back to the hospital where they originally went. There is a seamless, sort of seamless, say 90%. So inter-provincially the...it is usually in, what I heard, it's the rural places where they have difficulty retaining because they – in that aspect OSD did not because it's not only supplying demand, it's huge pull factors.
- Michelle: I suppose I would need to speak to someone from rural if I needed to find out and I think they would probably be able to give me exactly what's happened there but you have a point, cause there it's perhaps the case where you've got one pharmacist doing a lot of work and not being perhaps paid or ranked accordingly plus there is no other attraction like there is here.
- KR: The other issue is that a – sorry I forgot now – anyway, continue I will get it later on.
- Michelle: No problem. Just keep your thoughts so you can come back to me on anything. I think you have answered a lot of – I've got a lot of questions but you've kind of really answered a lot of them. So do you think, cause you were talking about us, that this doesn't – OSD only really speaks about remuneration so we've obviously we don't have a very – as flat structure as we did before but do you think there is space to improve the breadth more, such as now we were talking about where we discussing obviously this clinical position, I mean is there other roles besides a clinical pharmacist. What's happening with a clinical pharmacist firstly?
- KR: Nothing. There is no pharmacy councils got no standards as far as I know. There is no , at DPSA level, there is no post with a job description and

standards. The other issue is that two huge things have happened, is that this country from 1996, we moved to a district health system. So the services being rendered at the different level while with people that got changed roles in their competency, what they allowed to do and huge emphasis on clinical nurse practitioners, now we have out of PAC, what does it stand for...something assistant care but basically it's a professional nurses, PN has certain scope.

Michelle: That they allowed to...

KR: So the role of the pharmacist is changing so where you used to be a production pharmacist, or if you go up the [area], even in... it's a more supervisory role where you assist those people so the ratios is changing where you normally needed five pharmacists in a sub-district, you can perhaps have three if everything else is in place, that's the one thing. So the position in the bigger organisation

PART 2

Michelle: Yes.

KR: So that means that kind of skills and the job you are doing is changing significantly. Then you also, what happened in the meantime is that although five years ago and this must be talked about, there were very few post basics and there was no technician on the horizon, so now some of the tasks the pharmacists is doing is being shifted, so there is task shiftings as well and in the pharmacy. Now the bigger thing is there is a lot of task shifting, in the pharmacy there is task shifting, so saying that I think where we have production pharmacists everybody will be more on the - and I think internationally it works like that you know, technicians and hopefully we'll go more in a clinical direction.

Michelle: So naturally there should be a progression towards the clinical instead of just issuing numbers of medicine like we used to.

KR: And that's why here we said we need to say we want to get by and we said this is what we want to do, this is what we need, fortunately they fell for it, they listened and we not going to, although let's say [facility name] has got less pharmacists than [facility name], that's pulled the services up and pull everybody up so if the pharmacist there that you saw now gave him ward rounds and we can actually show on a graph once you start ward rounds, expenditure goes down and they did, that's what we're aiming for. So although within let's say, we have these categories, what these people are doing, is changing the whole time. So that is a role they don't know how to define – are we going to say that in a few years time you will suddenly have technicians that will do all the input work and the pharmacists will evaluate prescriptions and technicians and I don't know what way round, which way we go, there is two ways and that is if the pharmacist checks it and then the technician takes over, in America, the technician do it and the pharmacist...so that is the one thing. There is a lot of up-skilling necessary cause now the pharmacy, just to see in our CHC, the bigger CHC's, the pharmacy is now doing, going to the rooms where the clinical practitioners are dispensing seeing they are doing the right thing, doses, the education part to it, they are the cold chain manager, because all of a sudden as the priority shifted ARV's are integrated now, they're cheaper. Now our top expenditure is vaccines. Neumococo vaccine is R250-00...

Michelle: It is expensive...

KR: So one refrigerator you know, there is education, cold chain, immunisation strategies and then obviously the oversee of the ARV programme – you have

no (unclear) assistants dispense. We also have the CDU, it's quite a complicated thing, you cannot just somebody from you know, to check, especially if you have 60 clubs and to organise that becomes and then, I mean, [name] at [facility name], that's what she do.

Michelle: So you have a full time person basically.

KR: So it's more organisationally centred...what do you call it? There is a critical administrative tasks and stuff like that.

Michelle: So do you think the...will the job description of the general production pharmacist start to change or will special positions eventually become available for pharmacists with rolls in areas.

KR: To be honest, the approach, the broad approach is to have general lists in all the categories.

Michelle: And then you can move your pharmacists between those areas.

KR: A place like [facility name] has got six pharmacists and ten assistants, [facility name], four. So the best, it works well if there is rotation.

Michelle: And then a person doesn't get bored either I suppose and that would bring in other aspects besides OSD, so job satisfaction etc.

KR: So although it's, the way the districts and I mean, now we are going to go districts in a refined, refined way to the ward base system and we are not sure what the pharmacists are going to do but somewhere either its community based workers or post basics you send somewhere to give out CDU, the pharmacist will have to go there.

Michelle: So the pharmacist will be with the assistant in those situations?

KR: I don't know at this stage.

Michelle: Cause I am always a bit worried about, in finality, what I found with post basic assistants is because they have a very high work or a high ratio or a large workload, inclined to make more mistakes whereas a pharmacist, because they take ultimate responsibility, tends to be a little more picky about each item so that is always the worry.

KR: The issue I think is what is the scope, if it's primary health, if it stays primary health care I think it is manageable.

Michelle: Absolutely.

KR: IMCI trained nurses, just IMCI, Pulsa Plus, that kind of stuff but if you want this kind of generalist thing that's going to...

Michelle: Chronic medicines and diabetes management and ARV services running into homes couldn't happen I suppose.

KR: No, see it's difficult to talk for the rest of the country but stable patients straightforward CDU, I mean that's fine. I think then other, clinical parts not sorted out although I think it's training capacity because you will need a post graduate training and pharmacy schools are just coping.

Michelle: And so we would need to actually develop that degree, so it's another thing of whose going to write out...

KR: And the big thing now is the technician qualification you know, I think NMU's started but I don't know anything else. I mean down here at Western Cape, you don't have the capacity and you need OSD for academics as well cause it is terrible if you hear you know what professors and...

Michelle: Yes, I know they are struggling 'cause they don't fall in any of those...

KR: Then we do not know what is the council put out a very strange requirement for the 24 hour pharmacy services.

Michelle: Oh really?

KR: I don't know if you saw the latest GPP?

Michelle: No, I actually must go and have a look there.

- KR: There was a...it was circulated for comments. If I come across it again I can forward it to you.
- Michelle: That would be great.
- KR: Because the changes not that we had the capacity in this country, even if we need to open between three CHC, open one, it changes the whole thing so then we must...the problem, the big problem with OSD is that we did not, they did not get a very – bargained a very good after hour/ extended hour remuneration.
- Michelle: So I have heard yes. 'Cause are we all on level 1 production, I think that's what the overtime payment is on.
- KR: You see now I understand how they reason because they say when you work afterhours you do up to a certain skill but any medical officer gets commuted over there...your salary scale or according to a formula. That's also basic you know.
- Michelle: We should have had something similar implemented. Do you think we will still be able to negotiate that then if they open for comment on the 24 hour pharmacist?
- KR: Yes. The problem now is that they...we will have to do something because people are no longer willing to work...
- Michelle: They don't want to work the extra hours.
- KR: We had a specific CHC, we had that problem now, they downed tools and so the facility manager was threatening and there is no decent policy as well. Although to comment, the responsible pharmacist, some of them are making a plan – I also feel you cannot, you can only do so much. For instance [facility name] has got a flexi time policy, they get scheduled to work on the weekend and then they do not work on a Friday or a Monday or that kind of thing.
- Michelle: So they take the hours off, come in at different hours.
- KR: Ja, we are not allowed to say we are taking hours off, we get scheduled. You see it's a basic service, basic conditions of employment if people work, contracted to work from 8 to 5 or whatever, you cannot force them you are now going to work four, 12 hour days.
- Michelle: But if you contract, if you let them sign a contract where they told it will be flexi hours, then it's a different story isn't it, cause then you can shift people around.
- KR: So, they need a further refinement to meet the service needs.
- Michelle: Yes.
- KR: But the question is how much the service is. The Pharmacy Council are saying 24 hours or just taking care of extended hours because there is a huge, to me it's already there, people that work, especially [facility name], they come 5 o'clock, between 5 and 7 and they get their CDU parcel, they bring their children for immunisation and they come for the women's health and then for the minor injuries and so on because...
- Michelle: Yes, so they could do that before work in the morning and then go off or after work in the evenings. So that is more extended hours, that is not really 24 hours.
- KR: The 24 hours, it's a emergency centre that is open but they all for instance have, at [facility name], they got the...it's a club, a ARV club for people that is working and comes after hours and then they come on Wednesday at 6 o'clock in the night and then get their medicine. They also have like a paediatric room will be open until 7 or something like that or similar, although there is huge budget constraints because of...you know, it's overtime for the nurses and the whole thing but the pharmacy cannot just say we are closed because you generate a lot of extra work for you the next day.

- Michelle: So it's better maybe like you said, extend the hours, get the work done so that each new day has got its challenges and you can start fresh.
- KR: Now and this is questions we now channel to pharmacy council and so on because even if there is a clinical nurse practitioner after hours, at what point, when do you need a pharmacist, they must indicate that. I can understand in the [facility name], now that is the one gap, you cannot expect, it's not the right thing to nurse dispense all that and then she is not do what she is supposed to be doing, that kind of thing happens here as well. We need guidance on that but that's fine, it's not, at this stage it's not a limiting factor as far as...
- Michelle: So do you think there is anything, if you can just highlight some things that stand out in your mind, some of the true benefits you have seen come out now, I think you have mentioned some of them, but anything that you think stands out in your mind about the new structure and also if you can just maybe mention if there is anything, I think you have mentioned this all, I mean you were saying supervisory and production, getting paid similar salaries. I know a lot of people have been talking about the overlapping being a problem, some people think it's positive, some people think it's negative, what do you think?
- KR: I think with overlapping you have a choice. It's with the people, it's to accommodate the people that choose, to stay where they are working because it suits them, they have family commitments and stuff like that but there is also the person that or somebody that want what's important for them....
- Michelle: So maybe learn some of those skills that go with supervisory or improve their career in that area.
- KR: I think the positive thing we are seeing is that there is a push for people that would like to stay here because the intern community service pharmacists, we attracting a lot of people.
- Michelle: Than moving from each within the state instead of going away...
- KR: Ja, it helps them to make a career decision and when they make that decision they get an immediate benefit financially and the...I am not sure if the 1.5% notches if that is a retention strategy, at least there is a little bit of a recognition and obviously that is linked to the SPMS process and the Key Result Areas.
- Michelle: Is that automatically 'cause now you saying is it's linked, automatically an annual, do you notch up every year automatically or is it only if you've fulfilled...? go through SPMS properly?
- KR: It's a weird formula.
- Michelle: 'Cause sometimes it's accelerated I know in some roles I see that they can actually accelerate the notch climb...if you are above average.
- KR: Ja, I don't know if you see in the SPMS document....
- Michelle: I have seen it.
- KR: It's not out of 100, it's like 160%...
- Michelle: 160 correct. You are either 100 on a 100 if you get 3's and then you get about....
- KR: So you at least need to get 3's to get that notch. If you score somewhere in the higher figures you get an accelerated.
- Michelle: Ja, that's what I recall as well, something like that.
- KR: It's difficult; I don't know how they do it in other places.
- Michelle: I suppose it's also human resource figures all laid out once the person's actually done the SPMS.
- KR: It's normally some human resource practises and standards and stuff where they do it you know, these practises.

- Michelle: And do you think we are definitely retaining our community service pharmacists cause you know there's quite a big jump salary wise from intern to community but not such a big jump from community service to Production 1 and yet we are still keeping those people?
- KR: Okay, obviously we have the bursary holders and it's also the way that pharmacies are going. Previously everybody had a job, now it's not so simple. The past two years there is people that by January/March they are still only doing locums and applying for jobs and so on. I think the market forces change, I don't know what is the rates now between public sector and...
- Michelle: I think the state is quite comparable now, they might even be a little better because of the benefits that are offered.
- KR: But even the – how many people work outside and how many work in-house, that kind, I don't know cause we had a tremendous increase in posts, what I have seen in the four years. And that is the ARV program, meeting that needs and so on, so it will be interesting to see how many we retain after five or ten years.
- Michelle: So I think we need to hang on a bit longer and see what's gonna happen.
- KR: It's almost to the five year mark now.
- Michelle: Correct.
- KR: But it's, for us it's been the easiest because people are up-skilled already and you just go for it.
- Michelle: So it's much easier in that case.
- KR: Last year I think that there was five community service pharmacists, I thought half of them wouldn't be interested to work here and all applied for posts so I don't know.
- Michelle: That's good.
- KR: For some of the incentives, I don't know.
- Michelle: Ja, but it's obviously working, something is working?
- KR: I think it's Cape Town you know, it's location.
- Michelle: Absolutely, maybe not willing to go away if your family is here, etc. You were talking about just saying that it's a choice with being, whether you are gonna be in production or stay there or if you gonna move over to supervisory roll – do you think some of the younger pharmacists can actually – are you noticing that they plotting some sort of career path now more than they used to in the past? Can they see what kind of positions are available in the state, is it transparent enough now in the government?
- KR: Yes, I think it is transparent. Where previously you could have worked, there were no supervisor positions now every responsible pharmacist post is a supervisor.
- Michelle: So there is actually opportunity as such?
- KR: Yes and we had [facility name], [facility name], [facility name] both of the pharmacists [names], [facility name], there was people that were, you know, that stayed on after - post CSP, so after the year and so on and so out of the eleven pharmacies, there is quite a number of them, where it worked and it's becoming...it's no longer, unfortunately it's no longer a job where you can just walk in...
- Michelle: No.
- KR: JAC and CDU and it's tough and you sort of need to know your way around.
- Michelle: Ja absolutely.
- KR: It's wonderful. I don't know you know.
- Michelle: So you got to have skills like you said, up-skilling skills and whatever to get into the position now. It's not like you can just, just being a standard graduate pharmacist can just enter into any of the positions anymore. Well, do you

- think, let's summarise this...so you think OSD is actually reaching its intended goal at this stage?
- KR: I would say it is reaching it for the...especially the entry level pharmacists. It makes a huge difference. Previously the intern, Comm Serve, it was very, it was based on the old levels...I don't think they...
- Michelle: Yes, there was much there happening there. So you were saying it's working for them, then what about the senior pharmacists?
- KR: The problem is that from supervisor to assistant manager there is quite...very little posts. Then higher up it gets fewer and fewer.
- Michelle: It becomes less and less.
- KR: I am thinking any other organisation it works like that. From personal experience I worked in a chain pharmacy in the states, it was extremely flat. Everybody worked at the same hourly rate.
- Michelle: So there was nothing really like this?
- KR: Although it was perhaps a good rate but there was no incentive and I was just always...and like the manager of pharmacy would like get 4% more or something like that.
- Michelle: Who wants to be a manager, basically?
- KR: Ja, why would you take all that nonsense you know. So now there is, it makes it worthwhile. Yes I think for the first five to ten years of people's career, OSD is catering for it...
- Michelle: So they are getting the people in?
- KR: That was, I think I remember in 2000 there was a huge crisis in the pharmacy, people were not entering, not enough people were entering into...
- Michelle: Into the government into the state...
- KR: In the Western Cape...all of that. Because at that stage, it was a matter of remuneration and there was very little people, there was no ways we could convince people to. Now they just coming, so I don't know if it is other factors or if it's OSD I mean I always keep at the back of mind it could be that it is perhaps more challenging working environment.
- Michelle: Interesting, we don't know about the other factors, this is the thing, there are definitely other influences but it's good to see there is some change happening, that OSD could be contributing to that. So, also just as another summary question at the end now, what is your future, is there anything else that you have been asked to comment on recently with regards to OSD, what is your future plans being involved? I know there is obviously different pharmacists from different places that are still involved and currently involved with things when they get asked, cause I know it depends on what...
- KR: It's a very, it comes to me, OSD at the moment is...
- Michelle: Is quiet.
- KR: Yes, it's at a very high level, I think there is some movements about technicians because that post class needs to be sorted out...
- Michelle: Finalised and...
- KR: I think the thing that's going to happen next is overtime remuneration and there is also, interesting, there is...we were asked to comment on, that's what I wanted to mention somewhere, on work flow aspects, what happens, who does what in a pharmacy.
- Michelle: I remember you were speaking to me about this awhile back, that it was of interest.
- KR: Ja because if you need to quantify how many people you need to be sure everybody is doing the right thing so you need a set work flow, so there was funny little diagrams of who does what in a pharmacy, [name] was busy with that so I think if they, whoever decides on the posts and stuff, if they look at

the work, they have some magic formula and then we can predict how many people is necessary, that is what up there, DPSA and these people. They are making that link...it can be either positive or negative, we'll see. That's that other thing, otherwise Michelle I cannot think of anything else that is currently...I know there was talks of the review of it but I think every five years it gets reviewed.

Michelle: So it is probably gonna come up at the end of this year.

KR: But it's most probably part of a bigger bargaining process for all medical professionals and then the things get very diluted usually.

Michelle: Absolutely. Which is another thing I wanted to ask you...were you involved in any of the negotiations when we had to go to national, because I think a lot of people were frustrated with the fact that they had to use unions for their communication. What do you think about that?

KR: Yes, I wasn't really at that level involved but I can just...I mean all this is bargaining council resolutions so it goes through...DPSA...that's the way they do it and interestingly enough many of the unions has got the technical know how of this stuff where we honestly...

Michelle: We don't...so we need the union for the technical side of...

KR: Ja, because there is certain common stuff that works across in any workplace for ranks of people and HR [jargon] or whatever because they always put out something...

PART 3

KR: ...so I don't see it as a negative, because pharmacy is still a very small group.

Michelle: In the big picture of service delivery as such...

KR: Ja, in the public sector, it's extremely small and we are usually – and in the facility they are outnumbered, I mean.

Michelle: So our negotiation in that bargaining council is going to be a very small piece of the pie, as such.

KR: So, medical associations, they're there, the whole toot, you know, so whatever.

Michelle: Ja, so with the doctors, they have bigger, they have their own associations and unions that are talking for them.

APPENDIX V: TRANSCRIPT FROM INTERVIEW WITH KEY INFORMANT “KS”

PART 1

Michelle: Alright, maybe you can just say hello.

KS: Hi.

Michelle: That’s just to get the distance. Okay, just as a start, in your opinion, what was, why did we have to implement Occupational Specific Dispensation? If you can remember back?

KS: Well look I have been there 8 years so I was basically around when the resolution was being put into place and also at the time I wasn’t in my post specifically. What had happened in the past is, there was a lot of ...[CONFIDENTIAL] ...basically gives an indication as to remuneration for all categories and it was very very obvious from what we were noticing that we just couldn’t get pharmacists into public sector. At the time we used to have two categories basically, we just used to have “filled” and “funded” and that was it and we used to have the funded just sitting there because we couldn’t actually get people in and the section that we struggled with the most was the entry level which shouldn’t have been a problem, we should have had some sort of passage where people...we know that entry level is a section that is very fluid, it’s young people, they coming in, they feeling themselves, seeing if it’s okay for them and they move out and you would actually notice that at the time we never had a supervisor post as well so we just had this one huge post, it used to be called principal pharmacist that we had and then we had pharmacist and principal pharmacists and...

Michelle: And chief I think as well.

KS: Then you had chief and then you had – you didn’t even have an assistant manager and then there were deputies.

Michelle: Oh, that’s right ja.

KS: That was the range that they had. And then there was this post, you know, the starter post that people just couldn’t fill. The post would just sit there forever and I mean, I used to do exit interviews when I first started out. I was doing exit interviews all the time for places like [facility] and [facility] because they were just bleeding pharmacists. Then when this resolution came into being, we fought it, unlike nursing, because what happened with nursing is, nursing had, when they went into discussions regarding the OSD, they decided that they would not remunerate their what you would call technical administrative section. It was only those people that were on the ground and providing a service which made no sense at all – mainly because that technical administrative section provided the strategy and provided the direction for the people on the ground because they just don’t have the time, they just do what is expected of them and unfortunately there is very little time for reflection when you dealing with masses of people you know, just like...

Michelle: Get your work done...

KS: ...am I working smart, I don’t actually really care as long as I get all of those people out of the door and the people that were doing the technical policy strategy administration, those were the people that actually had the time to reflect, they were the ones that would ask the people on the ground what was going on. But anyway that’s neither here nor there. So of course when resolution 3 came in and pharmacy was up for discussions we fought very hard for our career pathing so that we had production and then we had 1,2,3 and we had supervisor but we had a problem with this. They had a problem

with these, especially with production 3 because they felt that production 3 was such that this person would move into this, could sit here but take none of the responsibilities that this person could take and supervisor 1 over there and production is very much the same when you look at the remuneration and this one is accepting more responsibility and is more accountable. So people were not really happy about this and that. The other thing that also then came about was the fact that we then were supposed to do career pathing for pharmacy so a lot of where this was at the time, and I am talking about supervisor, they had an idea in their head that supervisor is somebody that actually has to supervise and we were saying it doesn't work like that in the pharmacy because you might be sitting in [city] at a hospital which might not have many beds, you might have a 10 bed hospital but you have 10 peripheral clinics that you providing medicines for.

Michelle: Services to, yes.

KS: You understand?

Michelle: Yes.

KS: So just beca...and you might have, because the supervisor also said you supposed to have pharmacists under you, now if you have a problem with pharmacists being a scarce skill, how are you gonna have a whole lot of pharmacists under you when you can't actually get hold of them.

Michelle: Absolutely.

KS: So your supervisory capacity would then be supervising of pharmacists and ensuring that the district that you are in is looked after as far as medicines supply.

Michelle: Yes, okay.

KS: Then what happened with this particular one, because there was such a fight especially in the Western Cape, we were actually saying if you going to appoint somebody as a supervisor, if the person is the responsible pharmacist that person then becomes a supervisor because of the duties that they would have to carry out. Those functions cannot hang on how many people you are supervising. That hangs on your responsibility and your accountability. It doesn't hang on people.

Michelle: Ja, looking after people. So the word supervisor is maybe not the best word or title, but how do you...?

KS: It's not really appropriate but I would, yes, how do you actually distinguish between all of those things? So then of course when this thing started being put in place and also, I don't know if you know other provinces, but our province is quite structured in that we've got pharmacy services which very few people have, but I suppose it's got to do with you've got the skill so you can get the skill...

Michelle: Yes, you can actually...

KS: ...so you can get the skill to do what is needed and we very aggressively tried to get our bursary holders in because what used to happen in the past, we would have people being given bursaries and because they never had a clear direction as to what they were supposed to do after they were finished their comserve here they would just drift into the public sector, even though they might have wanted to be in the private sector, they drift into the public sector and they would actually be lost to us. So with the OSD plus our bursary holders so at the end of the year we would either actually say to them: "Look guys we having a meeting, call all the bursary holders" and then it's a case of "This is the way the interview process goes, I need all of your CV's", all of those CV's get sent out to all the pharmacy managers so that know these are bursary holders, they entry level posts. The beginning of the year I'd get

called “I’ve got this post entry level, have you got anybody?” I’d call all the bursary holders together, they go for the interview. So in that way we’ve managed to plug up the bottom end because they had an obligation to the state and also the salary looked much better than out in the private sector. I think a lot of them initially went out into the private sector and thought “ooh it’s gonna be great” until of course they arrived there and the shifts were long, I mean if somebody doesn’t pitch up, tough, you’ve got to stay there.

Michelle: You’ve got to stay there until they close.

KS: Exactly, so in that way it definitely, those two things actually plugged up the holes because now I don’t that many exit interviews, it’s not necessary to do that many.

Michelle: That’s fantastic.

KS: And there has been an increase from 2010 to 2014, I mean we sitting at about 419 at this moment in time.

Michelle: That’s fantastic, it’s good.

KS: And we increased about 30 pharmacists since 2010 when that implementation kicks in. We now have another problem. Our problem is that we’ve gone from the little section that “funded” to “in principled” which means this is on your establishment that there are no funds for it.

Michelle: Aah yes I have heard about this. So there is supposed to be that position there but we can’t give money for that position.

KS: We don’t have the money for it.

Michelle: We don’t have the money yes.

KS: Ja, so this is the problem that we sit with in that especially in the rural areas you will have like quite of a lot of “in principled” posts but no funds to give...

Michelle: No money, to actually pay that person coming in, whoever you are going to appoint.

KS: Ja, I mean the Western Cape is actually in a very good position as far as skills is concerned. We sort of a sought after province, our CSP posts are filled in a snap.

Michelle: That’s true.

KS: And people are applying from Potchefstroom to come to the Western Cape.

Michelle: To come down here.

KS: And you know we’ve got the situation like we’ve got these bursary holders, we’ve got to place them and then we’ve criteria that has to be used to place people so invariably you land up with about 70 applications – you only allowed as a province 10% of the whole so even if you had 50 posts you wouldn’t be able to fill them because you only got 10%. So if there is 400 in South Africa you would only be able to get 40. In our case we don’t have that many because what has happened is we’ve actually filled our posts so you know, even places that weren’t really sought after things up the western, like Vredendal...

Michelle: Ja, the West coast is actually going well yes...

KS: We’ve actually had people that have as they said “Vryed an Blyed” you know...

Michelle: Appropriate.

KS: ...and you know and they’ve now actually filled those posts so we don’t actually need the CSP’s to come in there.

Michelle: Hmm...interesting.

KS: Which has become difficult for us because now as a province we don’t really have that many CSP posts.

Michelle: ...much to offer, ja, we don’t have to offer...

- KS: I think most of our CSP's what they then do is more, almost like locums, they relieve.
- Michelle: Yes, I know they do this...
- KS: But they don't actually stay flat in a place permanently that used to be the case before. I mean we used to have places like, it used to be Stikland that never had, they had a community service pharmacist, we had Victoria that had a community service pharmacist, we had Somerset Hospital that had a community service pharmacist. Because of course they could pay them at a lower price plus and but, the flip side was that they would actually attract people into coming to work there at the salary that they were offering.
- Michelle: That's right. So you would have this turnover like when your CSP goes and you've gotta retrain someone again.
- KS: That's right, which bigger hospitals felt you know, really we actually need some permanency here...
- Michelle: Stable.
- KS: ...if people leave it's fine, you know if somebody goes on leave, because this person has been there quite some time they understand what the process are all about so they can just step in whereas if you have a community service pharmacist, bless their heart...
- Michelle: Good luck.
- KS: ...you basically talking about, you talking about somebody that is basically entry level and then can't fill a supervisory post if the supervisor were to go on leave you know, they wouldn't be able to step in and do what needs to be done.
- Michelle: That's right.
- KS: Whereas if you had a production pharmacist and the production pharmacist was there for quite a period of time because they knew how everything operate they could step into the supervisor post, you understand.
- Michelle: Yes, beautifully said.
- KS: So ja, we've not had too many problems. The only problem that we've got is got to do with the remuneration and over-time and we've also discovered that because of the fact that the whole system has been re-engineered and moved out to primary health care, the focus is on primary health care because of the devolvement that has taken place from the tertiary hospital, a lot of the work has fallen on the CHC's but that whole staffing, has not been looked at so...
- Michelle: Yes, I am aware of that.
- KS: ..you've got all of this work that's there and you've got all of these "in principled" posts that are there but you have no cognizance taken of the fact that you have re-engineered and now you actually have to sort out your posts. And it's not unique to pharmacy only, it's across the board. All of the categories are moaning and groaning and we at this moment in time are getting to a point where we have our bursary holders but we don't have posts for our bursary holders, which is a bad situation and nursing sits in exactly the same situation whereby they are busy training these people, we desperately need nurses but the problem is that the entry level nurse where those nurses should go are clogged up and the people are not, the skill is not in the right place so they have to re-shuffle the board so that the skills mix is right and so that place is made for this group coming in to move through and do what they supposed to do.
- Michelle: What a lot of work, what a lots of works it's going to take, a lot of admin and...
- KS: Well at this moment in time HR is working quite hard to try and sort the whole thing out because what they have realized is that a lot of times we

actually depend on stats and stats don't show you what's actually happening on the ground. It's very deceptive. What we actually discovered in the CHC's especially, what used to happen is, they had their own system of collecting stats. The province has got their own IT interface called Sinjani...

Michelle: Sinjani, that's it yes. I remember Sinjani.

KS: Which means like we've got then, we then have data capturers that capture information and load it onto Sinjani.

Michelle: Correct.

KS: But the CHC's didn't have that, so when you try and look for information, at this moment in time what I am busy doing is we trying to work out staffing norms for pharmacy and so you look back and you know that you've got this problem with CHCs but you've got no info so you go back to 2010 and there is like nothing. The other hospitals, the bigger ones, they actually started out and there is stats for them so things like Groote Schuur, Tygerberg, Red Cross, there is stats for them – not fantastic but there is some stats. But for them there is nothing. But you know that, you know...

Michelle: Something is not right but where do you go and adjust things if you don't know where the problem is basically, exactly ja.

KS: So what has happened has actually helped them quite a lot is, and also you know you've got this manual thing that that you like crossing and crossing and you must remember now you get called to the phone, you forget to put this in you know... that whole story, so now they've put in JAC which is a computerized system where you entering in so you get to know what's happening.

Michelle: Yes, which is fantastic.

KS: So instead of them checking manually how much has been done, the JAC now goes to the data capturer and this is what it is that pharmacy is correcting and what they discovered, that the gap between when JAC came in and before JAC came in there is a huge jump...

Michelle: Up or down?

KS: Up. Some people were doing much more than they were recording mainly because you know they just couldn't keep up with the recording.

Michelle: They just couldn't get to the recording, but that's good news, it's good news, not good news for them cause they struggling but it's good news to know that actually we doing more than what we thought.

KS: Ja but the problem lies in a lot of models that have been put in place for pharmacy which actually skews the picture. It skews the picture to more pharmacists instead of the other way down you know...

Michelle: Ja, assistants.

KS: Ja, it's got like a whole lot of chiefs and no Indians. It's ridiculous because you thinking okay fine, you understand that pharmacists are expensive as a commodity to pay for so a pharmacists assistant, it would be like two for the price of one.

Michelle: Ja, that's right.

KS: And what we would then have to do and this is what department is doing, they actually looking at the tasks that pharmacists are actually doing and some of them are die hards, they hanging on to that big stick thing you know and some of them are like "Okay you might be a production pharmacist" but actually a lot of the tasks that you are hanging onto are actually PA stuff.

Michelle: Ja, I see what you are saying yes. I know that.

KS: And we not prepared to almost relinquish this role...

Michelle: Let go, yes.

KS: ...but there are so many other things that they need to do....

- Michelle: That they need to do and they can't get to that if they still doing PA things.
- KS: Ja, so a lot of what has to happen is we've got to...
- Michelle: Change our mindset.
- KS: Genetically modify...
- Michelle: Genetically modify...
- KS: I've actually realized that look guys, we know that you went in doing those things but times have changed and we expect this from you now you know so the emphasis has come in, I mean like, [name], is doing a lot of, we did a policy framework for our rational medicine use, you probably heard about it.
- Michelle: Yeah, that's good. Yes I have heard.
- KS: And that is also basically then teaching our pharmacists about VEN analysis, ABC analysis, those are the things guys that you actually supposed to be doing. You supposed to be looking at this, you supposed to be seeing what it is that are your top movers, how much they cost, why is that happening, doing things like MUR's...
- Michelle: All the financial...
- KS: ...you know, there is a lot of more research and analysis, the lick stick has to sort of fall by the way, but before we can do the lick stick fall by the way, we then have to bulk up that bottom section and then of course it didn't help with Pharmacy Council saying "Oh by the way, I know that you training like crazy those PA's but you know we bringing you that pharmacist technician".
- Michelle: I know, they confuse the whole thing.
- KS: Ja they have and I mean, our poor assistants are just thinking "ding ding dollar signs", how much more are we going to get for this.
- Michelle: Yes, how we gonna pay to get this new....or moneywise to be paid, you right.
- KS: But it's not even on the department's radar, they just don't function, there is no category for them nothing. Pharmacy Council hasn't bothered to promulgate the regulations. These people are being trained, they don't know where they going, they rocking up at our institutions and asking if they can do an internship and we like...
- Michelle: We don't have one available for you.
- KS: We don't have you as a category so we can't even pay you so there is nothing we can actually do for you, you just don't exist on our radar.
- Michelle: That's right, although I have to go out and work somewhere else then, where there is for now until we can decide.
- KS: I don't know and the funny thing is that, before we used to have the situation whereby sometimes we used to take the lead from community pharmacy; it has done a complete about turn.
- Michelle: It has, I agree with you on that.
- KS: Whereby because of the structures and things that we have put in place you know, like we've got all our SOP's and things like that that are in place, I mean we like rigid as hell, I mean we can't even go to the loo without having an SOP.
- Michelle: I agree, I know that, it's just fantastic, but it's...
- KS: And then of course we've got the PPTC's that we have in place which sort out that medicine situation so a lot of them are actually and I know from the private hospitals, a lot of them have asked to look at the essential medicine lists, you know see what it is that's being put in place because they know that when National Health comes in, they might have to go that way because...
- Michelle: They have to be prepared.
- KS: Yes, because I mean we have put a lot of work into trying to give our patients quality service although they might not think so.

- Michelle: They don't realize what they have. There is a quality service there, I mean they get the full package. You might wait long maybe but they get the full package.
- KS: The problem is I mean, like with waiting long, the problem with that is that there is a lot of regulation around pharmacy, you can't just store anything any old how and not only that you are bound by security and we've got this like weird situation whereby people, I am talking top management especially are saying we need feet out of the facilities. But it's easy to say feet out of the facilities but what does that actually mean? You know like...
- Michelle: What are you saying? I know, I know what you saying.
- KS: You can't send a pharmacist to a church or let's not use the church, to a ward, to a civic centre and say "Look Michelle, we expect you to render this service" as a pharmacist because a pharmacist is attached to a pharmacy.
- Michelle: Premises, registered premises, yes.
- KS: And she is sitting in a hall she cannot actually execute her duties because she needs the pharmacy.
- Michelle: Yes that is correct, it's the environment because medicines are stored in a certain environment, we know that.
- KS: And this is where we've got this problem going right now you know. So it's...
- Michelle: Interesting you mention that, I was always wondering about why, there is a lot of talk of that at the moment. I thought how are we going to do this? We need to be so careful.
- KS: Some people have done, you know you get scenario 1 where they try and get them out completely and then you get scenario 2 whereby you would have a multi disciplinary team where you would have a doctor, you have a nurse and you would have a pharmacist that they not acting out of the pharmacy, they act from a different place where they have clubs and they would get seen by that multi disciplinary team, now that still works.
- Michelle: That can work, I agree with you.
- KS: Because the pharmacy is still there, the pharmacist is attached to that hospital and that pharmacy – anything they need when they finish at the end of the day, they take all of that medication and they place it back in the pharmacy so the storage conditions aren't, they not compromised.
- Michelle: The integrity is basically there yes.
- KS: Whereas when you take it off site to a place that's got no air conditioning or whatever is needed to look after those medicines then we have that kind of problem.
- Michelle: Exactly, you right. My brain, you've actually...your knowledge, unbelievable.
- KS: So this is very problematic for us because now it's a case of okay fine, we, at present what the department is doing is we looking at the information that we getting in, we looking to see whether the tasks that are being executed by certain professionals and most of the time they look at our scarce skill range so we talk pharmacists, nurses, doctors and dentists, they would look at that grouping because that is the group that was giving them the most headaches as far as money is concerned but of course if you have a problem then you have a big problem because if you bleed from that particular group then...
- Michelle: Services are gone, what happens with your patient?
- KS: Yes, and it's not a case of...I think that the nice thing is that before we used to have the situation whereby you used to have the doctors and the nurses consulted and, what's that other group again? Oh yes, the pharmacists, you know and it's almost ridiculous because take that away and....
- Michelle: And you've got nothing so you can diagnose the patient and do what?

- KS: Ja, and then it's like okay, we need medicines. I mean we before they always used to give you the toilet you know as the pharmacy, the smallest place imaginable they used to give to the pharmacy. I mean like at Victoria, that dump that they've got there used to be the morgue you know...
- Michelle: It's scary when you...what are they thinking? I mean ja.
- KS: But now there is a big drive as well with regard to infrastructure revitalization so pharmacy is very high up on the whole revitalization.
- Michelle: That's good news.
- KS: Which means that like pharmacy services, [name]'s portfolio is [KPA] so she would then look at, and we all started out there because that's what the whole overlap so you had to know so many things and it was difficult to really be an expert but you actually learnt a lot because you learnt one another's stuff.
- Michelle: Good, it's a good foundation, a fantastic foundation.
- KS: So what happens is now if a new place is going to be built, then pharmacy services would be called in and we'd actually look at it. Like with the two new district hospitals, [facility] and [facility], we were in there right from the beginning...
- Michelle: I can see that.
- KS: ...when they actually drew up the plans you know, like this is not going to work, no storage area, no you haven't got a plat for me, you need a road to come...you know all of those kind of things. I mean if you look at the old pharmacies, we slap in the middle and like they taking the medication through the front door...
- Michelle: And down the passages...
- KS: ...and fall off and do all kinds of weird stuff, you start out with 20 and you count there were 15, who would know.
- Michelle: Exactly.
- KS: And this is the kind of thing so a lot has been happening and I think part of that drive is also National Health that is coming into being. I don't know, I've got very little opinion on it mainly because I have listened to both sides and you never quite know how anything is gonna work until you actually do it.
- Michelle: That's the thing. I am also not sure how I feel about, it can be good it can also be bad but ja, there is so much, it's so difficult, ja, it is a difficult thing.
- KS: Ja it's very difficult but what has happened and it's been a good thing for pharmacy is National Core Standards because National Core Standards have made that...[end of recording]

PART 2

- KS: It's not just the hospital, if pharmacy fails the hospital fails.
- Michelle: Yes, that's right. So it's put us at the pinnacle basically.
- KS: Before it was a case of "oh well, you need an aircon, it's not our problem, we actually need porters and we going with that". Now with the National Core Standards it's a case, you know pharmacy has failed because they haven't met these and they have used the Pharmacy Council Inspection Report, they don't actually use it to do it, they use the document from Pharmacy Council to see that you've actually been approved as a training site.
- Michelle: That's fantastic.
- KS: And then the rest fits on, the tracer medicines that you have to have and whether your counselling is correct and you know all of those kind of things. So if you weren't able to meet your Pharmacy Council Report and you failed on it because you didn't have the necessary...
- Michelle: Correct, then you fail National Core instantly.

- KS: Automatically and the CEO's are finally cottoning on to this so if pharmacy now complains about something that they need they will go and scratch out the funds to put that in.
- Michelle: Yes, because it's an essential basically, they now seeing it as an essential. Fantastic.
- KS: So ja, there has actually been a lot of spinoff's from a whole lot of things that actually made our environment much better. I mean I worked at CHC's, way back in the day, it was terrible. I mean I would start out at a hospital which is a two man post and a one man post would go one man missing then I would have gotten all the people in already for that two man because there would have been two people...
- Michelle: That's right.
- KS: ...and then you have to leave and go to the one man show, you'd get there at about 10 / 11 o'clock, by that time the patients are majorly agitated...
- Michelle: Yes, then you would have to calm them down...
- KS: ...some of them have wondered off to do whatever. You first have to do some major reshuffling with the folders, who's here, who's not here put in the piles that at least you know who you are helping and then just and then crawl out of there, dog weiry
- Michelle: And then you have to basically put the fires out.
- KS: And then the following day go back to your own site and put the fires out that was caused by the one man show going missing. It's crazy.
- Michelle: It's ridiculous.
- KS: At least they have sort of sorted that out by actually putting agency people in place, but that has its own problems.
- Michelle: Yes, there is not too much problems.
- KS: Because you never quite know, I mean, they were actually mentioning this, that when you go out to the Pharmacy Council website, you don't actually know if that person is current.
- Michelle: Yes, that's the thing hey.
- KS: I can come there with my card and I can say that I am current but have I really? I could have been kicked off or...
- Michelle: Ja, that's exactly it, there isn't, why hasn't the council got something better in place for that?
- KS: Well I think the thing is that they actually just struggling at this moment. I've actually got a lot of respect for Pharmacy Council, believe it or not, compared to, compared to other people...
- Michelle: Ja, no I'm sure...to everyone else.
- KS: Ja, I'm like protecting the council and saying "you traitor, you traitor", they terrible, but they've got a huge task you know, the thing is like, this moment in time what they have done, I'm talking Pharmacy Council, they've made it very easy for compression of com service. Before you couldn't do that.
- Michelle: Ja, that's a good thing.
- KS: So now what you can do, and you can also eradicate people that float through comserve and aren't registered and cause all kinds of chaos with your posts, so I mean like at the end of the year all that you do is, you've got your list of people, you know when they started, you know when they registered because you've got their certificates, we've kept their certificates...
- Michelle: That's right.
- KS: ...(unclear) or death, if you don't get rid of you, they know that, I've become quite a dragon.
- Michelle: No, it's good, it's good, it's right.

- KS: So then at the end of the year all you do is, you go onto their site and this one has completed their comserve, this one has completed their comserve so it's a computerized system that you've sorted that out you know and you just send that to the CSP, here's your completion letter, it's not really a completion letter but it just says that pharmacy service has completed their part of the administrator tasks. The next task now is pharmacy within Pharmacy Council and they the ones that will then sort out and make sure that you pay your fees and save up for it because it's a hellava lot of money...
- Michelle: It is a lot of money.
- KS: Ja, but it's like something like R4 000.
- Michelle: Ja, I remember I had a shock, I had a little bit of a shock when I had to pay up.
- KS: I say to them "Look guys..."
- Michelle: It's worse now than it was...it's worse now.
- KS: It's like please put away some money for the end of the year, don't buy that car like now.
- Michelle: No, not yet, wait a little bit.
- KS: And then it's done. You know they don't have to hang around trying to find out and things like that.
- Michelle: Ja, cause I know in the past it was difficult.
- KS: So they not too bad. I mean that is something that they have to sort out and I don't know how they going to do it.
- Michelle: Ja, they will, they will, they'll have to do something.
- KS: It's just you know, it's just that it has the current...
- Michelle: If there has been disciplinary action then, you have to kind of get it on the system soon, they need to kind of have something like that and when you've gone through that disciplinary hearing, if there is a problem you need to basically immediately sever your...(unclear) administrator.
- KS: Well I suppose they put it in the Pharmaciae, but...
- Michelle: Yes they do.
- KS: ..but how many people read the Pharmaciae?
- Michelle: That's the thing.
- KS: It's like okay, they have to sort of like point out to you and you've got to like keep this list up against the wall.
- Michelle: That's the thing.
- KS: And said oh ok, so are you, you know?
- Michelle: Ja, how you going to remember?
- KS: Are you the oke over here... they not exactly going to put your P number and whatever else on there so that you can do a little comparative you know, there could be like 10 J Smith's.
- Michelle: Absolutely and there are probably.
- KS: So ja, it becomes problematic.
- Michelle: Ja, it is. Well I think that you really have actually, I was gonna ask you a few questions but you've really said a lot just by talking which is really fantastic. I want to speak to you now about little bits of specifics. What's happening with this clinical?
- KS: Well the problem with clinical is Pharmacy Council.
- Michelle: Okay, so we waiting for them.
- KS: Pharmacy Council hasn't got that as a specialty and until they have it as a specialty, there's...you cannot then employ them because they then have to stipulate what qualification the person then requires to be placed in that clinical post. Because we have had this thing come up time and again within the service where people feel that they need a clinical pharmacist and they

also feel that you know, the person would add quite a lot of value if they actually did do that.

Michelle: Very much.

KS: But it would have to be very clear cut because if you gonna be paying that person that kind of salary you then going to want a qualification attached to it and you have to have a very clear delegation as to what a clinical pharmacist is and what a ward pharmacist does.

Michelle: Yes, that's what I'd like to know, there is a difference.

KS: Because you see, the ward pharmacist would be here in production who would actually be carrying out ward rounds and seeing that everything is done correctly.

Michelle: Correct, ah you so fantastic for clarifying this, thank you.

KS: What is going to – what will happen if you decide to take from somebody here...

Michelle: Yes and place them there.

KS: ...then put them as a clinical pharmacist you will have a riot because a whole lot of people from here are gonna say "look I'm doing the same stuff as him, so how is it that he's getting paid more than me?" You going to have to have the qualification to...

Michelle: To go into that so it will be...it will be some experience plus your qualification.

KS: Ja, you would probably need a DPharm or whatever the case may be because that's why we felt that when they did the whole DPharm it was like wonderful but the background for it was not there because we couldn't employ anybody. We've got the category sitting there, unlike the poor pharmacist technician, but we've got that person there but that person comes with that. And I mean there was an incident at [facility] where they were like '[name], you know we want to get this clinical pharmacist...'

Michelle: I know they were wanting someone there.

KS: I am sorry, we can't because that animal doesn't exist.

Michelle: Ja, that's right.

KS: When the animal exists then you can employ it with all of the bits and pieces that is attached to the animal and put them there and you won't have a riot at your place.

Michelle: Yes, that's right.

KS: So all that they doing is like they would then take say a production pharmacist and then put specific tasks that they would want for them...

Michelle: Key Performance Areas...ja okay.

KS: And then use that to get a person in but they couldn't call it a production pharmacist. I mean they couldn't call it a clinical pharmacist.

Michelle: They would just you a production ward based pharmacist maybe, something like that.

KS: Ja, we need these particular skills for you, we don't actually need you to have a specific qualification so what you could have is, you could have of your production pharmacists that are actually quite savvy.

Michelle: That are good yes.

KS: That could actually come and then apply, they could be in say level 2 and they could apply for that job that's sitting at level 3...

Michelle: Level...oh at level 3 ok.

KS: And then everybody would be okay about it because...

Michelle: You only taking a little leap in salary and you doing something specific which maybe we don't wanna do.

- KS: Yes and also you know, your tasks would be such that okay, you would have specialized tasks but if you were needed you would have to be...
- Michelle: To come there ja, so you basically on staffing, they need you in an emergency, they can shift you but you need to make sure your duties are done and your duties are to be in the wards and check on the doctors and make sure, watch the nurses and..
- KS: Because we work, you know that we very pedantic so we've got KPA's.
- Michelle: Yes, that's right yes.
- KS: It just freaks everybody out you know, when it's SPMS time then you can just see this like, this tension, this floating around, everybody is noting down their incidents and who they spoke to and how many times they spoke to one another, you know, it's a crazy system and it's the only that we've got. It's supposed to be fair but of course you have the human factor in there that can always skew everything so those KPA's for that person that's now sitting here would have certain parts loaded but it wouldn't change that, that would change to talking the qualification.
- Michelle: They'd be actually absolutely an individual probably, you know, obviously working with production but given individual totally.
- KS: And this lot would respect them because the qualification would dictate the remuneration.
- Michelle: Ja, correct because they would be doctor so and so, if you've got a DPharm doctor, I see what you are saying. I am glad that you clarified that, you've been the first person to really clarify that for me, thank you very much.
- KS: Oh okay.
- Michelle: Ja, no that's very nice because I had this idea from little parts I'd heard from people what the problem was here but I still couldn't say for sure what the problem was so thank you, that's helped a lot. Okay, and are you happy with where your role is as [position]? Or is there still some things you would want worked out there, changed a bit or...?
- KS: You know the thing is I've been in pharmacy for so long and training has always been a passion of mine so to actually go into [position] and have a [KPA] has been great because of the problems that we've experienced and I am talking specifically PA's cause they a passion of mine you know, mainly because most of these people come from disadvantaged backgrounds, they don't have money you know and a lot of them have been able to be uplifted through having the PA whereby you know you provide the service and you get paid at the same time, but they've had a very raw deal in that they would go into a facility and because of the flux that we have with our pharmacists and the whole OSD, you know before OSD, we had this shift so you know this person that would be busy training and the pharmacist decides I have got a much better opportunity then, phoops, they gone and then this person's without a tutor and then the site becomes not approved by council and we had the situation, I did an audit in 2010, strange sort of things happened in 2010.
- Michelle: Big year!
- KS: Big year, not that I knew about it but we actually discovered that about 60% of our component of pharmacist assistants were all in training.
- Michelle: Wow, it's a lot. 60% shame.
- KS: And we also then discovered that with services, increasing services moving, especially with ARV roll-out and all of those kind of things, we would actually need 50% of what we had at the present in that component and what we then did was we approached the HR and said this is our situation. We can't depend in [organisation] funding, that stuff is like blowing in the wind basically you know, you will start out asking them for 80% and they will give

you 20% and then you got to struggle to get the money out of them and then you can't pay Pharmacy Council and it was just absolutely crazy.

Michelle: Nightmare.

KS: Ja, and then what happened is somebody then suggested the [organisation] Fund and I mean that has been absolutely successful because what we've done is I co-ordinate that and I said I will prepare to move forward with this project if what has been found in the past is that if the learner does not have support they do not work well. So what has the beginning, they recruited and at the same time then the [department] then provided funds for the trainer pharmacists then went into production but that production was according to their experience so the quality of person that we actually got coming in for those trainer pharmacists was really great. I mean it was people that were absolutely passionate about doing what they were doing and pushed through those people. I mean, and our head went through to national and then discovered that our province is the only province that has churned out those people just like that. So we trained 73 across the province, the people that we had in our system that were sitting at 56% that needed to be trained, had been pushed out. We've only got 18 at this moment that's in the [area], we've got 4 that need to be trained in the [area] so all of that is out and is being sort out by the trainer pharmacist because the pharmacists, they don't have the time. The most important thing is the service, it's not the training and so training is seen as this tag thing that you supposed to do and the pa's come with a lot of administration you know, I mean I only actually realized how much administration when I went into it, was like, my goodness you know, you've them coming in to a learner basic then they're a basic then a post basic and each one of those need registrations and its funds and things that need to be put in and a lot of the time those learners don't have monies so as part and parcel of the project we actually pay for their registration moving forward as well so when they graduate from the project, they actually registered for Pharmacy Council as well.

Michelle: What a bonus, I mean it's a lovely gift to give someone hey.

KS: What happens is they just get snapped up because we've then managed to employ 29 of those people in the Metropole area.

Michelle: So you take the cream of the crop if you want and you've got the choice.

KS: Ja, and before you didn't know this person from a bar of soap, now you can pick up the phone, phone the trainer and say "what was this person like?" And he can say "oh, avoid like the plague!" or you know this is...and now we had another batch that that we have so we've now got 96 that are in, that other group is out and the Metropole as asking "can't you fit another batch?" because you know, so if we sort out the whole thing with the "in principled" posts and they realize that this band we talking about, this band here, is although they are important, they need more Indians...

Michelle: Yes, so we need to work basically on that.

KS: So then this group will get absorbed, of course Pharmacy Council doesn't cover that Pharmacists Technician, we then just land up going into all kinds of labour dispute kind of things because that is what will happen.

Michelle: Yes, that is gonna land up where it's gonna be hey.

KS: I am hoping I am retired by that time.

Michelle: I hope so too for your sake cause really.

KS: You need a younger person with a hellava lot of energy to fight that battle.

Michelle: Cause that is gonna be tough. Ja, I can see also now from what you saying, I see the picture, it's gonna be a problem.

- KS: I think all of the [position] are okay with where they are because we've sort of grown into our speciality. I wouldn't say that we not replaceable but I think what I've noticed...
- Michelle: Very carefully though.
- KS: What I've noticed over a period of time is that it's the people that you've learnt, that you've picked up along the way to make your job smoother that has made the job smoother.
- Michelle: Yes and they are the ones that are...ja,
- KS: So you know, I would know who I'd phone at Pharmacy Council if I have a problem, I would have a contact in HR if I have a problem and the people that you interact with are not people that are scared to give you of their knowledge. Sometimes you have those people that you know, they'll help you...
- Michelle: Ja, but they like this about tight about...
- KS: Yes, they very territorial about it and I have found, I don't know, people have been so magnanimous you know in giving out their knowledge that's it's made a lot of difference for all of us to be able to do you job.
- Michelle: To be able to do actually your work, because that is the key but the thing is, that is why you saying not irreplaceable but it will come with difficulty because I want to say, because you have your contacts and you know you've got your structure in place, things flow now. For a new person to come and be able to do that it's gonna take them a long time to be at the level that you're at you see.
- KS: You see the thing is I think, where we sit now is where we have the organizational footprint, a new person coming in won't have that and also...
- Michelle: None of that foundational...
- KS: Ja, and we have to work very carefully. There is like a whole lot of egos that you playing around with here, you know with all those doctors over there, me with all those [position] that can explode at a moment...
- Michelle: You sitting on a boiler.
- KS: And [name] with her contacts that she has in quality assurance and infrastructure and such things.
- Michelle: All tough kind of, tough kind of environment. Now if you were going to suggest someone to go into that post you would probably want someone that has got experience in management though wouldn't you? What do you think? Because at least they will have an idea of what's happening in the structure a bit.
- KS: I think they would have to come from there.
- Michelle: I mean just out of interest or...
- KS: Ja, because you see the thing is, ja, I'm just trying to think it through now. A lot of us that are there, you know when we were there we actually discovered that we need to go and study further.
- Michelle: Ja, because I would reckon...
- KS: I did mine okay...
- Michelle: So what did you do as an extra to help you, in human resource or?
- KS: [CONFIDENTIAL]
- Michelle: It does help a lot hey.
- KS: So all of those things and you just tend to look at things differently if you've gone through it. [name] at this moment in time, she's doing [degree].
- Michelle: Good, good for you guys.
- KS: And she is doing hers in [study area] and well [name] was doing [degree] but she said she was doing it through Medunsa and she was saying it just didn't fit where she was at so...

- Michelle: I think that is a bit of a problem. The law side they do such basics and we really need specifics when it comes to medicine and all the laws around.
- KS: I think it's terribly broad you know, they cover just about everything. I mean she said like, I was thinking that they were gonna do this medical stuff and then it was like weird stuff about, what was it that she was talking about, it was something about [confidential] and something like that and she was like, no, I don't actually want to do this and then she just sort of gave it up after having done a year and a half of it.
- Michelle: Aw, that's so sad.
- KS: ...put herself through the...but at least you know, again it wasn't lost completely, it's never quite lost.
- Michelle: It's never lost. Because you have learnt something in that time, whatever it may be, you learn something.
- KS: I suppose, and a lot of us that were there, like [name], she managed [facility], [name] managed [facility] which had a district hospital, I managed at [name], a couple of them so each one of us...
- Michelle: So you were actually in you see, you were actually in management.
- KS: We were, not heavily so that we knew about matters that happened in PMF.
- Michelle: But at least, at least a supervisor.
- KS: A supervisor could possibly move around.
- Michelle: I am just wondering for interest, like who you know, just for if you, cause this is the whole thing with career pathing. If you wanted to make a move from one place to the other, can you see where you going, is it transparent enough or?
- KS: This one over here with the new trainer pharmacists links very closely to [position] because a lot of them are doing HR and they very involved in HR and HR training, not the other side which is HRM because HR consists of the two parts.
- Michelle: That's right.
- KS: So they could also make the transition to [position] and a lot of them are eyeing it.
- Michelle: That's fantastic.
- KS: [CONFIDENTIAL]
- Michelle: That's good then actually that you implemented that then.
- KS: The nice thing about the trainer pharmacists now is that it's actually become a post that's quite sought after you know.
- Michelle: Wow?
- KS: People are actually...
- Michelle: Yes, they wanting to get into it. Well it is another option isn't it?
- KS: Ja, and if you not wanting to do the whole service and management and if you enjoy training then that's not a bad place to be because it's not just about the pharmacists assistant, it's about training in general because what that group is doing now, [CONFIDENTIAL], they actually doing medicine supply management for our whole category.
- Michelle: That's fantastic.
- KS: So that's become their baby as well so they quite busy.
- Michelle: That's very interesting, I can imagine.
- KS: We busy you know, so we busy.
- Michelle: You keep them busy, that's good.
- KS: Ja no, I do, like what it is that she want now again? Because we knew that we've got such a problem, we've now got this huge data base that we can call up exactly how many trainers we've got, because we've got not trainers, how many people we have in training, I am talking about our PA's again because

we've got NGO's that also use our facilities so we actually in a situation whereby, although we've got a problem with people, the pharmacist assistants particularly that we haven't got enough of them on our system, we actually have enough of them when we take the learners that we have in place to actually execute that system.

Michelle: Yes, so we getting there, it's actually shortly away if you say.

KS: The problem arises that if you take away this technicians, if a technician comes in, what happens to this cycle of people that you training and filling posts and training and filling posts because you've got the learners that are there providing a service and at the end of it they go into the service so that the attrition that you would have from that particular category is covered.

Michelle: Yes, that's right.

KS: But if you take that away then I think there is going to be a bit of chaos.

Michelle: They just gonna leak out basically like you said.

KS: Because even, I mean, like you've you got the [organisation] that are in there and they've got about 28 that they are busy, it's like a combination of people that they have put there to provide a service so they are stipends and then they also provide funding for those people that are in the system so you've got them as a stabilizing force and then you've got the [organisation] that's running parallel to theirs and pharmacy services overseeing that whole thing so you know, we've snuck in over here but I am actually watching over the road, is the progress being done, all of those things. So you take those two things away and you would basically be down by almost a hundred people, that's across the province.

Michelle: Can't happen hey. So tricky tricky.

KS: It would be very tricky when they did come in, because everybody is, and the weird thing is that in other provinces nobody can actually tell you exactly how many people they are training.

Michelle: That's another thing I wanted to say, differences between the provinces, have you spotted them more now with this structure in place? Can you...were you able to see that there's or hear?

KS: We don't have much contact with the provinces.

Michelle: So we not quite sure.

KS: [CONFIDENTIAL]

Michelle: [CONFIDENTIAL]

KS: [CONFIDENTIAL]

Michelle: [CONFIDENTIAL]

KS: [CONFIDENTIAL] [end of recording]

PART 3

KS: [CONFIDENTIAL]

Michelle: [CONFIDENTIAL]

KS: [CONFIDENTIAL]

Michelle: Yes, I can, I mean I don't know that for sure, but I can imagine it.

KS: Because I mean we don't have as many 'Dues Out' mainly because our depot runs quite well.

Michelle: Yes, firstly that's a big bonus, your depot does run well.

KS: We don't bleed out on out on our staffing mainly because we've put systems in place to stabilize everything and I think a lot of it is because there is a effective pharmacy services that manages certain areas so we've got an effective PPTC because we've got here many that's been there since the inception of that whole thing, knows exactly how it runs, knows what to do you know, is very good at putting policy framework in place and things like

that and then of course now with National Course Standard and [name] and that [KPA], a lot of that then will become okay and the trainer pharmacists fixing up the sites for the training which is then assisted her with Core Standards and then of course the HR component whereby we use our bursary holders effectively. We coach and look after our interns. We've got proper programs in place for them so those intern posts are actually sought after not only sought after in the province, but sought after outside of the province

Michelle: The whole country.

KS: Ja, so you know we sitting in a good place. I am sure there is a hell of a lot of room for improvement but we much better off where we are.

Michelle: Ja, I think you right about that. I think there isn't really much structure in other provinces at all to be honest.

KS: I think the problem lies in the fact that maybe they don't have the skills mix you know, people sort of know that everything sort of works down in Cape Town, they will come down to Cape Town. So you can sort of pick and choose. Even our foreigners are coming down to Cape Town and I mean it's really heartbreaking because you sit with the situation where you have these foreigners and you just can't help them because you have to sort out your South African component first and foremost before you can even look at foreigners and I don't think we are unique in any way. You know, if you were to go to Canada you would probably get put in some god forsaken place out there in the sticks you know, you don't want to get a job out there where everybody are quite prepared to be so they would have to put you in a place where...

Michelle: Where no one else is willing to go.

KS: Exactly.

Michelle: No one from their own people are willing to go.

KS: Ja, and I mean that's unique.

Michelle: I think you right.

KS: And it's sad for them you know, because I, you've got [name] here, I mean he was the two of us struggled for something like five years to finally get him to do his community service and then to...

Michelle: It's a mission hey, it is a mission.

KS: It's an absolute mission and it doesn't help...it's almost like that department is like, I cannot put it kindly, like a mist you know. Now you see them, now they gone, now you see them, now you gone. It's like, you know they like...

Michelle: How can I nail this down.

KS: Who are you and are you there for long and how long have you been there you know.

Michelle: Will you please stay until we get this sorted out.

KS: Yes, like when the phone finally gets answered you like...

Michelle: Someone's thinking of me today.

KS: Ja, it's very much like that and the problem they have a hard time.

Michelle: The problem with that is is if you do have someone that's really gonna be a good employee for your country you missing out.

KS: Big time.

Michelle: Cause I mean obviously number one is to employ our own people but when we have done that there should be space for others as long as they've got the credentials you know and we don't want to miss out on it.

KS: That's another problem. I know that Pharmacy Council comes across as quite rigid when it comes to that but then when you consider what risks you would be putting your population at, if you had somebody that didn't have the right qualifications, then it's a problem.

- Michelle: And they need to be – also the other thing is – they need to be up to date with our Act and our South African Law for medicine and everything.
- KS: If you went to the other side you would do exactly the same thing.
- Michelle: The same thing. You'd have to do an internship basically and then from there you can go and work, you know, they force you to do most of the countries force you to do.
- KS: The only problem is that sometimes I do think that they almost like their worst enemy because you cannot come to a country and then by property in central Cape Town and like "Can you please give me a comserv in central Cape Town?" You know, you missing the point about comserv completely because comserv is there to source the under-resourced places.
- Michelle: That's right.
- KS: It's not to sort out the Metropole. The Metropole is okay.
- Michelle: Metropole is okay, Metropole can attract anyone they want to basically.
- KS: We need you out in the Northern Cape and in the Free State and you know all of those places that just can't get people. So if you were going to buy property and really wanted to get sorted out, buy it in the Northern Cape, they will ask you to come.
- Michelle: Yes, it's true. So true. You have a point hey.
- KS: It's a problem.
- Michelle: Ja it is, yes. Very much, yes.
- KS: And I just suppose they just thinking they probably not only thinking only of themselves you know. They come with a husband and he needs to be employed so they settle in a place where his skill might be used but the flip side of that coin is yours might not be and especially if you want to move further you might have to go where we send you.
- Michelle: That's right. Where we send you might be wherever we choose.
- KS: Well, when it comes to National it's where you are not resourced and that's where you will go. And you must be prepared to do it. I mean there have been some people that have been quite okay about it you know, they have uprooted themselves from their families and have gone for the year.
- Michelle: It's only one year, I mean that's the other side you have to see it as.
- KS: But then the thing is they put this clause in as well which actually says that they give them almost like limited registration whereby they say that you know, you must do your community service but afterwards you have to work in a public sector environment which makes no sense at all really.
- Michelle: That's interesting, I didn't even know that was in there.
- KS: Ja.
- Michelle: I didn't obviously read properly but I mean did, I did know...
- KS: Because, then you back into the catch 22 situation whereby we must first sort out our South Africans and if we can't get somebody for the post then we can take a foreigner which means if in Blikkiefontein we need somebody right? And you're a foreigner and you don't speak Afrikaans, Houston we've got a problem because some of those Afrikaners are not even prepared to speak in English.
- Michelle: No, no they are not, they will not. We know I think, all of us has experienced it at some stage.
- KS: It's like the weirdest thing. When I was speaking to one of the trainer pharmacists and she says you know, she worked in, she is working up the West Coast and she says 'Nee [name], daai mense is ander nê. As jy Engels praat en hulle weet hulle kan eintlik Engels praat maar sal nie Engels praat nie'.

- Michelle: Ja, nee nee, hulle sal net vir jou kyk. 'Ek praat nie Engels nie.' That's what you get 'Ek praat nie Engels nie.' It's true, you right, you can't just...
- KS: Even though you would love to put somebody there and you would have the post there, they would be so overwhelmed by being in a place like that. I mean they just wouldn't be able to communicate. It's the same like somebody says like you black you know and then automatically they expect you to speak the other five languages quick.
- Michelle: Exactly, it's like are you from the Eastern Cape? Ja, exactly.
- KS: No, I'm Congolese. I don't speak Xhosa, but you're black.
- Michelle: The mentality ja.
- KS: I mean I had an intern and she was Sotho which is the same story you know and they like, "so why can't you speak Xhosa? I speak Sotho, so do you speak Sotho? No, I am Xhosa and I am from here and in the Eastern Cape". You going to be Cape Town, that's the language you supposed to speak.
- Michelle: Yes, that's it.
- KS: And then the rest of us can only speak English. We can't speak 5 words of Xhosa.
- Michelle: It's so sad isn't hey, we're so bad aren't we but you need time to learn a language and be dedicated.
- KS: You actually need to be immersed in that environment as well.
- Michelle: Yes, you right.
- KS: Because when I started out, I did my internship in [city] and I was predominantly English and then like these people were like talking a foreign language, they were literally speaking a foreign language. I mean it almost felt like...
- Michelle: But you sound like you don't have any problems so you obviously learnt very well.
- KS: Well, it's gone very rusty because there they just spoke pure Afrikaans.
- Michelle: That's it.
- KS: We didn't throw slang or anything, they were just speaking 'Die Taal'.
- Michelle: And quite deeply because you know Afrikaans can get technical.
- KS: Extremely. I mean, they were like talking "Gee dit vir die boorde" and I am like, "boorde?", you know they were talking about the driver.
- Michelle: Wow, you see what I mean?
- KS: And so I was like "Who?" and you know like (big sigh).
- Michelle: It's like "Can you not understand me?"
- KS: We'll get there, it's fine. So at the end of the year I could at least speak Afrikaans.
- Michelle: Yes, I can imagine, very well I am sure.
- KS: But of course it disappeared, it's practice, you need to be immersed in that thing. You need to actually eat it, sleep it, think it, you can't be thinking in English and talking Afrikaans. You actually got to do the two together. It's the same like Xhosa would be if you immersed in the language and when I was at [facility] I actually thought to myself "Ah I am gonna learn this language" because the pharmacist assistants were Xhosa speaking, a large portion of the population there were Xhosa speaking so I thought you know, got out my book and started trying to do that you know, handing out the stuff...
- Michelle: Dispensing (unclear) I agree.
- KS: And then I moved.
- Michelle: Did you even get a chance to get to it?
- KS: [CONFIDENTIAL]
- Michelle: [CONFIDENTIAL]

- KS: [CONFIDENTIAL]
Michelle: [CONFIDENTIAL]
KS: [CONFIDENTIAL]
Michelle: [CONFIDENTIAL]
KS: [CONFIDENTIAL]
Michelle: [CONFIDENTIAL]
KS: [CONFIDENTIAL]
Michelle: [CONFIDENTIAL]
KS: Well it's thing is when they did the infrastructure for certain places, they also took that into consideration – it was like okay, we gonna take the CDU on but to do the CDU we need to have a separate hatch for them so instead of having three hatches, we now have 4 hatches and we have to ensure that the shelving is correct for that particular area because we would have a situation whereby you would actually be dividing your pharmacist because you have the CDU at one place and your pharmacy at another place and you were thinking you were keeping it separate but if your main pharmacy went down, then you would have to call that person in...
- Michelle: Correct and then that means you have to shut there, and how would you do that?
- KS: Ja, and it's also the same kind of situation that you had for ARV's, there was that time that the ARV pharmacist was very elite, it was much better to get an ARV pharmacist than to just be an ordinary pharmacist and their salary was better.
- Michelle: Actually more, I didn't know that.
- KS: It was better than you know than working over there so everybody was just falling over themselves to be an ARV pharmacist and then they discovered that the ARV pharmacist would be sitting there looking at the ceiling and then the poor pharmacy was dying because there were like a 110 people sitting here...
- Michelle: And they just trying to get the medicines out.
- KS: And then they realized that like this is just not, it is a waste of the resource, a very expensive resource as well which means like, just close that down and putting it in and putting into that.
- Michelle: I came in when that was altogether so I don't remember a time when it was apart but I heard, I remember I heard someone saying that that person was an ARV Pharmacist and I thought ARV Pharmacist? Was there such a thing?
- KS: There was that kind of thing with quite a nice looking salary attached to it and they were like very elite so they weren't just like this common garden people that were sent to these chronic patients, and we only saw to and we had to do you know, counselling and it was very important because you know it's so important for them to know that if they don't take their medicine and that they gonna die meanwhile you know chronics, if you don't take your medicine you also gonna die.
- Michelle: Exactly, it's all the same thing at the end of the day. Ja, it's like counselling diabetes and hypertension and ARV's, you have to use the same methods basically.
- KS: Exactly, so you sort of reduce them.
- Michelle: They not so happy about that I am sure.
- KS: I don't know, I think the new group coming through doesn't know about it you know, so for them it's like no biggie, they going into the place, ARV's are there, they know they have to know about it and they know that counselling is important and they just do it.

- Michelle: Ja, everyone is aware of it and everyone jumps in and you got to go for it, I agree. That's a better way of doing it.
- KS: Ja well not only that, you taking a resource that is expensive and you utilizing it fully.
- Michelle: And also it actually reduces the stigma a little but because everyone sits together you know, you've just got to...and medicines go out, no one even knows what is happening, you know what I am saying so the patients are all there together, so there is no feeling now as an ARV patient, ooh, everyone knows now, I am sitting here cause I am in this separate queue over here you know.
- KS: Because that was when [name] went (unclear) you know I was talking about the clubs and the whole legislation that that is flying about so initially they started out with just the ARV's as a club and then the patients actually complained about it.
- Michelle: And said if they here in a club they know exactly who I am.
- KS: So then of course then they found okay, that they're right so we have to have clubs for everything so they not quite sure which club is going and what time, it could be any club so...
- Michelle: That's a clever way of doing it so just say if you a chronic illness, your're in a club basically.
- KS: But of course now that they've got these clubs that multi-disciplinary teams there all of the time which means that you have to replace those people that have been tasked to do that.
- Michelle: That's right yes. So then comes more things again, it never ends does it.
- KS: Ja, but I think that is the nature of health and that's what makes it so interesting. It really is not a boring place to be.
- Michelle: Ja, you basically in a flux constantly.
- KS: Ja, and every time you think you've actually reached the point like okay, we comfortable then something else happens, like oh #@%*, I've just got this right now I am getting in this type of #@%*.
- Michelle: Enough to give one grey hairs I must say.
- KS: I am glad I am not transcribing.
- Michelle: Ja, no no thank goodness ja, you don't have to, I do, but it's good for me cause I hear it over and over and then I can pick out the most important things so, I don't think there is anything else, let's just quickly see. We've touched on what you think about the other provinces, we have really touched on your concerns in the past, the benefits you've looked at now, okay, so is there anything else currently that you would say you would still be a concern that needs to be talked about. You said the over-time? I think that was the one thing that's still being negotiated?
- KS: Currently there are just two things in my portfolio that I have got a concern, actually three, is the bursaries and allocation of bursaries because we don't want to get into a situation whereby we giving bursaries and we can't place people within our system so it's like we training people for private sector, that's a problem. And then the other problem is the over -ime, is the remuneration, the over time remuneration where pharmacists are remunerated at level 8.
- Michelle: Yes, that's I think, I know...I gave up on claiming.
- KS: It's absolutely crazy, people are not prepared to do it anymore, they prepared, they know within their contract they've got a situation whereby you know, if you are required to do over time because you go into a situation which is not regular, you will jump in and we will help but if it's a situation where you are doing it regularly then people just say "No, this is not on, this is not in my

- contract to actually do that” so what they are going to do, and this is not for noting, [CONFIDENTIAL].
- Michelle: Yes, because it depends on the facility.
- KS: You can’t just use the staff that you’ve got to spread them, it’s like an elastic band, something is going to give.
- Michelle: Yes, well what will happen is when you have a pile of patients in the middle of the day you have to be careful that everyone is there because if everyone isn’t there because of the flexi then those patients won’t move am I am right?
- KS: Exactly. So you need to have sufficient staff to cover you from this time to this time and from this time to that time because it is no good saying okay fine, we will cover from 7 o’clock to 10 o’clock, it’s just not going to work. Because I mean we had a situation where we were actually, and you know our career or our profession overlaps a lot with nursing, nursing is one of the most hard done by professions. Whenever somebody doesn’t want to do something, zap – it lands on their lap cause they feel that they need to because they need to care for the patient then they take this thing on but they actually take it on to the detriment of the patient because they now so (unclear) you know, they doing theirs, they doing stuff for pharmacy, they doing stuff for doctors and then when they shout at a patient then they get reprimanded as well but meanwhile I am doing everything.
- Michelle: Correct...everything, the pressure is on basically.
- KS: When they were doing this too they discovered that there was this one nurse that was sitting up the West Coast somewhere, she was actually the sister of the clinic but she had no cleaning staff so the first thing she would do in the morning before she opened the doors would be to clean the clinic and then do a little bit of the admin, because she didn’t have an admin clerk as well. She was like this lone ranger out there and then...
- Michelle: Then let the patients in and then it’s doing the patients.
- KS: ...then she would start doing her stuff and sort out things as she went along. They said they were surprised that they poor soul just didn’t have a nervous breakdown...
- Michelle: Yes, or heart attack or something long ago.
- KS: Now the same thing happens with pharmacy, when we close our doors, our nurses land up dispensing scripts.
- Michelle: Yes, I know.
- KS: And they not a pretty sight if you have seen the labels.
- Michelle: Yes, I have seen. Unfortunately I have had packets and stuff come to me and I’ll (hmmm)...
- KS: And not only that, I mean they are not authorized prescribers you know, they’ve been given authorization by whoever in the hospital so then you have the situation where they are carrying the can for us and it’s...
- Michelle: Actually we can’t allow that really.
- KS: It’s messy. Because you can’t do away with them and you can’t open the pharmacy because the consequences are not gone. If you then do take on and staying late...
- Michelle: Like casualties people which is what you need to be there for all the emergencies and services or....
- KS: I mean if you supposed to be there 24/7 then that means that you then need pharmacy staff.
- Michelle: That’s right, cause you can’t open your premises without a pharmacist being on the premises, as simple as that. So how are you going to?
- KS: [CONFIDENTIAL]
- Michelle: We need to come up with a solution basically, is that what?

- KS: [CONFIDENTIAL]
- Michelle: They can't let the patient not go with the meds, they need the patient to go home with some treatment otherwise what's the point.
- KS: So let's....
- Michelle: So that's interesting, what you say.
- KS: That's just like another can or worms that's gonna be opened that I wish I didn't open, it just mean like aaahhh.
- Michelle: The thing is it needs to be looked at, I mean it doesn't matter what you do, we know it's a problem, everyone knows it's a problem. So you can just sit back as a pharmacist and go, you don't want to be involved but inevitably you will be involved if you there, you will and you will have to...whatever gets decided you will have to decide how you going to run with that you know.
- KS: It's very much a management thing you know because that is, it's a management thing and it's a staffing norms thing because staffing norms would then have to take into consideration that you have got this particular service area that is generating prescriptions and because it is generating prescriptions, it then needs that pharmacy to be in action, it can't really close down and what has happened as a result of looking into this, people have just said you know it's actually better if we come in on a Sunday as well, but then again you doing that to the staff. You then again pulling that elastic band of the available staff that you have to cover for those periods of time and there is just so far you can pull it before something gives...
- Michelle: Ja, and someone will run away. That's normally the problem. People run away.
- KS: They were like okay, I don't think I can do these really, really long periods...
- Michelle: I can do this anymore, I can do it for...
- KS: I mean this was one of the main reasons why the exit was that you know, because they never had sufficient staff and because they couldn't replace the staff, the existing staff were just completely over-burdened and then left and that's why the tertiary institutions bled out like that because of the work load but then of course, and the funny thing is we actually thought okay, if we shift the workload so you have got the tertiary and they had a huge workload so now we gonna take this we gonna shift it to the CHC's then what you should actually see is, you should actually see a decrease here because you've increased there.
- Michelle: Shifted, yes. No, it hasn't happened.
- KS: All that has happened is, it has created a gap for the people that you couldn't see now there.
- Michelle: I know, I always knew that, I always thought to myself...
- KS: It was like so weird because I was doing the stats and I thought okay, so they've moved them there so, now at least with them you had decent data so you could look from 2010 when they actually did the re-engineering for the primary healthcare so you thought okay you would see this huge total, you knew you would be seeing this total but you thought that come 2014 you would see a drop off.
- Michelle: Yes, it hasn't happened, it just stayed the same because basically when the patients come in you just keep adding am I right? More and more patients just come.
- KS: No, and the thing is it's almost as if the patients that couldn't be seen because they were so overloaded now because they have shifted this they have actually landed up being able to now see those patients. We have got a very sick population.

Michelle: We do and we've got a very big population, that's what it comes down to, it needs help. We've got a big burden you know.

KS: So then it's that, it's remuneration that and oh, the staff norms that must be sorted out.

Michelle: So you don't think there is too much of a problem with other overlapping between production and supervisor? I mean you mention it is a problem but...

KS: The thing is that although there is very seldom people that aren't prepared to go into that post, even though this other post exists and I think we getting a whole different generation of people who are actually not prepared to be in the production group 3. You know you will get certain people that are prepared that okay, I am not prepared to apply through, but the younger folk are actually quite adventurous and they don't actually mind applying and having an overlap, it's just like, it's them thinking of their career and okay fine, you know I am doing this, I know I am overlapping with somebody else but so what you know. On my CV it would be supervisor with all of the things that it entails.

Michelle: I see what you are saying.

KS: I mean the other people complained about it bitterly and they thought you know that there would be a problem but from what I've seen over a period of time and the interviews that I've been to, there was never a shortage of candidates for the post and you know that's the way you normally see, you know if you've got this lone soul that has pitched up for that position then you know, okay we've got a problem here but if you've got 6 / 7 people applying for a post then you know okay.

Michelle: It's okay, it's working.

KS: I mean it's not ideal... [end of recording]

PART 4

KS: ...and they definitely could make it a bit more lucrative with the person in supervisor but it doesn't mean particularly damaging when you look at it realistically...

Michelle: I just needed you to say something about that you know. It's important to hear your point of view and you say 6 / 7 people applying so that's good.

KS: And you also, I mean like especially in the bigger facilities you'd have like four people from a facility apply for that post and I mean if they stayed long enough they would get to that post if they stayed in production and then of course you'd have the other people also from outside also applying for the post.

Michelle: So it's actually a nice combination of internal and external.

KS: It's quite a mix.

Michelle: That's good.

KS: And the nice thing is that when you actually do that interviews where you have people from inside applying for a post, you actually see the gap and how at least management it's a case of we need to develop the person in A, B and C, which you wouldn't know if they just working there. The only time you actually see it when it's in a interview situation.

Michelle: Cause all the documents are there and you ask the questions that are pertinent and...

KS: Not only that, you put them into a lot of times what they do, especially with supervisor and assistant manager, they expect you to know the basic core knowledge and so they not going to ask you clinical stuff, what they gonna ask you is a whole lot of management stuff and then you actually see the gap between here and there and there and there.

- Michelle: And you might even be surprised to find someone totally different that's not even...
- KS: And somebody who you thought would possibly be able to fit in there, you actually discover that they don't have the necessary skill to fill in over there and that's another thing that should actually be in place but I don't know where we going to put that, to put in a decent mentorship program in place.
- Michelle: Interesting you say that.
- KS: So that this overlaps...
- Michelle: So that the production can go, yes, into supervisors...
- KS: Yes, because people can't really think themselves into a post if they not actually doing it and if you don't expose them to that post then the tasks that that post is doing then you can't let them, you can't expect to come in there and suddenly by osmosis they supposed to know it you know, it doesn't work like that.
- Michelle: It's very interesting what you say, so relevant.
- KS: I wouldn't know where to put it. It would have to be done, it would have to be very structured, because I know that DPSA actually has got a whole structure worked out for mentorship and how you would actually go about doing mentorship but I mean, I am, it would fall into my portfolio but I am stretched so thin between what I am doing that even though I would love to do it, I wouldn't want to do a half baked job. I would want to do it something similar to way we did the project for the PA's you need the same kind of thing, fit in all of the structures in place.
- Michelle: I agree with you.
- KS: Otherwise it will fail and then people, you would have wasted your time and your energy. You would have to first put some sort of policy in place, you'd have to pitch it to the top management, it would then have to go into their KPA's so that it's there as a KPA, you know that it's a official task that they supposed to do, they will allow them time off to actually go and do their mentorship and do whatever they need to do and they would actually be rewarded for it as well.
- Michelle: Cause it would normally fall into their SPMS basically.
- KS: Ja, you can't just have it as a tag on and nice to have, it doesn't work like that. If it's not recorded, you know how rigid we are...
- Michelle: If it's not recorded no one knows, it didn't happen, it doesn't exist.
- KS: You know we need an SOP, we're pharmacists, we need that SOP we can't just do it you know.
- Michelle: So true. Okay, so that's a very good point you made though, very good point because I was just wondering about like how would you do that but that is a very good point you said, a mentorship, it's a key word, a very...
- KS: People talk about it a lot and I know that I actually came to [institution] because they actually have a mentorship program in place. I don't quite know, I don't think pharmacy is in involved in but there is a designated person that does mentorships and she actually has the mentors are trained and they have mentees, I think it's for these people coming in and they almost like a little buddy system and they show them around so that they don't feel completely alienated and lost and then they have activities for them and things like that and I was listening to this and I thought this sounds fantastic, I can just see myself going to the PMF and saying "Look guys, I looked at this mentorship programme in for you but I am actually gonna need like 2 hours of you people's time" I can just see them.... 'aarh what's gonna happen to our patients?'

- Michelle: Ja, that's exactly it. That's the problem hey, that's actually the big thing, how do you implement it without affecting production because it's a production pharmacist or a supervisor to management you know what I mean, how do you do it without?
- KS: I suppose you would have to, if you going to put it you going to have to show the value, it would be the same like the CDU, like the PA project you know, once people start seeing the value of it then it's like "Oh, actually you know we moving the people from here to there because of that mentorship program, they so much better prepared you know".
- Michelle: Yes, so soon as they've had that first boost and it's actually worked then they will...
- KS: It's like their whole attitude change exposing people.
- Michelle: And then all of a sudden it becomes 'I want to do as well', you find there will be pharmacists that would request 'Can I be in the mentorship program?' and there will be people that want to be mentors and all of a sudden you got the ball rolling.
- KS: Yes, but again you would need the proper structure in place to ensure that it works and I haven't wanted to touch it and when I went to her, I was like 'Aah this is so fantastic, how do I pitch this?' Sometimes you just know that the environment is not right for something and it's like a matter of like a year, it's like "Oh yeah, it wouldn't have worked last year" but this and this and this has happened so now the environment is such that it's more conducive to putting that particular system in place, but it wouldn't have worked. It would be one cranky old person...
- Michelle: Exactly, that's...okay you've moved the (unclear)..
- KS: (unclear) it's all sorted out.
- Michelle: Ja, no wonderful. Thank you so much.
- KS: Alright Michelle, I think I have covered your stuff, I don't this there is anything that I have spoken about with the exception of some facts...
- Michelle: That you said and I will take that out, that's not an issue. Wherever I hear...
- KS: [CONFIDENTIAL]
- Michelle: Ja, no obviously I will do that, but thank you it's been ...[end of recording]

APPENDIX W: TRANSCRIPT FROM INTERVIEW WITH FOCUS GROUP “FA”

PART 1

- FA1: Alright, firstly Michelle, I've got a couple of concerns. Currently, the grade 3 pharmacist entry level, I call them entry levels. So it's number 1,2,3,4 and 5. So I call those entry levels, currently earns the same salary as the grade 1 pharmacist supervisor, yes, so to me I feel it's not fair as the job descriptions are not the same. Secondly, it's not fair to a person who is already on grade 3 level 5 to become a supervisor. I don't know if there, is there any, do look at what you earn , and then, because you can't down grade on your salary, obviously, so let's say I've got this 15 years of experience, I'm already now on grade 3, level 5. I'm earning...
- Michelle: 589
- FA2: 589
- FA1: 589, and now there's the supervisor, there's an advert at my facility. it's a grade 1 pharmacy supervisor, it's 555 0.. something, I won't be able to apply , because now that would mean my scale now is dropping.
- FA3: I think you will be appointed on the scale that you are, I don't think you will be downgraded
- FA2: They won't downgrade you.
- FA1: Is it?
- FA2: You will be appointed at 589
- FA1: Ok. And another thing, there's this person we are working together, I am a supervisor and this person is more experienced to me, but now the job descriptions is not the same and this person now is earning way higher than me.
- FA4: That's the way the cookie crumbles.
- FA3: No, no, no. That's the wrong way the cookie crumbles.
- FA4: No no, that you have out-outside as well.
- FA1: Ok. And another thing. Another question that I have Michelle, what happens when a production pharmacist reaches grade 3 level 5.
- Michelle: They stay there.
- FA4: Stay there.
- FA1: forever
- Michelle: They get their cost-of-living adjustments every year.
- FA2: 2% plus 5%
- Michelle: 7 ya, basically. 2 and 5, ya. That's as far as I know, you see, now this is from what I have read so see FA2 is sharp on that, that's why you're also here, ya.
- FA3: You get your annual increase.
- Michelle: And your increase forever.
- FA2: What you can do, ok, is... is you can negotiate. Can't you?
- FA1: With the government? Negotiate?
- FA5: You can't negotiate, no.
- FA2: Labour law says that the government is your employer and you are the employee, (unclear) the employee is free to negotiate with the employer. Where the employer wants to negotiate back is something else. I mean, government is still... it's not the government, the government is your employer. Okay, that's the way I see it. The government is your employer. Okay, now what's making, what makes the government different from any other employer. If you work at [facility name], and you're not happy, what you going to do? With your salary? You're going to negotiate, yes or no?

- FA1: Yes, I'm going to negotiate.
- FA2: Now why are you not going to negotiate with the government?
- Michelle: You've got a point FA2. Anyone else want to say something about that?
- FA5: Can we just go back to the pharmacy supervisor, the pharmacist grade 3. So if they are earning 589 and the person, pharmacist grade 3, 589. And then you have a pharmacy supervisor who has just come in as a pharmacy supervisor and is on the bottom scale earning that 555 figure.
- Michelle: Yes
- FA5: The pharmacy supervisor is responsible for what happens in the pharmacy but now you have a production pharmacist who's earning more than you, they don't really care about what's going on because you're going to have to pick up the flack, yet you're earning on a lower salary scale than them and you are responsible for what's going on in that pharmacy. All, everything, the implications you're responsible to pharmacy council, you're responsible to the facility you work for, we respons... I mean our responsibility goes back and it's going to come on your head, where as that other person may or may not even care about their job. They're just there doing what they feel like doing and that's where I have an issue.
- FA3: I agree with you, because a supervisor has got so much more responsibilities. You've got much, a bigger work load, you've got more stress than all of them - who's the one that jumps in when there's a staff member short.
- FA5: Exactly.
- FA3: The supervisor. You help dispense or you say "okay, wait I'll do my admin, my financial year end admin documents later". Who delivers the ward stock when there's short staff. Nobody else jumps in. Not one of them will come and tell you, you need to order labels. They wait till there's just about no labels left. You're the one that has to be..have like antennas out, pick up, the labels are getting low, the containers, the bags are getting low, you're the one you says you know, "we need a fridge, you need to bags (unclear)", they just come in, stick to their job description and go home and they sleep well. But you're at night thinking, "tomorrow morning I have to pick up the backlog from yesterday because I couldn't do my job I had to help the production pharmacist and at the end of the month, they go home and earn more than you". So I would think that the, the pharmacy supervisor level 1 and the pharmacy production pharmacist grade 3, should not overlap. The pharmacy supervisor should come in at a higher level than the production pharmacist 3.
- Michelle: So you still think that, it's still attractive, it's better to have, I'm just concluding this now, it would be better to actually have them totally separate that there's no overlapping
- FA3: There mustn't be overlapping
- FA1: Yes exactly
- Michelle: Okay. What about you FA2?
- FA2: What do I think, okay, let's let's ok this is now another can of worms. You've got your pharmacy supervisor, okay I'll use FA3's at [FACILITY NAME]. Okay? We've got how many pharmacists? 2?
- FA3: No No. Me plus... 3, we're 4 pharmacists.
- FA2: 4 pharmacists, okay. right and you've got a big responsibility. Okay. Now you take a normal pharmacy supervisor like me. Only 1, only me.
- Michelle: And FA7, and FA8.
- FA2: And FA7 and FA8
- Michelle: So single pharmacist CHC.
- FA2: Single pharmacists. I have got...
- FA3: At CHC's

- FA2: At CHC's. I just wanna...
- FA4: Setting the scene
- FA2: ... set the scene for you, right. You can delegate, to your other 3 pharmacists.
- FA3: Well, in theory
- FA2: In theory, no I, I am painting the theoretical picture. Whether you do it or not, I can't go into that ,Okay. Which you can delegate pharmacist responsibilities too.
- FA3: Yes, not management responsibilities.
- FA2: Pharmacists responsibilities.
- FA3: They can supervise the assistants.
- FA2: They can sup...exactly. They can answer questions to the doctors okay, I will now go back to, as well as the FA6 over there...now I paint my little scene. I am 1 pharmacist working at a CHC okay? Which has a trauma unit, we've got no overnight facilities and we don't have wards but we have trauma unit, we do paediatrics, we do chronic medication okay, we also have a MOU okay?
- FA3: Ja, so you basically have a ward.
- FA2: We basically have a ward.
- FA3: Is your trauma 24/7?
- FA2: Trauma is not...that is one of the reasons why I would not going for it, for extended hours. Now to get back to what I am actually okay, I know you have got great responsibility okay, now between the two pharmacists like me and you, just to paint the picture, if you fall sick, what happens?
- FA3: Ja, one of them has to step in.
- FA2: If I fall ill, what happens?
- FA3: Close down the facility.
- Michelle: Bingo.
- FA6: Correction, community service pharmacists can take your position.
- Michelle: Do we have one by the way?
- FA2: We have got one. Now you are painting another picture...my community service pharmacist is working at FA5. FA5 is not there and say [name] is not there, will she be able to spare that community? What will she say?
- FA5: No.
- FA2: That's the one thing. The other thing is, how long, I am involved in accident say on my way to work – how long it is going to be for everybody to pull together and say...let me put it to you...will it be business as usual?
- FA7: No. And to add to what FA2 is saying, now I am sharing a CSP with FA1. I'm not sure with who else is using [name], and I will be getting him apparently for only 2 days, now [facility name] it's four days that are craziest so now I don't get sick, it's difficult I can tell you, you have to be sick at work whilst you are making the calls to try to find a replacement otherwise if you don't come at all. Shame, FA5 has to be told in the morning when she just got there to spare another pharmacist to go to [facility name]. Now she also comes in, receiving a call that no [name] is not coming in, such and such is not coming in and I can't help you as much as I want to, now what is happening at [facility name]. They have to close, the call goes to [name] [surname] now our director. He has to find someone somewhere to go open up, to work so yes we do have CSP's but how many community service pharmacists do we have here...
- FA3: Ok, wait, what we did...
- Michelle: So, no but this is, this is part of the point and the thing is there are discrepancies between supervisory roles okay.
- FA7: Yes.

Michelle: And so what the policy specialist and your director pharmacy services says is that they have a general supervisor kind of layout on what your duties are but they need to be fluid and unfortunately then this comes in on how fair is it? How fair is it? The fairness...each one has got their things and they looking at someone else going "I wish I was rather in that position", am I right? I don't know if I am concluding correctly. So now if you look on your sheets, there is some comments there – these are just sayings of sayings and there is one there that says "I don't know why a fellow supervisor is moaning, to be a supervisor is to be a supervisor no matter where you work". So we don't agree on that?

FA3: No.

FA7: No.

FA5: Because in the case of FA2, FA7 and FA8, I don't know about anybody else but there is more and more paperwork that we have got to do. I don't know when you guys are finding the time, in all honesty to do...I don't find it and I have had [name] and when we sharing a Comm serve but I am not finding the time so I don't how FA7 for example is finding the time because I know when we don't have [name] on a Monday and a Tuesday I don't even go walk into the office, I don't turn on the PC to check an e-mail – I am in front with [name] and I don't...

Michelle: You don't know how...

FA5: So I don't know how you guys are doing it, that are on your own.

Michelle: So now you are all getting paid the same salary okay, so now it's the whole thing of comparing salary with responsibility. So do you think there should be some sort of par-separation in OSD? So that you know what you are getting into and that your salary is according to really what you do? Not just so generalised? Am I suggesting?

FA2: Yes

FA5: Yes

FA1: Yes. In that Michelle, it moves me to another point that I was about to raise. Can't CHC's have allowances?

Michelle: Yeah ok, bingo. Good suggestion.

FA1: We saying they look at those allowances, let's say we have a standard salary then they look at the busiest and the availability of pharmacists in that facility, I don't know if I put it right....

FA3: The staffing model...

FA1: Yes, and then based on that, then there could be an allowance say okay, in this CHC, this is the situation and this CHC, this is the situation.

Michelle: Or even to group CHC's with single pharmacists together and say those guys get a bit extra for locums and also for pulling staff from different places, whether it's from municipal or whatever and this is the negotiation that needs to happen, so that when things crash you've got a backup basically.

FA3: I think what you also try to say that, single pharmacists, CHC's, the supervisor should get a special allowance.

FA1: A special allowance.

Michelle: Scarce skills or rural...

FA1: Rural...

FA3: If it's a single, if it's a CHC with a single pharmacist doing more than X amount of scripts, they will get X, if they doing more than Y scripts they will get Y, so it will be sliding scale on the amount of work you do, what the extra set of rural will get like a CHC allowance.

FA2: [00:15:09] Now that will also be something else. Take now for instance, do you have a MOU?

FA1: No I don't but I've got an ARV clinic.

- FA2: I have an ARV clinic as well. Okay, you have an MOU?
- FA1: Clinics like [facility name] have a separate ARV clinic,...(unclear) managed by two or three pharmacists at a time.
- FA2: No see there is a difference between...
- FA3: I agree.
- FA2: With...
- FA3: Some CHC's and some... other CHC's
- FA2: To make it even more complicated okay, there is some...and this you pick up among the locums, there are some CHC's the locums don't want to work in. Like for me for instance, I booked a locum 6 weeks backs and he thought it was [facility name]. I called him to confirm and he heard [facility name] - he cancelled.
- FA3: Ai, you've got a terrible reputation.
- FA2: It can get a bit wild, FA6 worked there...you see...you understand...
- Michelle: It is wild I know.
- FA3: Don't you think that there should be a different staffing model then? For a CHC? Because do you really want the money or you want more joy in your life and have more staff?
- FA2: You want more staff.
- FA3: You really would like to have more staff. So I think maybe the staffing model needs to be looked at because we were like you, nobody, [FACILITY NAME], no thank you. But since our staffing model was re-looked at and adjusted and we've had the vacancies, the posts created and it's not for...we've got more staff. Now everybody wants to work at [FACILITY NAME]. So I think your biggest problem for you is your staffing model needs to be changed.
- FA5: [00:17:00] But for everybody staffing models are important and they not even at...they are not looking at the CHC's, they only addressing hospital staffing models because I have been fighting about a staffing model for [facility name] and they...the concern at the moment is to get the hospitals right. I feel that the CHC's is everybody goes from [FACILITY NAME], [facility name] to wherever their feed down are and then I feel that the CHC's are not even looking at, they not even considering our staffing models at the moment – which is wrong.
- FA7: I do agree with you that with the staffing norms, you supposed to be such and such pharmacists but then we don't either have funds or...
- FA5: The posts...
- FA7: The posts is frozen or we can't have another pharmacist. My famous quote now "Your place is too small". Ja it is too small but it is still too busy.
- Michelle: We would rather be 2 and work in a small space and at least feel like we are happy.
- FA7: Exactly.
- Michelle: And fall over one another than actually just be me on my own – and I'm struggling.
- FA7: And they of course creating the post, then you will be sent through a whole list of as we know, government...(unclear) my part, now I am waiting for such and such so...
- Michelle: Red tape, that is a very important thing that you are talking about there, cause it is going to come up a lot amongst other people as well. Okay, let's just see – you have basically covered something very important, that is about the fairness thing and the fairness, production to supervisory and the fairness supervisory to supervisor, when you comparing to one another – that is part of OSD – straight forward. But now let's talk about something else. I think you

have made your points and those will all be put down. What about, firstly when you came in, when you guys took your jobs, did you have any idea what it was going to be like? If you could do it, is the comments on there on that comments page, that says “If I know now I would do it again or I would think twice”.

FA2: [00:19:14] Actually I would do it again. The reason why, my reasons specifically, that’s why I didn’t want to comment on more staff. The reason I said in my interview, when they saw me at the salary that I was earning then, I actually took my salary drop by two thirds and the only reason I did it was I told in the interviews as well is, I don’t work Saturdays, I don’t work Sundays and when I am done with the place I don’t need to worry about anything else, I am done. That doesn’t happen anymore.

Michelle: That changed.

FA2: That changed. Okay so but....

Michelle: The weekends are free.

FA2: The weekends are... at least I see what my wife looks like in...I mean when the sun shines now. I don’t see her like dark when I go...understand, that is it so all being the same, I will still and that is the reason.

Michelle: And anyone else?

FA3: I agree

Michelle: FA8? How do you feel?

FA7: [00:20:14] Except with the part of the weekends free and again, when I started here I was working a lot with FA8 and I kept asking her a lot of questions because as a CSP and when you doing your intern that is where you have to ask a lot of questions. So seeing her working alone, I kept asking her “How do you do your paperwork seeing that everything you doing? No FA7, I am working over time. Are you getting paid for all that overtime because when you take work from work to home...
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FA5: Ya, that’s overtime.

FA7: Over the weekends you have to do your paperwork so, in a way I knew like I was going to be the only pharmacist now having to take work home but I thought ok, maybe no offence, FA8 ...(laugh)

FA8: You would manage it, no,no.

FA7: Maybe she has got...

Michelle: She told me the same thing....

FA8: Thank-you, FA7

FA7: And I am (unclear) it will be easier for me, but also that is why I am saying, you supposed to have weekends, holidays, but we don’t. You can’t claim overtime...

Michelle: Okay, there is a bottom statement, “we claim overtime in our facility without any problems”.

FA7: We don’t.

FA3: [00:21:27] If necessary we do.

Michelle: But how do you do that?

FA3: Well if I know I need to work overtime to pull the time I just motivate and get authorization for overtime so when we have to do stock take or scrub the floors or put in shelves or whatever, it gets authorized, we work and we claim the overtime but for other little things like coming in on a Saturday, quickly on a long weekend to do TTO’s, my staff prefers to have the time off. So certain things we say okay this you have to claim money, when it’s more than three hours you claim overtime, when it’s less...because we can’t afford to give anybody more than three hours extra off.

Michelle: So you only allowed to give three hours off....

- FA3: No, no, in our place it's not practical to give more than three hours. So if you have to claim more than three hours you have to take the money. It's an internal agreement between us.
- FA1: [00:22:25] With us we claim via persal. It's not a problem if we maintain that 30% of your salary cause we mustn't work over that. It's not a problem but once you exceed the 30...working extending 30% then it starts being a problem because you don't get paid all your money at the same time. They pay your money with portions.
- FA7: [00:22:58] Lucky you guys because we can't claim overtime. I can't claim overtime because there is no other pharmacist who is going to be in my place, you know, even just come here now. I mean the e-mails have been sent and all those things so, do I want to have my half day, no I can't because there is no one, there is no replacement for me. I can't claim because my facility manager will tell me that he still have to send it to Mrs. [surname] but it's a long process up to a point – I don't know how much I am owed currently, up until I said okay no overtime anymore. Like if the patients now are left over or if there is any other thing that needs to be done above that overtime then they must go to the office until they sort that whole thing out because I have worked at [facility name] and as FA1 explains it, we used to do it like that. You had to claim through persal, there are funds, I know there are funds that accommodate that, just like FA3 said you know, but why isn't it available at my facility.
- Michelle: Ja, that's a good question.
- FA5: [00:24:08] At our facility we...well we're linked, we were working until 7 o'clock every night till I decided we are not doing it anymore because we put in all our overtime and it's just not approved...we don't get it.
- FA3: [00:24:20] Do you think there is a problem with your facility manager?
- FA7: Our facility manager is... okay...
- FA5: And [name] [surname] doesn't sign it off. She doesn't sign it off.
- FA4: I haven't said a thing yet.
- FA3: Come FA4...the floor is yours. She will come afterwards.
- FA4: The thing with overtime is, is that you need the budget for overtime. In other words if you don't budget at the beginning of the year and say to your financial people "I want to budget so much for overtime for the year" then it is very difficult to claim. So you must budget and say "I want to budget so much". They'll either agree with it or not but at least it's a planned overtime and that is the only way you can get anywhere. If you don't then certainly in this area you won't get anything.
- Michelle: [00:25:10] Do you guys...are you happy with the rate?
- Everyone: NO!
- FA2: I was waiting from somebody to....
- Michelle: Never mind that. This is...listen...you, that is a separate problem and that must be addressed by someone. I think, look I am an outsider, but what I will do is, I will kind of nudge [name] and say there is problems okay, just say that I heard you know and just see what he says about that because we need someone to kind of knock him on the shoulder and say "What's up? What's up?".
- FA4: It's been like that all the years, is that they pay the basic pharmacy salary...
- FA5: Forget about overtime, they won't even sign off the locums. Don't you battle to even locums they won't sign off locums.
- FA7: But guys I think its...this is per facility. How organised is your facility manager because it relies on him or her, because with ours as I've been saying, we need to plan. It's about planning. Your facility manager knows

- there should be an overtime and should suppose to know how many people works and then you submit that to her when you...
- FA3: But he can reject because he has got all their overtime from this financial year.
- Michelle: From the previous years...you just take your register. It is planning but...
- FA7: With the planning from [name]'s office it is always done because you to submit your leave plans for the following year and coming year so they've got your leave days but now come April this next week that I'm, that is coming up, I can't go for Easter because they haven't found a locum. I submitted my plan for that week last year but now I find out no, like it wasn't approved or like we are still waiting for the funds from last year to be allocated for this coming year and all those kind of things. So for us who are we supposed to speak to because I promise you, Mr. [surname] does know, [name] [surname] does know.
- FA3: I think you need to go to the union. FA6, also wants to say something.
- Michelle: Did you want to say something?
- FA5: Because I have [name] off from next week for two weeks, [name] and an assistant and I have no locums approved, not allowed locums. Now we two pharmacists, three assistants – two are gone, it's one pharmacist two assistants – that's half the staff. So we half staff for the next...with all the holidays. It's ridiculous.
- Michelle: Is it ridiculous.
- FA3: FA6 what do you say?
- FA6: [00:27:50] I just wanted to mention to her who the guys to the budget is, like last year we had like a pool of finances where all, you see we're at the hospitals, so we have got our nurses and the clinical and the pharmacy staff you like, benefiting from that but, also due to staff availabilities at the end we depleted the finances quickly so we need to work on a plan and had to budget before the time but eventually it ended up also with us taking time off to compensate for everyday that we open, even weekends as well. Now, for the next financial year there is not actually money available for the locums, they actually...
- Michelle: Cutting the locums.
- FA6: Now we had to divert to the persal payment which will be more beneficial for the assistants than for us. So also to still make up for that, we must still take off that because the proposal that we all...
- Michelle: Take time. But FA6, yours is a bit different because you, are you guys on flexi-time, when you sign your contract, you sign... and you have done your probation, are you a flexi-time employee?
- FA2: [00:28:58] Yes they are.
- Michelle: Because your facility is going to be extended hours, you are an extended hours facility. If I am right?
- FA3: They are.
- Michelle: And you as well?
- FA3: No I haven't got a flexi....
- FA2: And that is the reason why I don't want another pharmacist, my own selfish reason, because then because we have a MOU in other words, they going to tell me that I have to work flexi-time and that is the actual reason why I rather prefer another post basic assistant...
- Michelle: And keep it...
- FA2: Ja, and coming back to the overtime, I did my sums...
- FA3: It's an insult.
- FA2: And it works out after taxes and all that, R89 an hour if you lucky.
- FA1: Exactly.

FA3: It is.

FA2: What I usually do, I got a agreement with my facility manager and my staff as well, when they work overtime I add it up and I give them a half day off. And what I do is we plan ahead with that specific, in my case, for that specific day we give 2 months supply so we know we gonna be [end of Part 1]

PART 2

FA2: Tell them okay, my post basic assistant, you can go, you can go a locum, and earn double the money. As I said, I won't even....

Michelle: R89 is really a joke.

FA7: It's a joke. But there you also have that understanding with your facility manager because they won't be questioning you why do you have to close at 12 o'clock or whatever time you have to take.

FA2: No, we don't close, I just give them off but then again it's...and this is another shall I say, not some pharmacists and supervisors is, that I have found that the pharmacy is our domain, we run it and basically the facility manager, technically speaking, and I told my facility manager has this understanding as FA6 now knows that the pharmacy is my domain and I don't actually answer to her. As a pharmacist I do not answer to the facility manager. Okay so it's, if we had, we had this discussion with, I had a discussion with the facility manager right in the beginning and I told her this is what act says unless she wants to rewrite the act and then she has to put it in writing and then we take it from there. So we have this understanding so the pharmacy is...as long as things keep on ticking over and there is no...she doesn't have an issue with and she told me with the time off, it's not actually government policy that have to payroll. The government policy as she says, you cannot take time off, you have to claim for overtime. That's the government policy.

Michelle: Claim overtime. That's what I know as well.

FA2: It's an internal arrangement we have, is we take the time off.

FA3: [00:01:48] We also have an internal agreement for that because as long it doesn't negatively affect the work flow and the patients outside and the hospital get the medicine, what happens inside is actually not their concern as long as it's documented and nobody can come back and say you are stealing time or you doing something wrong, it's all, I can show you the papers and everything why its happening but the patients are not affected by it.

FA7: [00:02:20] With my situation you being hindered now by the operational manager because we have got operational managers but we share the same facility manager. You being hindered now from this level because: "no you can't claim"...he knows the last week we going home at seven or eight or whatever time but now I want to claim: "no, but we don't have funds. Okay fine, I am going to take my half days. This is what I have planned – further like not next month." I am saying like...

FA2: May I interrupt? When someone tells me it can't be done, my response is usually "where's it written?". If you tell me this...

FA7: I have fought with so many...oh but those things...I do understand what you are saying.

FA2: The question is, you tell me it can't be done okay. It cannot be done, where is it written? Government got policies for everything. So where is the policy that says it can't be done. You show me the policy and if you can't show me the policy I do, and that is what I told my super...my supervisor, my facility manager. This is what the law says, you tell me something else or show me, show me that contradicts this and I will accept it but if you can't show me. They can't discipline you if it doesn't...

- FA7: But they do internally in a way that you know you, you know you're being victimised but at the same time it doesn't look like it, but you know and the other staff know because I am telling you, currently I am being victimised, I am under that scope where I am being watched what I am doing, what I am saying and all those kind of things because of what I've said. I've told my managers, the operational manager, together with the facility manager, you don't have any say as to what I do...
- Michelle: Happens in that....
- FA7: What happens in the pharmacy, that is why pharmacy supervisor and on top of me I've got my director and I promise you, call him right now, I haven't said anything to him. Ask him about this situation – he knows – because before it even comes to you, he has already found out because we keep that communication with him.
- Michelle: That's it.
- FA7: So when it comes to you, yes manage the facility what happens around the facility but here, but then I started becoming now this number one enemy because....
- Michelle: You made a reputation for yourself..
- FA7: So now I won't be getting leave, even if I planned my leave, I can't be sick I still have to...I was deducted salary because of approved leave that I taken now, something that happened. For now everything to be resolved, now I always have to run to union because they solved that first case and now I don't, like I do know my job description and what I am supposed to be doing, now I come at work in that mood, say what you say, repeat it because now we have to speak through e-mails, what I found out because you won't know what is said over the phone or if when we are talking personally.
- FA2: There we go.
- FA7: So now please talk to me through an e-mail because now I will call you, have my directors or whoever then this is a print out of whatever was said.
- Michelle: Was said, that's it. I agree with you...
- FA7: I'm at that level but why do I have to even get to that level?
- Michelle: I agree with you.
- FA7: It was not personal or anything.
- Michelle: But FA7 okay...let's not get off the topic though.
- FA1: [00:05:55] You know, getting back to the overtime, salary or percentage, my question is, if doctors can get paid according to their levels, what pharmacists are not getting paid according to their levels...
- FA3: On the overtime, FA7?
- FA1: On the overtime yes. Because as far as I understand, the doctors get their certain percentage according to their levels but when it comes to tax we get taxed according to our levels of which it is not fair.
- Michelle: [00:06:31] And you have got a point there, there is a problem with the overtime thing because if we have an extended hours facility, how are they going to pay you?
- FA2: They not going to pay you, they gonna change your contract to flexi time and that means you come in later and...
- Michelle: Yes but, but still there is still problems cause you still gonna run over and no one is going to accept an R89 an hour....let's be honest hey? There is problems with that.
- FA1: [00:06:58] And the flexi-time with my facility doesn't work because as the people, let's say flexi-time people must leave at 3, I'm just making an example, that's when the patients are there all over the waiting room and

- that's when the people who are left behind fill the work, with one person that is not there, it's a train smash.
- Michelle: Ja, so you can't have people coming in later and leaving earlier etc.
- FA1: Exactly.
- FA2: You know what the problem is with the pharmacy? That's actually the crux of the matter with pharmacies...is pharmacy is something people, other people consider anybody can do.
- FA1: Exactly.
- FA2: You see, the problem with pharmacy is this...this is a problem with pharmacy, you know with pharmacists in general. If someone sees a lady walking around with a white jacket, what they call her?
- Everyone: A doctor – sister – nurse – male nurse....
- FA2: [00:08:10] What do they call you?
- FA1: [00:08:12] They call me Mrs Sisi.
- FA7: [00:08:25] Me, I am still a sister.
- FA2: Or they call you...
- Michelle: [00:09:28] I've been called a sister as well.
- FA1: They call me nurse.
- FA8: Sister...or I even have "FA8ny".
- FA2: Now that is...
- FA8: People I don't even know, don't even recall having had that sort of intimate conversation with ever..."FA8ny".
- FA1: You know it starts from the top because I remember there was a strike, I think in 2010, and actually the minister of health said that ja we will still have skeleton staff, there are actually a few nurses that are dispensing and are saying...ja, if I am putting it right, I am not quoting the exact word but I was surprised, where the pharmacists? There is no mention even when they mentioning it on the news, doctors and nurses, no pharmacists. So I am like...
- Michelle: Can I tell you guys, when I started doing my foundation for my research, I went and looked in all the big journals for articles on OSD okay, so obviously the doctors had written article upon article upon article about how they fighting for money okay, and the sisters also had their section, there were a lot of spelling mistakes unfortunately in their section as well and then we had one, one article in our [name] journal you know, one article. So it us, we've got to actually start...it was [name] [surname] that wrote it and he had basically gone and put some input in as a consultant for bargaining council and so he was really getting involved so he wrote a whole article about where we were standing at this stage with our negotiations but that just shows you, it's us, it's pharmacists, I don't know why we are like that. We are not doing it on purpose – we carry a heavy burden everyday but I think, and I speak for myself as well, you know, you just think ag, do I have to go to this meeting? Ag, do I have to be involved in this?
- FA1: Exactly.
- FA5: Ten years ago our pharmacy council was brilliant, today our pharmacy council is not really up to much.
- FA2: [00:10:45] Our pharmacy council is actually been whittling away in that our responsibilities and all of that since I finished in 1990, and since that time, the pharmacy council is the biggest enemy of pharmacists.
- Michelle: Ja, but that is why we need to support people like the PSSA and organisations so that they can basically stand against pharmacy council, to have our side of stuff. Okay, who is going next?
- FA3: [00:11:09] We have allowed the public and the other medical professions to treat us as second hand professionals for a long long time. The pharmacy

council is not on our side. With the medical council they help their doctors bury their mistakes. Our new president, just see what's the quote? Her vision is to protect the public against the pharmacists. Who is protecting the pharmacist? Nobody. And we not fight for ourselves?

FA1: I was going there to that statement as well.

Michelle: But that is why we need...need societies.

FA1: Check on the internet.

FA2: I have one, I asked...I actually asked the pharmacy inspector, I asked this one question. I asked him like "listen here, you have to have a responsible pharmacist name in your books don't you?" so I asked him like "now what happened if every single responsible pharmacist refuses to pay his fees? Are you going to close each and every pharmacy?" Up to this day he still owes me an answer, but then he got me back and nearly closed my pharmacy.

Michelle: [00:12:21] Nice FA2. Okay, let's go onto the next thing okay. Let's just go back to some foundational stuff right, start at the top. Firstly, are you guys happy with your salaries? Just answer that...

Everyone: NO

FA2: Okay in my case I am happy I am working, I actually get what I want, weekends off and that's what I wanted.

FA3: [00:12:48] Can I say something? I want to...I want to differentiate this. I think despite all this stupid sliding scale about the supervisors overlapping with the production pharmacist level, I think we are getting a good salary in the government because I worked in retail and it doesn't give you recognition for your years of experience. There you got paid according to the size of the pharmacy you managed and of course, if nobody showed up you stepped in and that, but I think in comparison with the hours you worked and that and your experience, I think we get a decent salary. If they can just fix this supervisor scale then I'll be very happy, then I will be 100% happy.

Michelle: So are you...can I just ask this question, do you think more and more people want to come into government, pharmacists want to come into government now?

Everyone: Yes.

Michelle: How do you guys know that?

FA5: Talking to people.

FA3: [00:13:49] They phone you all the time.

Michelle: How do you guys know? Talking to people? Friends?

FA1: My friends.

Michelle: That you studied with and colleagues

FA1: Who have worked privately.

Michelle: Ja, they want to get out of private and in...

FA4: I go to meetings and courses every now and then and you meet people there from private pharmacies who are "any position, can you find out, who must I contact?"...all the time.

Michelle: And FA2, you and FA4 especially and FA8, do you find that, I mean, has it really flipped for you quite a bit now? Cause you guys, were you ever in private, you were in private before you came here, so was FA8?

FA8: And FA4.

Michelle: So you've seen...

FA4: I'm happy with the salary cause I am older...

Michelle: Cause I'm older...you weren't allowed to say that.

FA4: We getting as you said, very well paid compared to retail. I was talking to [name] last night and these guys work hard. You say you work from 8 to 4,

- but I don't but I could...and they work from 8 to 6 or something and they have every second Saturday off and they don't earn what we earn.
- Michelle: No, and the benefits?
- FA3: The benefits, that's a big thing.
- FA4: You get paid for your courses, your leave, you get your maternity leave...I don't.
- FA3: Okay now but I must say if you work in corporate pharmacy, you also get to go on lots of courses, they pay your council fees, they pay your responsible...you just send in the bill that gets paid. Private independent pharmacies are a bit different. But corporate is not, it is the hours, they pay you less, you not guaranteed your bonus – it depends on the economy, what is...
- FA2: Nor your increase...
- FA3: Your increase you don't know, and you give it your best shot. You can't help it if the economy crashes, and you get more days leave in the public sector, that's very important.
- FA4: At least we get our increases. We might not get our bonuses that everybody is working for SPMS because they were R200 million over budget in this past year so there is not much money but at least the cost of living, that comes automatically, which you don't always get in retail.
- FA2: No we don't get it. I mean, I have made how complaints already...
- FA3: If the boss needs a new car for Christmas there goes your Christmas bonus. And we guarantee, well we can structure our salary for the thirteenth cheque but lower level pharmacists, they, ag not pharmacists, lower level government employees they are guaranteed their thirteenth cheque, which you not guaranteed your thirteenth cheque in retail and private.
- FA4: The last year I got I R100 I think.
- FA3: Ah, R100...
- FA8: [name] doesn't get one.
- Michelle: [name] doesn't get, you see.
- FA4: Couldn't afford it.
- FA3: No, the boss needed a new car then there goes your bonus out the window.
- FA2: You see in retail you work a 40 hour week then there is the Saturdays, Sunday, holidays, a 40 hour week. Just think about it, I'm smiling all the way to the bank, this, all this holidays that I get and I am working 4 days, I'm working 3 days...some days I am not working at all but..
- FA4: But that's what I said earlier on, I don't even look at my pay slip.
- Michelle: Ja, cause you know the money is there. It's in the bank account.
- FA3: Yes.
- FA4: I will look from now on.
- Michelle: For other reasons. To make sure that they actually doing their admin.
- FA7: For me I check because now after that whole deduction story that I never even knew of and I was not even told that my leave was cancelled or wasn't approved or whatever story they had, it was off my salary.
- Michelle: Off your salary.
- FA7: Because at first I also had some months where I felt like it's going to be on top of last month's salary so I don't even need to check but the moment I make big plans and I know I always go to my statement and always look what is going and I had this huge chunk of amount like that was missing and like this happening, called HR, now it's three days unpaid leave, what is unpaid leave? Cause I've got this new circular that they generated about all those days and even when I signed in my contract I knew about the leave, so what is this

- unpaid leave you are talking about, only to find out, and I had all records with me...
- Michelle: Fortunately ja.
- FA7: But still my facility manager was like “FA7, we are not paying anything back, go to the court, do whatever, I didn’t approve this.” Okay fine, if you didn’t approve it, why didn’t you say so that day? Why didn’t you sign that you didn’t approve it? And the documents, because we sharing facility managers, he’s at that side at [facility name] so from my side to there, it will take 2 to 3 days to get the documents to him and that document was signed 3 days after I took my leave but then again, in that leave form, there are those areas so like your contact details, your address where you live, that’s when you can actually let the person know, no, come back from leave like you...
- Michelle: Ja, just like come back. It was nasty FA7, it was nasty and unfortunately okay, but now you know.
- FA2: Is it when they took out money from your salary without your consent?
- FA7: Yes.
- Michelle: They can do...HR can do...if you got unpaid leave...
- FA7: That is why I am saying for me, it’s more along those lines because I think like, I am being targeted wherever like for my...
- Michelle: [00:19:33] So you actually need to make sure that you are up to date on all your legislation and all that and I also realise that when I had left, you know I was still on probation when I had left [FACILITY NAME] because my manager never ever put leave over onto...
- FA3: Never signed off...
- Michelle: Never signed off but FA3 will know the history of what she had to come and take over there and it’s kind of scary when that happens cause...
- FA5: Well the only reason why mine was signed off because I threatened the union.
- FA7: Yes, because I have already sent them to the union now.
- Michelle: I know it was my fault because I didn’t actually go and sit there, I was just fresh then, fresh mind.
- FA5: Because I was on probation two years (unclear) she said that there is nobody to sign it off, she is in charge of the hospital, she can sign it off – she refused to. She said “I am sorry I can’t do it”. So I said “Well that’s fine” and I got the union in, so I had to get the union in and then she suddenly signed it off.
- FA4: I’m in a very good space here.
- Michelle: You got it easy FA4.
- FA4: I’ve got it easy I tell you. I am so fortunate, I am lucky and I mean that and one of the things here with the probation is, you confirm or e-mail a week or two before the next probation report is supposed to be in to say “listen, you must please, it’s time for the next probation report for that person.”
- FA3: Ja, we also, it also gets done like that.
- FA5: But who did that? Nobody did it when we had our previous boss.
- Michelle: It was probably...you see unfortunately if your manager is difficult...
- FA5: [name] never did it.
- Michelle: ...then he will have the information but he keeps quiet about it and I think that that’s what happened in my case. Okay, can I just say, going onto the next thing.
- FA3: I had adequate skills when I entered this position.
- Michelle: Ja but this is all coming up, we can, some of them, they don’t all need to be done. Okay, would any of you guys consider leaving? Why would you consider leaving?
- FA4: Feet first.

- Michelle: Okay alright, let's go to. FA8 do you want to say something about that? Would you consider leaving, where would you go, what would be the attraction point if you wanted to get out?
- FA8: Hmm...
- FA4: Lotto.
- Michelle: Are you too deep in?
- FA8: I'm too scared to leave because I want to be able to visit my children...
- Michelle: Ja, and you know that obviously financially what will you do?
- FA8: Ja, so that's my fear and the reason, the only reason for doing it is because I have to take everything home at night to do. I don't even have an office.
- Michelle: Yes, you have got a desk of about yay small, honest she does.
- FA8: And the computer is on it. I mean I don't have an office.
- Michelle: Dispensing, computer.
- FA8: I don't know, I don't know...
- Michelle: I just think that the work environment with you is not good and also the taking work home thing.
- FA3: [00:22:46] I also think she, ... the facilities have slightly less challenges are the ones who have good support from the facility manager, a good relationship.
- FA7: Yes.
- FA4: That's essential, absolutely essential.
- FA7: Yes I do agree with you because I will, I think two or three times a week I always want to leave and now with [name] I think hears always me threatening, "I am going to resign!" I can't do this either. But for me I always look back, I know that was the frustration of the pharmacist that left in that place, that is what I am experiencing now. When I entered into that post, I knew it had challenges, what the challenges were and I tried my best to you know...
- Michelle: Do what you needed to.
- FA7: But now like, you not getting support anywhere, so what are you supposed to do? But at the same time, reviewing all the scales, private sector, corporate or whatever...
- Michelle: Where you gonna go?
- FA7: Where am I going to go? When they going to give me this decent amount and still get the benefits I am getting? I am also like FA2, I like my holidays, I like my weekends. I don't work, I don't even locum, at times like if they call me and I'm like, "I'll let you know, please don't call me I will call you" if I need to locum because I still want to have that free time. So I would get back into that space and then think okay, now if I would have to work, I would have to work now on those bigger hospitals where I'll have to be a supervisor of say ARV clinic or be a supervisor of out-patients or whatever but do I again need to go there, because I have worked at [facility name]. I also don't want to go there because they also have their challenges. So this seems minor and personal, let me try to attack it also at a personal level so, it's more like frustration that will make you want to leave because you don't have space and time, support and all the other, I can't say benefits per se but with the other supervisors they do have that free time where they can do other stuff but you can't, you can't even have time with your baby, I am a single Mom at home, alone with my child, but I always have papers with me that she can't touch, don't you know.
- FA3: She'll be a good pharmacist...
- Michelle: So ja...
- FA3: I will leave tomorrow if I can afford to retire.
- Michelle: Ja okay...

- FA8: Well that's basically where I am at. That's where I am at.
- Michelle: That's realistic... that's realistic...
- FA2: [00:25:29] If I leave I will leave, I will leave. I will even leave the country and go back to New Zealand, that is the only...
- Michelle: The only reason why you would is to go overseas...
- FA2: Only ja, that is the only improvement I can see.
- Michelle: Would you go and work obviously, what you doing here now, there? So you will still work, it's not like you are going to leave to New Zealand to do something else.
- FA2: No, no no I will still work as a...you see with, the basic problems we, as I see it, my personal opinion, it's not the work, it's the volume of work. The money is...if you look at it, the money is...if you work it out like I did to per day, per day, then it's a fantastic salary. So it's the volume of work, it's not even the patients it's just the sheer volume and then the outside factors like, the space that you don't have...
- Michelle: The infrastructure type things.
- FA2: That kind of thing ja.
- Michelle: Facilities etc.
- FA2: Ja like with FA7, the facility manager, the outside influences, the doctors, okay in my case the...I just shout and whatever and...
- FA1: I don't have those problems because I put my foot down. I might be this short, but...
- FA6: Dynamite!
- FA2: It's like, as I said, the outside influence that some people have and that is just it but I don't think we can complain about the salary, I don't think we can complain about the working hours, I mean it is just that, that is just it. The other things I think is that what my opinion, is that we should try to change ourselves, because what I can tell you, is a nurse, sister, with the greatest respect, have no idea what pharmacy entails. They think you stand there behind the counter...
- Michelle: Ja and they think they can do it but they going to kill someone.
- FA2: Yip and what's happening in my facility is I gave all of them, they wanted to dispense and I said okay, no problems with it, and I gave them their stock and after the first week I got about 5 or 6 patients coming back to me, to me ja, and obviously what I did is I just wrote just typed letters, okay this and this okay, please sign there, and after I had a little stack like that, I gave it to the facility manager, you want them to dispense, THAT is what they now doing, can you sort it out, not my problem, I am now the only person doing any dispensing in that facility.
- Michelle: Wonderful.
- FA2: Okay, that is...It's like, but, some obvious some patients allergic to amoxicillin, we give him flucloxacillin, stuff like that.
- Michelle: Ja, and whereas you would have checked that, you would have seen it was amoxicillin, fluclo and you would have immediately known no.
- FA2: It's like...
- Michelle: Now we are going that way, you know that?
- FA6: With the nurses dispensing?
- Michelle: Yes, and we are going to be forced that way, what are you guys going to say? You got to prep yourselves, it's coming.
- FA3: I hope that the nursing...
- FA7: [00:28:51] As FA2 explained... but it's, while I was working with [name], she would've have agreed with me here. They decided that the nursing sister, the sister CNP's were already prescribing, should have those with whom have

dispensing license for them to actually dispense. Now to get a dispensing license just like any other license you need to go study. I just want to find out from now it's been five years now, because even then they struggled with that one module that they were doing...

Michelle: Ja, the basics.

FA7: And for us it's not even that first quarter of entry at university. It's child's play to us. But they were struggling with that and I promise you even now they had to close, not now-now but whilst I was still going that side, they had to close the emergency cupboard because they couldn't even trust the CNP's who opened up that cupboard just like (unclear) with the mistakes, the patients coming back the following day with all the wrong stuff and the medication missing, no one was [end of Part 2]

PART 3

FA7: ...to dispense you have to be accountable, that's the other part they don't understand. Yes you are a responsibility because you have to be accountable for everything. Yes they have said I've spent 100 000. FA7, where is that 100 000? I will pull up my file and see this is what I've ordered and this is what gave, this is what we have right now. But now I give you sisters a chance such all this I am coming back Monday, now you come back, I gave you 100 Paracetamols but in the stats it shows there was only 20 patients who came in the facility, now where is it? I know, but I wasn't here, the other sister was here...you know.

Michelle: She just gave it.

FA7: Ja.

Michelle: Instead of holding some ...

FA7: I do understand that is what we normally talk about when we talk about budget.

FA6: To be able to show where you spent it.

Michelle: [00:00:46] This is the thing, so you guys need to start prepping because this is where we going, less pharmacists, more assistants and nurses doing a section of the dispensing okay, and you got to control them because we were put in charge over areas, this is where we going you know, and that pharmacist will have to drive from facility to facility to check up on these people, you know, this is plan for services so just keep it in your mind, it's a little thing that I want you – when these questions that come up for comments, to managers of facilities or supervisors, you must read carefully and give those comments and say no, no, no, no, no and this is the reasons why or yes, if it looks like it could be a valid thing that is going to work but then they need to put that...ja exactly.

FA6: I've got a question sorry...I know [name] mentioned that there is some points that you would like to have mentioned here but unfortunately due to circumstances, he couldn't make it...

Michelle: That's fine...

FA6: ...or to some of the points.

Michelle: Sure.

FA6: He also mentioned to me that now when it comes to pharmacists with progression, how about pharmacists going on courses and where we can actually learn how to do dispensing, say if that for some reason works out in the near future, can that kind of out role the nurses dispensing or should it be as such by legislation that the nurses should dispense?

Michelle: Ja, are you saying that...

- FA6: If we equipped the pharmacist to do the dispensing only, or prescribing as well and dispensing to maybe roll out that part.
- Michelle: Aha, in other words replace sister and her dispensing with clinical pharmacists prescribing and dispensing.
- FA6: ...and dispensing yes.
- Michelle: Okay, now let's go onto the next section because you have just opened up a very big issue. If you look at the tables here, we have got a whole clinical slot with no position okay in it, it's been created and is something that needs to be opened up and needs to be opened up perhaps more and more, but needs to start somewhere. Do you guys, are you guys aware of that?
- Everyone: No.
- Michelle: There is this clinical band where you will have specific clinical pharmacist with a clinical qualification that can do the basics of what a doctor would do or a nurse...
- FA3: Or a probably primary health care...
- Michelle: Correct, but just the basics and be able to say, and prescribe basically and also, to a more technical degree if you are in hospitals, checking up on doctors and being in the wards, so it means you are moving out of the pharmacy into the wards and [FACILITY NAME] has kind of starting to get this going.
- FA4: We do this all the time. I've got a fulltime pharmacist that does that, and the doctors listen.
- Michelle: Ja, fantastic. And that's the thing. They need to get all that information...
- FA4: But she's not a qualified clinical pharmacist so she hasn't got a job but that's what she does.
- FA7: They do this at intern level at [facility name].
- Michelle: Ja, you have to go to the wards. But the problem then is that you weren't allowed to be there too long because you used to run back to the dispensary...and you noticed something and you basically run up to the doctor and say "Why are you prescribing this dosage, quickly change that, that's not right look you know" you would do that but when you would have to run back to the pharmacy because you running all the time because you can't...
- FA1: [00:04:11] There is one doctor who calls me clinical pharmacist, "how are you working my clinical pharmacist?", cause I am their..., I am on their backs if I see something wrong on the script I pick up the phone, I will first send the patient if the patient doesn't come right then I walk with them. Now every time he sees me "Hi my clinical pharmacist" I say "is this some kind of insult, or what?" now because...actually, we are actually doing clinical but...
- FA2: But that is what pharmacists actually should do more of as FA6 that worked in [facility name] will know that they will not do anything without checking with you first. Before they write up they call and they ask, she knows about that, she worked there and that is what we should, that is what pharmacists actually should do. If they see something okay, go to the doctor, go to the CNP tell him/her this is what it is supposed to be done, no this is actually the dose for Amoxil because they make mistakes like that as well, this is the dose for Azithromycin but I think there is in that mode is like it is written, it's done...
- Michelle: Just give that out to the patient.
- FA2: Just give the patient...
- Michelle: I think we all feel like that, we so under pressure but actually our job is to – and I hate it in a way, but we are kind of a policing because firstly the budget ends with us on the meds, so if we don't make sure that we are sticking to protocol firstly, that is a problem, secondly prescribing norms...
- FA7: For me I think it's the reporting part that we are actually doing the clinical, it's not that we not doing it, we are consulting with the doctors, you are rectifying

the CNP's with their prescribing (unclear) daily or every hour you get so many wrong mistakes from prescriptions and trying to rectify that, but where is the proof that we are actually doing that.

FA3: And also we have...

FA7: Because in the stats it doesn't say, it just says how many patients did you do, but how many lives did you save, or how many...

Michelle: Did you actually...intervene

FA7: Ja, intervene...to actually prove that we are also doing this clinical.

FA3: What we do is we have an agreement from our PTC, if the doctor writes Amoxil QID we just write there TDS and highlight it, we don't even phone them because we have got a trainee, lots of interns and cosmo doctors and that so we don't even phone them if they write TTO for Amoxil four times, we just correct it and write there "corrected as per" standardised. If they do something outside of the protocol, like now, Cefixime is out of stock and we've told them and we've sent out the circular, we don't phone them, we just change it to give Ceftriaxone 250 but if they do a blue board and they write for a 3 month old child Amikacin 700mg, then we phone them and say "you want to kill the child today or tomorrow?". I don't want to be a clinical pharmacist like [name] did, that you look in there and you start prescribing, I am not interested in diagnosing and...

Michelle: But now, shouldn't there be a wing for that? Cause that's what FA6 and [name] are saying is, we don't all have to do that, but for those that want to do that and actually can do that, why don't we have a special category for them instead of having and employ more people instead of having a dispensing nurse? Spin it a bit.

FA2: See, it's like to me it's being, having to prescribe, it's actually not necessary. But as I have said I've been like in this game now for twenty years, twenty years back it was just thrown on the table. You know how many drugs was on the market? Approximately? 80

FA3: 80?

FA2: 80, twenty years back it was about 80.

Michelle: 80 classes.

FA2: 80 drugs, different kinds.

FA3: Ek het in 'n groot pharmacy gewerk en sy rakke was minder as my slaapkamer. And the space that you needed for the dispensary...that was about that.

FA2: To now, basically now, I think at last count over 400 different kinds.

Michelle: Because there is – drug companies obviously we know. They just spinning out these basically E's and S's...

FA4: What disease shall we tackle now? What shall we now...

FA2: The actual job of pharmacists now is, I don't think it's, I don't even think pharmacists have heard of pharmacovigilance yet? That is actually, according to me, that is the future of pharmacy.

FA4: Not that we are pushing it now.

Michelle: I've got another friend that is passionate about that and he is doing an overseas course on pharmacovigilance...

FA2: And this other thing that I am doing is, is because, and I am being like cynical now, but is, I am busy studying law because I am picking up with that amount of drugs, doctors dispensing, that's a gold mine. I'm serious. They are gonna make mistakes and I am gonna work on a pro bono basis, pharmacists with a law degree...I know they gonna settle out of court – they don't want to go to court. My wife don't like it but I said that is where the money is, there is gonna be mistakes made.

- Michelle: There is your little retirement job that you can do for ten years and then just sit pretty.
- FA3: But have you been to the (unclear) at your facility? Do they have that?
- FA2: Yes and I am the only one.
- FA3: And I tell you it is scary what happens there and then usually they say "this is ...but why did you do this and this and this?" but they have lots of interns and community service pharmacists and they sometimes work unsupervised because of them working. But I don't want to do clinical and like [name] did you can do a 2 year course and...
- Michelle: Ja, you can do it through [facility name]...
- FA3: No, nee, nee, University
- FA5: [place]...
- FA3: [place]. It's a 2 year course, it's intense. 200 patients you have to see and that but if you interested in that line...
- Michelle: Ja, so that's, you know this is the thing, so instead of us just approving sister to do stuff, let's open up and I'll tell you why. Are any of you guys actually interested in climbing, I mean especially young people, not so much the older...
- Laugh
- Michelle: Okay, what about you guys, so you want to climb the chain, where do you wanna go, if you in government where do you wanna go?
- FA3: [00:10:46] The retirement chain.
- FA1: I've checked this clinical...but the moment they put up a post and they see that the trend the following year there will be 2 or 3 then I would go into it.
- FA4: I am at my level of (unclear), so I will stay herebut I am old.
- Michelle: [00:10:59] So clinical?
- FA7: So do I.
- Michelle: Clinical? Interesting.
- FA4: if I was 30 years younger.
- Michelle: It is the one section we don't have one position approved of....
- FA2: Exactly.
- Michelle: And, how many positions are there going to be? How many senior management positions are there? How many clinical positions are there? Very little guys and there is a lot of you with ambition.
- FA4: I think they've got one at [facility name] don't they?
- Michelle: Yes they are at the [facility name]'s...
- FA3: And Worcester has also got one...
- Michelle: [facility name] is also now I think developing theirs at the moment so I think all the big hospitals will have at least one to start off with but I think this a thing we've got to worry about. We need branching. Don't we need some more branching? Because...
- FA2: We need specialisation. Pharmacists actually specialise...
- Michelle: And there is something happening on the policy specialist level and production, funny enough, production level 3 there are some cold chain positions that open one I know and there are some ARV's you know, [name] is in one position, so they have now...
- FA3: It's more policy...
- Michelle: Yes, policy and also running of like management services in a way, like [name] but with just with a kind of a spin, so focusing on one area where we know we going to lose a lot of money cause I know [FACILITY NAME] is really focusing as the central hospital on looking at all these things where we have money leaking and obviously cold chain management is one of the big ones and ARV's are a big one, so how can we control that better? So those

kind of positions, we need more of those because they will help us supervisors as well so whoever you gonna eventually leave behind in your position will have it easier because the drug management side will maybe start because we've still got a lot of gaps don't we? I don't know...who is running out of stock you know, we are running out of stock sometimes, tenders not being signed and that's because staff in that office maybe don't get to that or they late on it...

FA1: [00:12:56] We don't have currently now Fluconazole, they stopped Griseofulvin, there is no fluconazole.

FA3: That's a dud.

Michelle: Ja that's it, so stuff like that. The more people we have there that is concerned about us, the better.

FA5: [00:13:10] They can't get Cefixime for...

FA3: But the thing is if they give you an alternative like instead of Cefixime they said use Ceftriaxone. With the Fluconazole they don't say...

Michelle: [00:13:22] I mean why is there no one that specifically, I know we are looking at...there is people in drug flow managements and stuff but why isn't there someone that's been in this position that goes there because they will say "ohoh, this can't happen, we need some solutions here quick".

FA3: Because it's not pharmacists doing the supplying.

FA1: Yes.

Michelle: That's it, so we need some, we need some links I think to other departments that's just us that know.

FA1: [00:13:46] I once said to [name], if there can be a connection you know, the people in head office can be able to come down and see what is happening in the CHC's and then when they make decisions there, they know exactly what is happening with the flow.

FA2: I don't agree with that.

FA7: But they do go, only when...

FA2: You asking someone to come down, spend an hour, two hours down there and then...

FA3: No, no...

FA1: No, not an hour!

FA2: That's what I mean. It must come from bottom up. This is the issues – when we have to go up, not they come down, you understand? Even if there's...I'll tell you what – you spend a month in my facility, you still will only grasp 10% of the problem.

FA1: You won't be able to...hmmm

FA3: Because you kill the fires as they goes along.

FA2: Ja. You see it has to be from the bottom up.

Michelle: And that's the reason why I am saying – if you got someone that's been in a supervisory position for 10 years, why are their expertise not being used, and I am not saying...and get some extra qualifications, but go into a role where...so these are lot of things – I know there is this whole functional interface and you know, there is a big district offices and us we have, supposed to have this communication that's rolling the whole time, we saying what's happening with us, we report it and [name] or someone takes it on and it gets logged and so when they have a meeting, that comes up as an issue and the supposed to cover the gap but I don't know how efficient it always is you know, this is the thing. Unfortunately we not up there at the moment to know.

FA1: I don't know if this question is...

Michelle: Related...

FA1: Related... who decides on the salary scales, levels?

- Michelle: Okay, so regionally, when we went, pre-2010, so in say for instance I think it was 2007 we started negotiating, there was a basic idea that government brought forward to us as pharmacists to comment on and our policy specialist got this document, it was the first time they'd heard about it and they saw this is the idea that they want for occupational specific dispensation, each career having its own salary structure instead of being in one general structure because back then we were in CORE and CORE was, it's like we were all bumped up into middle management salaries because our salaries were ridiculous, they were down here on the border of middle management and...
- FA2: R157 000 in 2007.
- FA1: Hmmm
- FA5: It was.
- FA2: Plus 15%
- Michelle: Something ridiculous. So what happened was then the policy specialist said "no ways, if we gonna do this we gonna do this properly" and what they did was they entered unions, each one of them joined unions and they started to change the structure, then they would go to the union member, whether it's someone, them, but not normally, someone else totally different and that union member would take it to bargaining council to be put on the table with everyone else's stuff – doctors, nurses and all the other specialists and whatever and then they would say yes or no, there would be a document written - we've still got problems with this and it's come back down to policy level, we negotiate again and then we'll have another bargaining council and I think there were 2 or 3 of those meetings, they went back and forth. The problem is, we relied on a union member to negotiate on behalf of us in the bargaining council okay...
- FA3: Who was not a pharmacist.
- Michelle: There was at one stage, we had one pharmacist going but that's it, the rest of the time it's done by a non-pharmacist.
- FA1: Exactly. The reason I am asking Michelle, okay I'm this person who always like to compare my salary with other professionals. You know, when I look at the Department of Justice packages and then look at Department of Health, I'm like, geez, why did I do pharmacy?
- Michelle: Ja, okay good comment to make.
- FA1: You see I just say "my goodness, I should have gone and do law".
- Michelle: Ja and had a much easier life and...
- FA1: Exactly, because also they don't work Saturdays...they don't work public holidays...
- FA5: And they don't take work home...
- FA1: And they don't take work home...
- FA3: And they don't get called on Saturdays...
- FA2: No they take work home. They take lots of work home....forget it...
- Everyone: Laugh
- FA1: [00:18:04] Okay, but they do some researches around but they...you know, I regret I did pharmacy when I look at Department of Justice.
- FA2: We didn't do that okay, you looking at that salaries, but must also remember there is 20, 30 other also law graduates doing all the hard work, that's not earning half of that.
- FA4: They get paid peanuts, I tell you. If you look at the levels of...
- FA2: I've...my case, that's why I am studying law specifically what I am saying, what I am gonna do, I know I have got friends working there okay and they work...
- FA3: Clerks, they also have clerks.

- FA2: Yip, and it's someone with a law degree and he is not...it's like that salary is...
- FA1: Look, I checked at other professional salaries...
- FA2: Let me put it to you like this, we are about 3 or 4 people in a certain department earning that salary, the other guys...
- Michelle: Okay, so you saying maybe, FA1, you saw some, some, of the positions being advertised and they were actually a little bit more senior to what...so what you need to do is probably go back to varsity and ask those guys that are coming out of varsity, "what are you earning?" and after 5 years what are you earning, but I mean it's not so easy, we need contacts to find out...
- FA3: And also, our job security is better than them because some of them come out of university and they have to do their articles and they sit around for 2 years before they can find a job because nobody wants to employ them because "no we can't employ you because you have no experience".
- FA8: They've got no experience.
- FA1: That's the thing, how can you get any experience when you don't have a place to work?
- FA3: Yes. But they don't want (unclear) R1000 a month but you do R50 000 worth of work but you so desperate you need to do your articles.
- Michelle: Ja, okay let's just...
- FA8: Conclude.
- Michelle: Ja, we gonna conclude in 5 minutes. There are some other comments here, if you'll look at them, like do you think production pharmacists think it's easy to be a supervisor?
- FA4: Mine don't. I can tell you that my staff sing when I come back.
- FA3: Mine think that, they think that...
- Michelle: Ja, they start to realise all the gaps you are and all the stuff that you involved in.
- FA4: And I think I am not doing anything, you know, "what the hell are you here for? Everybody does the stuff", and I feel like a spare wheel sometimes when I am gone and come back, they realise...they don't want to take over from me, at this stage, because they see the kind of things that we have to deal with. Like with our bosses and paperwork and there is a lot of stuff that is almost unnoticed or unseen, it seems to happen. They think it happens before you gone and that is actually it doesn't, it just...
- Michelle: It just happens.
- FA3: And that's what I said, that is why you cannot have a production pharmacist grade 3 have the same salary as the supervisor because of all those things that happens, happen, but they don't even realise it.
- Michelle: And do you think it's easier to apply for a supervisor job now? I don't know, I am just asking, because you know I said here in the first comment says, you only need 3 years in the government, okay it's about 4 years and not even in the government, you need about 4 or 5 years experience somewhere before you can come....
- FA4: There is one thing that peed me off when the OSD came in...
- Michelle: Ja.
- FA4: I've been working for 40...50 years, I've been pharmacist for 30 years and teaching before then, I was...it took me a year to get the supervisor post and these little pipsqueaks that had just qualified...they'd just qualified as, they just done their commserv got the same salaries, the same post as I did.
- FA3: Ja, that's what I agree.
- Michelle: I needed that out.
- FA4: That was for me the biggest problem. I'm not unhappy with my salary, I think we doing well...

- Michelle: You just wondering...
- FA4: It's just that one thing, is why did that happen?
- FA3: They forget about the emotional value attached to your salary. Because I also had like [name], just finished her community service, she worked with me, we had just about the same money but I was doing all the hard...not the hard work but carrying the responsibility and I've had like 15, 20 years more experience and I wasn't getting acknowledged for my skills.
- FA7: [00:22:42] And to support you generation I will call it, which generation...I was also surprised because yes we lacking the skills, the knowledge and all that and with doing that internship and commserv, I was keeping contacts with my peers because I knew when I was in that position where I didn't know anything, who am I going to call? Of course I am going to call FA4 because he has been through this situation and he has helped me out so why isn't he really recognized for all that? Seeing that he is also, kind of, not training me, but he is also supporting me up until I getting to that comfortable level where I can say ok, now I don't need you anymore.
- Michelle: Ja
- FA1: [00:23:31] Would you say you don't need him anymore?
- Everyone
- FA8: How can you every say that?
- Michelle: Don't we see we do okay, so you guys agree with me, just put the statement out there...years count okay, especially in our career.
- FA7: They do
- FA1: Years count
- FA4: [00:24:01] Not always because some people that have years and years and years and I tell you after 15 years, they the same as they were in the first year, cause they not interested. They come and they do their job and they dispense and they go home and...
- Michelle: That's that. It's interesting...
- FA7: (unclear) viewed in that aspect when they doing that as SPMS for each person, you know when the person has grown or they're stuck in that rut...or they're actually developing.
- Michelle: I think that SPMS is linked to kind of checking up on that person.
- FA7: But it's done incorrectly, it's...
- FA1: I've got a problem with SPMS.
- FA3: I also think that it is standardised the SPMS format they sent out to have done, cause different supervisors put on different things. You can have a standardised SPMS questionnaire and the ones that are not applicable you just say "not applicable" but now I have a questionnaire from my pharmacist and I can tell you, hulle skuit om punte te kry, and the other one, they nice guys and they easy and everybody scored high, it should be a standardised...
- FA2: [00:25:08] My personal bug with the SPMS, the SPMS should be, the pharmacist should have the SPMS like totally separately and done directly by the director, totally separately, that...because I can tell you that...
- FA7: I have that situation now with my facility cause there's a doctor pushing for that because she doesn't feel she needs to be, what do you call this, because they reviewing her work, whoever is doing your SPMS.
- Michelle: Ja, so she is being evaluated by...
- FA7: Now you are a CNP or professional nurse or whatever nurse you are yes, yes you are a facility manager but...
- Michelle: You still a professional over there in that career...
- FA7: [00:25:59] You're still a professional. You will have to consult through me but now you telling me about...

- Michelle: Are you doing your stuff correctly, let's see...
- FA7: What is my stuff?
- FA3: So your situation...(unclear)
- Michelle: Tell me what my stuff is...
- FA7: When he was doing my...
- FA2: [00:26:01] They have no idea what pharmacy is about.
- FA7: [00:26:07] Look for example, "you don't have Cefixime!". Dude, it's on dues out. Do you know what dues out means? I have printed out a circular for you guys, is it my problem or did I have to take my money, try to find another company, that is why...
- FA3: No, no, it's not available in South Africa.
- FA7: [00:26:24] You know.
- Michelle: [00:26:38] I just laugh when I hear this.
- FA7: But still now with the CNP, I had to explain to him that...
- Michelle: Ja, otherwise you just...
- FA7: ...my problem because now he wants to grade me with that, you didn't have this...
- Michelle: You didn't have stock.
- FA7: ...and last year you didn't have that...
- FA5: The other thing is at one facility, whoever is grading this person at this facility might think that person is fabulous and grade her all five and somebody else is doing far less work at another facility and you know I mean, how do you get, there has to be a consistency, there is no consistency, there is no standard, there is no limits, so...some people doing less work are being graded higher than those that are doing a lot more work.
- Michelle: That is the thing. So that's another topic because SPMS can be a whole research thing on its own because it is, it is problematic and especially when you're in a professional career – I don't even know how I feel about being evaluated for my professional career so...
- FA4: I don't like the system.
- Michelle: Ja, I mean we are our own standards and we have standards.
- Michelle: So how did we get that...
- FA1: There is the council standards that...
- Michelle: Yeah exactly so you it's like already you governed by all these things and when you enter and you take your oath, you kind of under oath, so you run with that feeling already and now you've got to have someone checking up on you like...
- FA3: And they want to come and do the national course standards audit of the pharmacy, when will be ready, when will...I said come now. "What you mean?" I said "Pharmacies are running in line with national course standards because it's the same standards as the pharmacy council, you can come any day, I don't have to prepare and change things, walk in now."
- Michelle: If the inspector walks in normally and...
- FA3: They don't know what the pharmacy standards are. Yes, FA1?
- FA1: I will like to be excused, at 16h40 I must be there (unclear) otherwise...
- Michelle: Should we end it there or would you guys like to go and we will end off, we will just take 10 minutes and end off stuff...are you guys ok with that?
- FA3: I can stay a few minutes.
- FA2: If you were in retail you wouldn't say that.
- FA3: No.
- Everyone: Laugh
- FA3: I will most probably still be here at 7.
- FA2: Exactly, you see how lucky you are.

FA3: That's my choice, that's why I moved.
 Michelle: Okay, so I mean we could carry on and talk about a whole bunch of things that are connected and maybe you guys want to, if you want to go home and something pops into your head, you e-mail me, whatever...
 FA3: I want to say something about progression possibilities in the public sector, actually in retail as well, because our job is so specialised.
 Michelle: Yes.
 FA3: You can only move on from a production pharmacist 1 to 2 to 3 to supervisor or maybe join the head office but then you have to travel on the highway so I think our job doesn't give lots of opportunities for, to progress.
 Michelle: That's why I said the branching thing, where it's a bit thing because we've only got.
 FA1: Before I leave...
 Michelle: FA1 got...
 FA1: Sorry man, I've got a question for you Michelle, the pay progression...
 Michelle: Yes.
 FA1: For example I am now grade 1, level 1 supervisor.
 Michelle: Yes.
 FA3: Welcome to my world.
 FA1: The pay progression, does it only depends on an SPMS.
 Michelle: First SPMS, 2 years okay, first SPMS and then 2 years and then notches unfortunately. When you come in you've got to wait.... [end of part 3]

PART 4

Michelle: Then you've got to wait 2 years and then you start to climb notches
 FA5: So for 3 years for, no, because I've been here... I've already had one SPMS...
 Michelle: Probation, then SPMS and unfortunately it's a long time before the notches start to go
 FA1: Jeez
 FA2: Unless you do very well on your SPMS and evaluation, then they can bump you up a notch.
 Michelle: Exactly, that's it
 FA6: You need to get 4, 4 and 5 on your SPMS
 Michelle: Yes...
 FA2: Ya, 4 and 5, ya. You have to do fantastically well and then you go up...
 Michelle: If your SPMS is above average, then you can negotiate for the notch move. But, if it's average, you're sitting.
 FA2: Now is that above a 137% or 129%?
 FA6: 133
 FA4: 129
 FA5: 130
 Michelle: 130 up
 FA3: ... maar julle ken al hierdie goed
 FA1: That means I will be stuck on this salary for 3 years
 FA4: I sat on the premodeling committee the day before yesterday, so I know and I chaired it last year, so I know.
 Michelle: But you've got the cost of living adjustment coming
 FA6: But you know the post-basics have it even worse because only get to qualify every second year for the time being while they are a post-basic
 Michelle: They have a bi-enniel or something
 FA1: But why is it so, why can't like every year you move and then
 Michelle: But don't worry, once you start moving then you're going to move
 FA3: It just means that the first 3 years you're screwed and then you climb.

- FA1: But why is that so, it doesn't make sense
- FA2: They want to keep you there for at least 3 years
- Michelle: I think it's got to do with, budget, basically, I think. They basically just keep the money there for a while, especially when they have created a post. But I don't know, there's a lot of other things, probably.
- FA1: That doesn't make sense
- FA3: That's the whole thing about emotional value attached to money. Why must I sit on the same salary level for 3 years and I work my ass off but I don't get any financial compensation because we are making the place a better place. We do make improvements. Pharmacists come in, they're problem solvers, they change things around, they deliver an excellent service. They bend over backwards because of the patient and they get no recognition.
- FA1: And when you go home, FA3, you feel like a real farm worker. Goodbye.



APPENDIX X: TRANSCRIPT FROM INTERVIEW WITH FOCUS GROUP “FB”

PART 1

Michelle: Everyone if you will just say your name and how long you've been at GSH, let's start off with that.

FB1: [00:00:06] I'm FB1 [surname] and I'm not actually sure...3/4 years.

FB2: [00:00:11] FB2 [surname], about 3...4 years, 3 years.

FB3: [00:00:14] FB3 [surname], about 3 / 4 years.

FB4: [00:00:17] FB4 [surname], 2 months.

Michelle: 2 months, you're new FB4. Are you guys wanting to join? Hey? Okay. So just your names and how long you've been at GSH.

FB5: [00:00:34] My name is FB5 [surname] and I've been here for 4 and a ½ years now.

Michelle: 4 and a ½ okay.

FB6 : [00:00:39] I'm FB6 [surname] and I've been here for...this is my 3rd year running, so 2 years a few months.

Michelle: Okay, sjoe, okay.

FB7: [00:00:46] My name is FB7 [surname] this is my 4th year.

FB8: [00:00:51] I'm FB8 [surname] and 29 days.

Everyone: LAUGH

Michelle: 29 years old but how many years at GSH?

Everyone: 29 days.

Michelle: Oh 29 days....I was gonna say.

FB9: [00:01:01] FB9 [surname] and this is my 4th month.

Michelle: [00:01:04] Your 4th month.

FB10: FB10 [surname], 4 and a ½ years.

Michelle: 4 and a ½, ja.

FB11: [00:01:08] FB11 [surname] 4 years.

Michelle: [00:01:11] Okay we've done everyone, alright. Okay, first question – why did you guys choose public sector? Talk about it? Why? Especially the people that are here for 4 years, that's quite a big thing and the new ones?

FB7: [00:01:25] I left private because I was attracted to the OSD but it didn't actually work out the way I thought it would, but besides that the other reason was I wanted to, um, I was in private, so I wanted to learn about how state works and further about different sectors of pharmacy where in private you a bit restricted so at state you like for example you rotate the duties, etc.

Michelle: So when you say the OSD didn't work out, what do you mean by that?

FB7: When I started, what happened was, the way the advert was, the package was, the way it was advertised sorry, I didn't actually realise at that time that your 13th cheque, your birthday bonus...what was the other thing...the 13th cheque, actually comes from your own money and your medical aid is actually all your own money so basically it's not a benefit actually whereas in..., so actually my net wasn't that much of a big difference if I subtracted what I had to pay in usually for those things whereas in private I could actually negotiate for..., they would have matched me but that wasn't like my only reason as well, so that's why I actually stayed on as well. Also in addition when I went to HR and after we complained our group actually changed the advert of how they sent it out so it's not misleading and when I went to HR, what they actually do is with the new OSD contractors they put on the last page a sheet from the old OS....not the OSD, the previous package, last page so when you signing that you thinking you signing for what's in the last page of the contract and they

said no it's just part of the agreement and that specifically says you getting medical aid and getting those things but in actual fact it's...you not and the contents of what you signed is what you supposed to be getting with it but you don't have any leg to stand on.

Michelle: Ja, once you've put your signature on there hey. And I think that that's the thing, now you see what I was talking about with total cost to employer, cause you have to go and really work out, but now what you guys think? Do you think it's more in private? Has anyone looked at...

FB1: I asked and it depends what you looking at. The private hospitals if you level 1 level 2 pharmacist it's pretty much on a par. Once you get to level 3 it starts to fall behind, maybe if you became a senior pharmacist or manager and I saw some adverts in manufacturing, it was either [company] or [company] in PE for someone with sterile experience and 3 years manufacturing experience R900 000 a year plus R150 000 performance bonus. So if you want money, manufacturing is the way to go, if that's what you looking, that's where the money is.

Michelle: [00:04:25] But not all of you guys are for the money, that's the thing.

Everyone: Hmmm, ja.

FB2: [00:04:29] I actually joined Groote Schuur mainly partly because I was unhappy where I was but also because I felt it was time to give back. I mean I just felt this whole thing about our country, it's time to give back to the country and that's why I came back here. Apart from the fact that I had to come back here and I love it because in all my experience in the private, I never got this exposure of cases and patients and you know, I hesitated when I came cause I thought the amount of meds we have is so small and the variety is so small but what they do with it, it's just incredible and I do like that I feel I am in outpatients when you want to kill the patient, I am still giving back to the community.

Everyone: Laugh

Michelle: [00:05:15] We all feel like that hey I think as pharmacists.

FB1: [00:05:20] You learn a lot more in the state. It's a constant learning curve, while outside maybe not so much, especially retail.

Michelle: True. I agree. I think if you are in the state you know why you are here okay, I don't know about you at 29 days, are you regretting it?

FB8: [00:05:34] (unclear)

Michelle: Not yet.

FB2: [00:05:39] I must admit something else that I also need to say is, in private the doctors, they all specialists just about, they are so rude and what I find in state is people speak more respectfully to each other and they more willing to teach rather than put you down and make you look stupid, the people here are more willing to teach, maybe because this is a teaching hospital? But that has been incredible to see, weird experience.

Michelle: [00:06:04] That is true, I feel that. Are you a pharmacist? Production?

FB12: Yes.

Michelle: If you need to say anything you just need to read the second page, the first page needs to be signed, it is research hey. Ja, name and signature...and your name? FB12? [surname]. And you been at GSH?

FB12: 7 / 8 months.

Michelle: 7 / 8 months so it's short, okay.

FB7: [00:06:33] Can I just add on what FB2 had said?

Michelle: Yes.

- FB7: I think what has kept me going and actually kept me here is the fact that you learn like everyday, is like something else that you learn and the rotation and that they also giving back to the community.
- Michelle: Otherwise you get bored. I think we get bored. You didn't study for nothing, you didn't actually get through a degree in pharmacy, the reason why you got through it is because you got the brains so you need stimulation and I think most people...what did you want to say?
- FB5: [00:07:01] The reason why I came here is because I have a disability and because of that I think government has the tendency to look after people with disability. They have been doing that so far but sometimes it does get to me a lot and I just want to thank government for their confidence and sometimes when I do try private, I've been sending my CV but no response and I think treat you when they see disability then they like get a fright and "oh, we don't want that person because...
- Michelle: They don't know what to do, they not prepared for it.
- FB5: Exactly
- Michelle: I think government is prepared, we look after everyone, that's the whole idea and everyone needs an opportunity, am I right? So, you are in the right place, for that you definitely. So okay, is anyone else want to say anything about why government? Hmm, or you all feeling the same reasons? Okay, so then let's ask the next question which is....okay, do you think it's more popular now, to come into the public sector?
- Everyone: Yes.
- Michelle: Okay, why do you guys say that?
- FB1: [00:08:10] Cause the salary is better.
- FB2: [00:08:15] I think also the hours. In retail you in private your hours are horrendous.
- Michelle: And you hearing this from...are people talking to you? Do people want in? Are you hearing anything? What's the kind of skinder amongst pharmacists?
- FB2: When they interview they get more applicants.
- Michelle: Ja, they do hey.
- FB1: I think the private sector at [company] and [company], must have improved their hours a lot and they've improved their salaries a lot. Their salaries almost doubled since we left cause I locum there on Sundays and they working strictly now 8 to 5, they not doing their after hours, their calls are once a month compared to us is still bad but a lot of them aren't doing any weekends, there's enough locums, cause they have also upped their rates. Their locum rates are very good now and basically all their weekends, there are enough locums around prepared to do their weekends. So the working conditions are [company] especially have improved dramatically.
- FB2: And then having to do late shifts?
- FB1: No. They've got loads of locums, they've got a list of locums this long and they reliable cause they not not pitching or phoning in sick or whatever and then they pretty much work in their 8 to 5 and one day a week 9 to 6 and they go and a couple of them do no weekends at all. Some of them do odd weekends or public holidays and they not doing nights, so its improved...salaries have improved dramatically and they, because they improving their locum rates so much, their afterhours thing, except for the calls – obviously they still have to do their call but now I think there are 6 of them so its 1 in 6 instead of 1 in 4 and [company] has quite a few assistants now it seems as well, so things have improved a lot. I think they've had to because they have had to follow the government. You know the government

- laid down the new sort of ground rules, everybody else had to basically keep up.
- Michelle: Kind of follow. So it seems we setting the trend in a way? So what are the, I mean would there be any reason for you guys to leave? If there was something that attracted you out? What do you think, what would make you go?
- FB2: [00:10:13] If it was me and I was a young pharmacist I would get frustrated because your chances of becoming a senior pharmacist or supervisor or something like that are very slim, very very slim and there doesn't seem to be any progress...you stay here 5 years, you go up a notch in salary, you stay 100 years you go up a little notch. You don't become, you don't get more experience, there is no financial experience for anybody here. They can't go from here and become a pharmacy manager anywhere else because there is no financial training. I work here, I work in-patients, out-patients sometimes [department] I never go to manufacturing, I never go to stock control or I never go to [department], to sterile, to anywhere else, I am almost like a robot so I think that is what kills people.
- Michelle: Is there some people that have different opportunities, like that can actually do sterile, whose the guys doing sterile then? You and? And you got to be trained up very well for that am I right?
- FB3: Only a few of us, yes.
- FB1: When we asked [name] about that she says you have to show an interest and ask to be put on the sterile, there is like a waiting list almost, the training takes a while. So she said that that was her thing. What I, would make me leave and there are days when I, and I've got a part time post so I'm far less stressed than anybody else, is that it is the same problems. In the 4 / 5 years I have been here, the same problems at out-patients, the same problems with whatever, the same people, the same whatever, nothing...you go the pharmacy meetings every month and you bring up the same topics every month, you told by management they will address it every month and nothing ever changes...ever.
- Michelle: [00:11:48] Are we talking about working overtime when you are in out-patients, everyday? Because you always got too many patients or?
- FB1: [00:11:56] Partly that but also the systems, you know people say well let's try this and see if this and see if this works...let's be honest, if it's better for us in out-patients it's better for the patients – it's a two-way...it works for everybody.
- Michelle: Absolutely.
- FB1: ...and they say yes ok 1st of February we will implement this, we'll do it per month and see how it goes and like July comes and nothing has happened so I just kind of feel that there is no movement forwards in trying to improve systems or trying to...like our stock takes, our stock takes are a shambles and I've been asked to do and they an absolute shambles and if anything they get worse, they don't get better and people come in from outside from the private sector, like FB2 was a manager for years and says we should do this and offers to help...nothing and that I find frustrating.
- Michelle: With JAC you should actually have a good time for stock take if you prep hey, am I right? And I think everyone probably feels that way.
- FB2: And that is frustrating because it is not that you don't want to work here, it's just that you can see...
- Michelle: Things not moving...

- FB2: And you can see that this might work a little bit better let's try it, but nobody is interested, it's like we just carry on doing the same thing like a hamster on a wheel you know, getting nowhere.
- FB1: [00:13:34] I think it's also the out-patient pharmacy and the in-patient pharmacy have not changed one millimetre in their layout, in the way things operate and the way they layout their stocks in how many years...
- Michelle: So the infrastructure is stagnating.
- FB1: Ja, so you still can't work fast because the desks are in the same place, the computers are in the same place, the tablets are in the same place; unless you start moving stuff around you know, and getting a little bit more modern and getting a better flow, but that's not going to move.
- FB2: And then the other problem is I.T., I don't know is your printer working yet? You know in out-patients you can't afford to have equipment that's not working and for example, I had to help there the one day and one of the printers wasn't working and it wasn't working for 2 weeks – you can't have that. If the printer is not working today, I.T. must come today and they must fix it or replace it today. You can't afford to...you don't want to work overtime because I.T. is not helping you.
- Michelle: Ja but that is someone's responsibility that's not being done so you guys must actually, cause there is always someone that's response – should be responsible you know, you've got key result area and administration goes on there and administration and equipment goes on there so you need to ask who is the person that is supposed to in their job description be dealing with that; it's not you guys cause you the production pharmacists, you have to report to the person that needs to assist you. But ja, you wanted to say.
- FB5: [00:14:24] I just wanted to comment on FB1, it is frustrating cause last year in September, was it what month before September, August, in August did a little bit of OT assessment and I am still waiting for that OT assessment even now, it's been so long because the month before I was off for a month because of my my disabilities were kind of failing on me and I felt I was of no use (unclear) stayed at home for a month and just thought I would try and get my (unclear) back and stuff and then after I met the OT and then they said no, they gonna give it to me in 3 months time, in a months time and then after a months time, 3 months time I am still waiting.
- Michelle: Oh that is terrible.
- FB5: It's been so long so I'm a bit anxious and so frustrated and I just don't know where to go.
- Michelle: Ja, what do you do?
- FB5: What to do with my problem? Where do I go? Question mark!
- Michelle: Not good, really not good, yes shame.
- FB7: [00:15:30] I agree with FB2 about technology, we are so backwards in the sense that in a pharmacy changing environment, the policies coming through from provincial, we don't have a system, an I.T. system, computer system where everybody...we use our personal e-mails and we don't have a computer system or anything.
- Michelle: Aah that's it, I was wondering about that. Supervisors are on, but why aren't production pharmacists on the... Why don't you have a state address?
- FB2: Because you have to be a supervisor before you get a states...
- Michelle: I don't know, that needs to be...
- FB1: They have generic numbers because we were told that we could get Microsoft, we just had to apply and you can get it for R81 the whole Microsoft Office. I applied but you have to put in your PWG whatever...email I don't have one...
- Michelle: Ja, address and you don't have one.

- FB1: So I asked [name], so [name] said “Oh, no we don’t get e-mail addresses but there are generic ones in the pharmacy” and she’ll ask if we can use that so that we can access that Microsoft R81 deal for the Microsoft Office so there are some generic email addresses but we don’t have.
- Michelle: a but I think when you...when you have, I don’t know, which meeting, but there must be some meeting where you can mention that that is and if all the production pharmacists from all the facilities start to say that they want an e-mail address. I know e-mail address allows you to report some things and so your admin levels are on a different level but I think that they should have a registered list, these are the supervisors they get to request these things, these are production pharmacists they can’t request those things but everyone still has an email because that just doesn’t make sense to me...anyway.
- FB2: I’ve got one more frustration – stock. At the moment we struggling with stock unbelievable shortage of stock and you know you are the one that has to go to the one and say to the patient “We don’t have this, we don’t have that” and then like for example, nystatin – I asked [name] when are we expecting it so then(unclear) told the patient. She said, July and it’s been out for what, a month or two already? So...
- Michelle: Is it the liquid or the...
- FB2: The 20ml drops. So you know, that is just one example but I mean there are basic things, senokot is out of stock, sorbitol is out of stock, certain ARV’s that are name patient only out of stock and the companies INH, IVI...I had to phone IHD last week and say we can’t give IVI INH to a patient and the patient couldn’t do anything else, the patient couldn’t have the injection.
- Michelle: [00:17:53] We are supposed to have backups but this is the thing. Your supervisors need to obviously know how to access backups from different facilities. You have to transfer stock but sometimes when dues out, no one’s got any more stock cause everyone’s distributed and then it’s gone. Then you wait another month and yes, that is a big problem for me, I hear all the time that the big boys come into the facility and they say “Oh, but have you ordered, have you gone according to your protocol?” “Yes we have, we have, the problem lies with you guys.” “Oh no no, we’ve got our processes” and I heard this so I know...
- FB1: One of the ARV problems was that they didn’t; you know the manufacturing guys, they plan the year because they got to clean the machines, it’s a huge performance changing from one tablet to another tablet – it’s not a simple thing. So they plan their year and they have done their tenders, they’ve done everything. Suddenly province or national or whoever changes their protocol but they haven’t actually adjusted or warned the manufacturers so suddenly, like the Atazanavir 150mg, suddenly we’re giving out to all sorts of people but we don’t have stock because [company] or whoever produced X amount because that is what we use and now suddenly we using X plus Y and we don’t have stock so they don’t...
- Michelle: I don’t know about that planning.
- FB2: Always think things through. Well that’s the impression we get that they don’t always think things through.
- Michelle: I think I tend to agree with you.
- FB2: I think just from a communication point of view, like we haven’t had sorbitol, we not going to have sorbitol for I don’t know how long but hasn’t notice gone to the doctors saying please stop writing sorbitol, they’ve told the odd people and I would like to get cc’d on that notice so I can print it at home and then say to the doctors I will forward it to you if you need but this is the notice

that went out because we writing to follow notes on things – there should be list of what is out.

Michelle: So you guys have a PTC meeting?

Lotsa voices

Michelle: Shouldn't there be one person that represents, like a supervisor or pharmacist that's kinda on the floor...

Everone

Michelle: You see now, all you guys need to do is actually write some letters of stuff and put it in [name] hand and say please, these need to be mentioned; these are the points that need to be mentioned. All those doctors and also another thing I thought of an idea one day is to have one doctor that sms's everyone. Sometimes you get someone that is willing to do that. You sms that doctor and they forward your sms to all the doctors to say "Pharmacy says....out of stock, please don't prescribe these things"....I don't it's just an idea.

FB1: All you have to do is cause, (confidential), all you actually have to do is let the prof secretary from each department know and they sent to their whole department because we get, occasionally when things like Glycopyrralate is a problem, I don't know who told her but she sent it to the whole anaesthetic department you know, so that's all they actually have to do, is to actually e-mail the relevant (unclear).

FB2: And it should be coming from the stockroom, not from us and then from [department] and then from [department] and then from [name]...one person that just sends it out, but I want proof that it's going out, because it doesn't seem to go out or I don't know that it's going out.

FB10: [00:20:50] Ja.

FB10: The one thing that I find with being downstairs is that we don't realise what the ordering pharmacists is going through because sorbitol has been out of stock for so long but there is one company that got a tender and they a new company so the government gave them the tender and they just not issuing. You can say formalin was out of stock and this company, same company, wasn't issuing and they been sending e-mails and e-mails and e-mails and it's so bad that the company just doesn't respond and it's when [name] or [name] sends them an e-mail to say "Look here, this has been going on long enough, you need to give us an answer now otherwise we will buy it out" but the process takes forever and it comes to we have 3 bottles and then it is like, full speed with all the e-mails. I think that it is difficult.

Michelle: It's terrible.

FB7: What she says also leading to my next point of accountability. Whereas in private you have disciplinary action if you don't perform, if you don't produce or hear the disciplinary action for a person will take a year and it will fall off or there is no accountability or you know.

Michelle: Ja, and at the end of the day you guys suffer as the end...

FB7: Or the team suffers.

Michelle: I'm gonna come to you, you know, yes....

FB4: I just wanted to comment on the e-mail address thing and all of that. I was at another public facility with this and production pharmacists were also getting e-mail addresses with the government, so I just saw that you can apply...

Michelle: So something can be done.

FB4: And then all the circulars like about things that were out of stock, we used to get e-mailed it, like the manager or the supervisor used to send it to the – I think it was the CEO or someone – and then they used to forward it to everyone.

Michelle: So there is maybe a possibility.

- FB4: It was on the HR system.
Everyone
- Michelle: [00:22:52] We getting off the point now okay, but yes all these things, what did we say? These are the things that frustrate us and if you gonna go somewhere that's gonna be better organised and give you the same salary and give you the same hours you gonna leave, am I right?
- FB1: [00:23:04] But you have more clout in stock – because it's not a tender system in the private sector, you can phone up the rep and say if you don't produce the stuff, I am going to go to Dr. [surname] or whatever and tell him that your company can't do it and then switch products and they jump. Let me tell you they will fly the stuff from anywhere.
- Michelle: Oh ja, no they do.
- FB1: But with the tender system the persons got a tender so they don't, the partially supply so we haven't the same clout with the companies.
- FB2: What I can't understand is, with your patients health, why did I yesterday, turn 3 patients away cause I couldn't give them lamotrigine. That is not a simple drug, that is not a nice to have.
- Michelle: I know.
- FB2: I didn't sleep.
- Michelle: No, I mean none of us do. I have been in the same position. Ja, Lamotrigine for babies, that's a child and I said to the patient I don't know what to do for you, can you get on a train and go to [facility] now? I called [facility] and said "how much do you have" and they said "no, they've got a couple of tablets" and I said "can this patient come to you?" because I didn't know what to do. Okay, before we carry on, what about climbing the ladder? Have you guys ever thought of being...applying for a supervisor role?
- FB1: [00:24:48] I did cause they've just had a vacancy now and I've got a lot of experience and then I thought nothing ever changes, I'm gonna get more and more frustrated, why bother.
- Michelle: Okay, ja...would you guys ever consider it? Don't worry, it's amongst you guys, no one's gonna judge you, I mean there's three comments on the sheet there okay, if you look at them, the first 3. I am confident I will make a good supervisor – you only need 3 years experience in the government. I plan to be a supervisor as part of my career goal – there is no way I want to be a supervisor. What does my supervisor do all day? We need their help with dispensing and they always busy with something else.
- FB1: Okay, I'm gonna say something but if this goes out this room (unclear)
- Michelle: But that's what it's about, so just...
- FB1: The problem is you got some very nice supervisors, very nice people, they got their jobs they young, they got their jobs sometimes straight of their comserv year because nobody wanted to work for the government; they were like the only permanent staff here. They very nice people, they very good pharmacists often but they not management material so we have a problem with them actually managing staff, managing...and it's not easy cause of the unions. The assistants they are very unionized so it's not easy, it's not an easy job but you know, some people are cut to be managers and other people aren't always and I think sometimes some of them are but (unclear) some of them, they not...
- Michelle: Do you think is then definitely a thing for experience or do you think it's character?
- All agree character [00:25:37]
- Michelle: Okay, so do you think all the supervisors that you have at the moment are some of them kind of got that, you can see they can do something with their supervisory roll and some of them not so much?

All agree (exactly)

Michelle: And then I want to ask, what about the other career paths?

FB2: Can I make just one comment?

Michelle: Yes of course.

FB2: If you take for example that we have a financial pharmacist who has not been at work for 2 years, it's an ideal opportunity to take someone who is interested and start training them. They have not replaced that person, they have not given anyone an opportunity, they have not mentored someone into a supervisory role to give them a chance to try if they don't like, or give 4 people, put them in for a month at a time but give everyone some exposure – you never get exposure to anything, you don't get exposure to ordering, to you know, anything that is mainly minimally management functioning so how can you grow? Then they take you with no experience and they stick you in a supervisor position.

Michelle: Yeah, really weird. And that's another thing that I wanted to say to you is also comments on there. There is two things there. I wish the older pharmacists would help me more – the older pharmacists being such great mentors and that pharmacist is so stuck in their ways. I mean do you find that – are some of you guys feeling like you wish someone would just help you, that's got a bit of experience, like you stuck sometimes and you not sure about decisions to make or you'd like to go into supervisory role but there is no one there to kind of hold you by the hand and take you through that?

FB7: [00:27:19] I would apply for supervisor post but not here and that I've made up my mind. I've been a team leader before and many times (unclear) but I wouldn't apply here and I also feel that...

FB1: [00:27:29] Why? Out of interest, why?

FB7: Ok I was a team leader, it was a smaller group and like I said there was things in place, your protocols, your policies, communication, disciplinary, so you have a back up and there is accountability and here I don't feel it.

Michelle: And you a bit worried if you had to go into that roll, would you have someone to back you up when you needed to make certain decisions.

FB7: That's it. And also, what was I going to say...oh ja, consistency. I don't feel that most of the supervisors are consistent. You don't have to be a brilliant supervisor one day and then the next day you don't perform, you just have to be consistent and do your work consistently and be dependable.

Michelle: Ja, so work every day.

FB7: You know because a lot of pharmacists we work independently so you need to be there for things that has to be your role.

Michelle: [00:28:18] So do you think when you've been a production pharmacist, do you guys feel like you learn a lot about – I don't know – code listing protocols, are you up to date on all your supplementary list things, do you have a good feeling about that so if you went into a supervisory role and someone came to you and said, I am not sure what to do here, you'd say you know, you need to go and speak to this person or that person, let me contact this person – do you guys feel like you've got any of that experience?

FB1: Yes and no, we get all the lists but they deviate from the lists all the time as well so you can go to the doctor or the patient or whatever and you say this is the situation and you can even produce the piece of the, the Clexane protocol and then the doctor throws a hissy fit so somebody higher up says okay it's fine they can have it, so you like an idiot.

Michelle: So your Clexane protocol: is three days one BD am I right for inpatients.

FB1: For ACS and for embolism and DVT it's 5 to 7 days per kg BD as well and if they want to take the TTO it's a release from [name] [surname] and then for

example what happened was, they changing the protocol all the time because it's not just from...in a pharmacologically often what the doctors write is fine but it doesn't fit the state protocol and then at a PTC meeting, one of the gynie's discussed sending patients, pregnant patients home on long term clexane BD, none of us knew about that because it was discussed, it hadn't been put into the policy yet. We then got a script we asked the intern to phone – the intern got screamed and shouted at by this doctor, so we then went to [name] who said “Ooo well ja, it did come up in the meeting, ja... maybe just let it go for now until the new policy has been decided”. Now that poor intern got an ear bashing of note and either it's been passed or it hasn't been passed, you know, they need to be a bit more clear cut on their...

Michelle: [00:29:53] It is clear cut normally like with even that, I know that you are allowed to give a person, a pregnant person that's been discharged...[End of recording]

PART 2

Michelle:they allowed to give them as much Clexane as they need until that child is born.

FB1: On 80 BD and whatever as long as they want...

Michelle: But now you don't know those things. And I know because I have had the exact same situation and later on I've seen some supplementary lists, waaaay back they had a list of all the categories of people but no one says anything I know that is why I am asking you guys, how informed are you in order to step into a role where if you are a supervisor you can say to the production “I know what to do”. Do you feel confidence?

Everyone agrees: No.

FB1: Pentasa was another example, when they switched from the Asacol to the Pentasa we were told this is the maximum dose for pentasa then suddenly [department] were writing up different doses and we queried them and we were told ag it's fine, let it go. You know, if you gonna change your mind you need to tell us. I'm not saying they can't change their minds but just let us know cause then you pick up the phone and you wasting your time and you wasting the doctors' time and then they get cross with you, you know.

FB7: [00:00:56] Even though I think Omeprazole I think they said they coming back to us regarding Omeprazole we still haven't heard anything about the final.

Michelle: What was the problem with that?

FB7: For the ENT and the reflux.

FB2: I think what happens is, no statement is always a clear statement so when these supplementary lists come out, to me it's a good opportunity to sit your pharmacists together and to say let's go through this. Do you have any queries with this? Do you find any exceptions? Then everyone is on the same page but that's never done, the supplementary lists are e-mailed out, I don't know how long after it comes out we get it but eventually I get it or I get it attached by someone else and come straight to me straight away okay, and we never discuss it. There was another thing, each department like surgery and gynie – they seem to have protocols about medicine which we never see so if you gonna give something to induce abortion, I don't know what their protocol is, I just see Mifeprostone one stat or whatever but I don't when to tell the patient must you take it tonight, to take it next week or is a doctor telling, there must be a protocol around and I asked last year for that because I was here last year and I was getting those scripts and I haven't had an answer. So that kind of thing must – when they change the HIV dosing for children,

- why aren't we informed? Because we the people that have who've got to issue the meds? And that lack in communication is so frustrating.
- FB1: [00:02:29] And the other problem, I don't know if this is just isolated to here because we not all in one pharmacy and [department] things change on a daily basis in patients then comes the weekend and say FB2 and FB10 work, now FB10 has been in manufacturing for a year and FB2 has been in out-patients and they will send a script back querying it because that was the last time they were here and as far as the protocols they have been given, that's what it says and then everybody says that "oh no no but that actually changed last week". Nobody is told what is going on so if you actually haven't got somebody who is currently working in [department] on your weekend you can...am I right? You can struggle.
- FB2: To me the nice thing of [company] was we all had our computers, everyone was allocated a computer.
- Michelle: So you just get your e-mails and see it instantly.
- FB2: And on your computer you had your standard operating procedures, everyone had access to it. The bloody cleaner had access to it, because it was standard for the hospitals. If there is a restriction list, it's on your computer you can access it straight away. If there is a policy for medicines anywhere it's on your computer you can access it straight away. Here it's like go and look in this book and ask that person, go and look at home on your own personal computer...there is no place and I have been asking since I got here for something like that. I also said what we should have is a clinical pharmacist because why are we the pharmacists but the expertise is going to Prof [surname] or someone else, is there a backup? But why don't we have one person who is training up one or two other people who is the centre of information and it mustn't be [name], because [name] is not here half the time.
- Michelle: Did you see that? That there is this whole clinical thing here but there is no positions yet. I mean, you, hospitals need this, this is a clinical pharmacist – would anyone be interested in doing that?
- FB2: We were asked to apply.
- Michelle: Because I think the thing is you do need one person that is in the wards constantly. Basically their day is to be out there. When the stocks going out they there, they checking on the doctors, they looking at the boards, they talking to the doctors, they saying "why have you done this? I wanna know" and then they coming back to the pharmacy at about 3 o'clock and saying "Ok guys, I am typing up stuff for you so that you can see what is happening in the hospital" and every fresh morning you come in the clinical pharmacist has put everything up for you guys, you can see what's happening. That's what their job will be. They will be there and they will be checking on IV's you know, so that you don't have a wastage. Do you know how much you waste because these guys – I don't know what they do with IV's, I mean they leave it open or they chucking stuff or they putting up one thing and they've put the wrong strength in there and it comes down again – clinical pharmacist is there, they will be able to immediately say "what you doing? What's this, what's this lying here, why are these tablets lying here, what's happening here? Why are these...?" you know, "I mean Vacolitres just lying on the floor here, where is that going?" So that would be their job. So I mean would you guys, one of you would be probably interested in that wouldn't you? Hey?
- FB1: [00:05:17] It's a tough job. I discussed it with (confidential) and he said in a teaching hospital you almost need a clinical pharmacist per department because he said things change all the time and he said if you want to keep up with the gynie profs and the medical profs and the urology profs and the...he

says they're at conferences, he said things change like almost daily and for one pharmacist to keep on top of all these policy changes, he says it's quite tough so he thinks you need more than one. It needs to be more than one.

FB7: It's not a one person job.

Michelle: It's interesting you saying that.

FB5: I really thought... there is 1000 beds in this hospital.

Michelle: Ja

FB5: 1000 beds.

Michelle: Ja that is huge.

FB5: So FB9 and I discussed it, it's like, they should just cut this hospital in half.

Michelle: Ja, I think so. Maybe you'll actually be able to get through your work every day as well if you did that. Okay now is the next question. Is the money enough guys?

FB1: I think so.

FB7: Not for me.

Michelle: Not for you okay.

FB7: [00:06:05] Because I think I mean, as a single person with dependents like my Ma etc, it doesn't work out for me.

Michelle: Ja, it's not like you in a...

FB7: Ja, so I think if you maybe...if you have a spouse and there's two salaries and a medical aid it works out but I think maybe for a single person with...

Michelle: No, very little. Do you feel like you working and using so much of your brain and yet the money doesn't match?

FB7: Ja.

FB2: [00:06:32] I think if you, it's not even that, I think it's almost if you look at it's a 4 year degree plus community service plus 2 years in (unclear) and that amount of studying you do, the salary we get is, compared to someone outside like my friend who has done a 4 year computer course is earning double what I am earning you know.

FB1: Counter argument that the clerks, the CA clerks earn R8 000 a month compared to our interns who earn – you can look at it – okay a CA there is potential after that, it just climbs, a pharmacist kind of stop at a ceiling but...

Michelle: Ja I mean I had friends who did programming, they are earning fortunes and I think why didn't I do computer science. Why you know? But I love medicine, I don't know how you guys feel? Maybe this environment is a bit hectic but don't you find you still love medicines? There is something about it and that's why you went and studied it? But, it's a tough one. Do you think you getting paid fairly compared to what people are – you were talking about outside rates? In comparison?

FB1: [00:07:32] I think - I honestly don't think the salaries are bad – I really don't. I think the salaries are, the only problem again I say is the ceiling you know. If you want to break that ceiling, you need to get out of traditional pharmacy. Like a friend of mine went into manufacturing, she is now an MD of a company, she doesn't touch a tablet but in those days you needed to be a pharmacist to be the managing director of a pharmaceutical company and that's how she got past (unclear) she went through registration or whatever, so if you really want to make and get to top management, like real top management, I am not talking about like [name], I am talking about really top of the...you need to then maybe supplement with a B.Com degree and you need to go that way.

Michelle: Corporate, do the corporate proper...

FB1: Yes, as opposed to this.

- FB7: [00:08:10] I think the salaries are competitive but it's not negotiable so I think it will be on an individual person situation like for me or somebody else you know, so it will be (unclear)
- Michelle: Do you think you would have a little bit more like, I don't know, strength or something to stand on if you were in private and you decided well maybe I am actually...do you think you can negotiate in private a bit easier hey?
- FB2: In private they have bands, so you come in as a pharmacist, they have a band, and they can manipulate that band according to how desperate they are to get someone (unclear).
- Michelle: So they know they can go to the upper level of the band and the lower level of the band.
- FB5: The amount of work you should do you have to stand the whole day, you literally stand the whole day and compared to private, when I used to go to private pharmacies, I see them sitting most of the time and then they stand and speak to a customer and then they sit down and then they stand.
- Michelle: Ja, and they have a lot of assistants running doing their things. I don't know about here. I don't know about how your assistants are here, are they really assisting you?
- FB1: Some yes, some not. We've got some fantastic ones and some not so fantastic. It's like anywhere, it's like us too.
- Michelle: Would you be able to leave your post basic assistant to do some more work in order for you guys to be freed up, do you feel that's a possibility or?
- FB1: Some yes, some no.
- Michelle: Some no, but okay are you feeling like I do, I feel like I am a bit of a control freak and I am scared I check everything, because it's our legal thing at the end of the day.
- FB1: [00:09:40] That's why I resigned from [company], because I wasn't happy with the assistants they gave me. The ones that I had were very good, the students and then they qualified and graduated and moved on and the ones they gave me and I had to sign off all of that and work and I just thought no, I didn't trust those assistants and I just said to them that's fine, I'm out, I'm not signing away my career because you give me people who actually don't know what they are doing. So the assistants are very important.
- Michelle: I agree with you.
- FB5: Are they willing to do what (unclear)?
- Michelle: Ja that's the thing.
- FB2: I must be honest...
- FB5: Why can't the pharmacist do it?
- Michelle: Ja, and then that's the thing you got to find out as well.
- FB1: Well I'm a little bit compulsive neurotic, but excuse me here you've got an assistant capturing your scripts, you don't know if they've looked at what that patient had before, you don't know if the patients had Omeprazole before, has it been Authed before so they print you a label, you just give the stuff.
- Michelle: Ja and in the meantime they could have a week ago been given the same thing, have got two files that are duplicate files. You can see it on the system on JAC but you can't see it on the file – it's all these things I think as pharmacists we feel if we're in control from the beginning to the end but you know, health care is moving away from us being in the traditional role so you kind of need to prep yourselves. What's gonna happen when they want to move you, let the assistants do more? You know, we going towards technicians now so they gonna be doing more of our work and we gonna be doing more supervisory anyway even in a production role. Are we happy with that?

- FB1: Well then I think legally they need to let you know exactly where you stand come litigation because otherwise you know, if you signing off things and you haven't actually seen it – I am not prepared to sign for something I haven't checked because then I am the one who goes to court, not the assistants or the technician or whatever so maybe they need to re-look at that.
- FB2: [00:11:24] Apart from the...I'm really uncomfortable with the state's handling of their documents. When I look at those files, that is a legal mess, I mean I would be petrified if I had to go into litigation here because I have no backup. Those files are so unsafe, the stuffs shoved in, it's lost...
- Michelle: All the scripts are here in between and then it's all the notes over here and it's this doctors notes there and that doctors notes there and the blood results...
- FB2: They use new sheets of paper. It's a legal nightmare. Apart from the fact is you can't tell what they had in the wards because there are not ward stock sheets in there, what they've been given in the wards.
- Michelle: That's the reason why we need a clinical pharmacist. I'm telling you now, to track that stuff so they can put all their little notes on there.
- FB2: Well let me tell you in the 80's, a thousand years ago when I qualified cause I keep telling the medical students when I take them up, I worked at [facility] which is much smaller, it's more like [facility] size and we had our wards and we went on the round with the doctors to like the male medical side in the morning and the female medical side afterwards. You get issued everything, from the panados through the...and there was 3 tablets and you know they would take it out the cupboard literally at 24 hours like in private and I would count the Amoxils, okay I issued 15 yesterday there should be 12 today and if there were 13 then I would say okay, who didn't get whatever. We counted everything, well here, an awful lot of stuff is ward stock cause there just aren't enough of us, you can't there isn't the time. We barely have the time to do what we actually doing and that worked really really well because the patients got their stuff. You were with the doctors on their rounds because it was...basically, much smaller so far easier and then in the afternoons you more or less did the same worked in the main pharmacy, we helped in out-patients but in the mornings we spent the whole morning – you didn't see us – we spent the whole morning in the wards with the doctors, with the patients, with the sisters and we literally issued every single...from in those days you even got Benylin cough mixture and they got their Benylin and you know if the Benylin vanished you okay, so who stole the Benylin and which sister is coughing you know, whatever. So it really does work but it's labour intensive.
- Michelle: This is the thing. I mean ideally, but what's happened is that we've just got so many people in South Africa that are reliant on the public health care system and ja, we're in a bit of a position but at the same time we shouldn't have to drop our principles and our career because the government can't get up to speed or there isn't some of system that has been in place because I believe some people can pay and they're not paying for healthcare. So they are riding, they are coasting on healthcare and I think as soon as we start getting our financial stuff up and going and those systems locked in, that people can't just wander in and wander out without spending some money, then we'll have money. Money employs people and employed people equals better service. That's the ideal but that's not up to us unfortunately, we are right at the end here you know.
- FB2: [00:14:04] I still think if you look at the legal requirements for private and you look at the legal requirements for government, it's chalk and cheese okay. In private I could not get away with not being accountable for every single tablet in that hospital...

- Michelle: Absolutely.
- FB2: But in government...
- Michelle: You can just waste.
- FB2: ...send up lorry loads of stuff to the wards, why are the nurses not accounting and why is not a documented system of what you took in and what you give out, it has got to balance. I mean there you have it doesn't have to be checked by pharmacists, it could check by a sister, by a nursing supervisor, by a nursing supervisor manager, it doesn't have to be pharmacy. But it has to be accounted for.
- Michelle: Absolutely and I agree with you. I mean they could just take a whole bunch of tablets home with them every day and no one would even know.
- FB2: And they do.
- Michelle: [00:14:58] Ja, I know. Well people have been caught – you're right.
- FB2: But why isn't it checked?
- Michelle: This is the thing. Okay, let's just speak about these, there is another comment. These younger new pharmacists are not learning fast enough. They are always playing on their cellphones, they don't realise how much work there is to be done or these younger newer pharmacists are so keen and energetic, I think they should consider supervisory position.
- FB2: Okay, can I give you an example? We have an intern, a lovely girl and I don't agree with that at all okay. It's how well you manage them. She is not a picker, licker and sticker. She sort of wanders around and I actually said to the supervisor – when are you going to speak to her? Because she is unemployable when she leaves here. No one is saying to her "Cookie, you need to pull your finger out and start working". And it's the supervisors job to do it and the supervisor laugh at me and say it's gonna be sad because she is not going to get a job. I am not going to employ her again.
- Michelle: Or she is going to get a job, just none of you guys will ever employ her one day.
- FB2: No they will employ them back....because someone higher up will employ them back and then you get that person back again. But why don't we have the guts to say to people "Really?" and I mean, to me it's still – I was a manager, I expect the managers to take that responsibility. It wasn't my other pharmacists' job to go and tell someone how to do the job, it was the manager's job.
- Michelle: Ja absolutely. So that's another thing. So it's coming back to – are your supervisors competent and if you going to be in that role, are you going to be saying actually I am a manager, I am not just a supervisor – supervisor equal manager. So in order for my production pharmacist to move I need to go in and say "I need you guys to do this, what's going on here, why are you sitting here?" You need to get in there you know and it's hard, you not gonna be popular.
- FB2: [00:16:42] Sorry, it's also linked to the SPMS system here...
- Michelle: Yes.
- FB2: ...which is the biggest farce I have ever seen in my whole life.
- Michelle: Thank you for mentioning that because that I need to hear from you guys.
- FB2: It is pathetic.
- Michelle: [00:16:51] Does everyone agree with that? Are you happy with the SPMS?
- Everyone: No
- FB1: [00:16:56] Well I have to do SPMS ever year and every year my contract re-starts in January so I don't actually know why I have to – I mean, I am not worried that I am not getting the SPMS, that's fine, I mean I probably don't do enough to get the SPMS but...

- Michelle: But they keep signing you every year basically.
- FB1: ...and they say to me well, ja they sign me every year and then I have to do the whole motivating thing to get more than the Basic 3 and the kind of almost not threat but what was said by one of the supervisors was, which is true, but it's in your interests to get a good SPMS because when you want a contract at the end of the year they will look at that and they'll give, which is true, but it's a bloody mission because they do it today and suddenly you got to rush home this afternoon. Okay again, my husband said to me every time you do something you should document it, which he's right which I never do. But you know, you do SPMS and then [name] will say okay well e-mail it to me by 5 o'clock this afternoon so you go home and you think "Oh god,..."
- Michelle: What did I do, what did I do?
- FB1: You drag something up and you send it through and all the time I know I don't qualify for SPMS anyway so I find it frustrating actually.
- Michelle: [00:17:52] You should still even though you are a cessional...
- FB1: No, because our salaries start every year in January...that doesn't bother me, that's fine, but ja, it's just the process.
- FB7: [00:17:59] Your supervisor should not be waiting for the SPMS time in order to tell you this is now what you are doing correctly, it should be a consistent you know, a development programme they should have (unclear).
- Michelle: Well that's how it's supposed to be you know, quarterly you supposed to go into a 5 minute meeting and you supposed to have a list when you come out of there of the things that you and your supervisor or manager have discussed about what you gonna do in the next three months and you make it a mission to do those things so that when you come back after the 3 months, you know, you kind of schedule meeting right then and there, that's the day I want to see you, 5 minutes please and I want your documents from what you've done so I can put it on file for you. Okay so that is ideal – so I mean you guys could start a trend if you wanted and just every 3 months you just say to [name] "can I come see you for 5 minutes?" and you throw down the documents and you say this is what we're supposed to be doing.
- FB1: We do it with the supervisor, we don't do [name].
- Michelle: Oh, do you do it with the supervisor, okay but do you with the same supervisor every time or different supervisors.
- Everyone: Different. With the department you are working in.
- FB1: And often they forget to do it and then like, so you actually been out... you've been there for 3 months, you've been here for 3 months and the OPD pharmacist will you to go over there and do your SPMS from when you were there last year in September and you can't actually really remember.
- FB2: To me they also, if you do something wrong they reprimand you in public. So if you..."Don't you do that..." and to me that is "Take me to the office..."
- Michelle: And talk to me about that.
- FB2: Strip a tear off of me but let's do (unclear)...
- Michelle: And then at the meeting, if it's something that is mentionable to everyone then in the meeting say "You know guys I was thinking this week.." so that you don't mention names hey. I think guys it's gonna be very tough for you but you have to make a way for your SPMS's you know that. You have to, because if you wanna accelerate your salary later when you get into production 2 or 3 you can get accelera...you can accelerate your notches. After so many years.
- FB2: [00:19:47] But the thing is everyone gets good SPMS, everyone gets a good SPMS.
- Michelle: Do you get 4's? Do you get 4 out of 4's or....

- FB1: [00:20:10] It's out 5. We have if you're 5, you're god, if you 4 you in the wrong job, you should be one job up, that's the way we were taught. 3 you doing your job with a little bit more.
- Michelle: Ja, 3 is basically satisfactory and you have to be on satisfactory. If you can get a 4 at least...
- FB1: Also some of the things, they have to give you a 3 because you haven't got access to it. Now why is it that some of the stock control, you know certain things in the SPMS that you not allowed to do so they can't give you a 4 because you never do it because you are not allowed to do it. So the SPMS's are also slightly...
- Michelle: That's the thing, it's not tailored for us hey? Because this is thing, they're trying to do this general SPMS but they made an OSD that's specific but they haven't made an SPMS that's specific. So that is something that needs to, I need on the file because it is something that needs to be requested when we go to bargaining councils you know, that when we're doing this that if there is anything (unclear) with performance management that we request as pharmacists as separate and doctors as separate so it's tailor made for you...
- FB1: And your department.
- Michelle: ...and your department can then tailor it again.
- FB1: Different departments do different, you do different things in different departments.
- Michelle: Ja, it should be basically this is the pharmacist's one and then within there.
- FB1: I mean with FB10 is not (unclear) you can't give a mark on accuracy on a dispensary because I mean when did you last dispense.
- FB10: [00:21:09] But I also find that with me being in manufacturing my supervisor don't actually know how to score me. It's like you must say what you doing in manufacturing because one of the supervisors or two of the supervisors that I know of has been in manufacturing so they know what's going on there. But the (unclear) SPMS is...
- Michelle: Being with other people or not?
- FB10: With other...well one with [name] but the others they don't actually know. They have an idea of what to do but they don't know the extent of what you do and the same is so for the SPMS for the PA's because if you rating them, you can't rate them zero because it is something that they actually not doing but because they in manufacturing and ja...
- FB1: You should be able to do a not applicable.
- FB10: Ja but now they saying, because you don't let me do that you can't give them zero so if say they not doing checking the stocks, they don't do that because we have something in place for it to be done so the thing was but you not allowing them to do it so you can't mark them down. But surely it must be something...
- FB1: But it shouldn't even be there if they not doing it.
- FB10: Ja.
- FB1: They not expected to do it so why is it there?
- Michelle: [00:22:40] So tailoring, SPMS's should be tailored per department.
- FB3: I also think that why, during SPMS you must write about yourself, what you did. Why must you boast about yourself? Obviously they can see who is the workers and who is not the workers, so why must you tell them okay I did this and I did that?
- Michelle: I know, that's the other thing that's very difficult for us as pharmacists because we are professionals and you feel like maybe performance management systems isn't applicable to a professional because a professional you know according to GPP, what you need to be doing right? So how do you

- score yourself? You know, either you are doing your job or you are not doing your job.
- FB10: [00:23:18] But I feel that your supervisor should be scoring you. Don't ask me to score myself because then I am just going to give myself a 3.
- FB5: When you say something and then they don't act upon it.
- FB3: [00:23:30] And even if you tell them but I think I deserve a 4, they will tell you no, but I think you deserve a 3 and then like no, but I went to all the extent to do that but you still give me a 3 and they like no but you weren't supposed to do that. So isn't that a bit unfair?
- Michelle: [00:23:51] So it's like present yourself then you present yourself and then they say okay that's not good enough. But they need to give you reasons why okay, this cannot be a 4 because this is kind of part of your key performance outputs anyway okay but what you did there is outside of it so you actually fulfilling more of your duty so I will take that as a 4 in that area. That's what should be discussed.
- FB10: [00:24:13] If you give yourself a 3 and they give you a 4 then you must motivate why they give you a 4.
- Everyone: LAUGH
- FB1: [00:24:21] It was controversial a few years ago, one of the supervisors got SPMS because she did do a project but where it became controversial was that she did that project in working hours so everybody else had to pick up what she should have...you know normal day to day stuff, she wasn't doing because she was doing this project so say FB3, FB2 and I had to do her dispensing and then she got SPMS. Now to me that should have been done outside of her...you know what I'm saying?
- Michelle: Yes, outside or it needs to be all of you.
- FB1: Yes.
- Michelle: So then you all get an SPMS because you basically group working. You're assisting her with maybe accessing some things and doing her work while she is actually doing the project...
- FB1: That caused a lot of controversy. I just got here and the cat had already been set amongst the pigeons and I remember it because I remember thinking ooh that is a bit...
- Michelle: Ja and I think all of us feel that way, we've all been in a facility where someone has got their SPMS but they haven't been around and you have just been slaving away getting the patients out and you thinking where is this person? The sitting in the office doing stuff you know.
- FB3: I think supervisors already have their favourites. They know who is gonna get SPMS.
- Michelle: Ja, phew that's good you saying it because I think a lot of people feel like this and this will come up somewhere – it's gonna be mentioned I am sure of it. Is there anything else you guys? You wanna wrap up? I think we are on time hey? Or we a bit over. Okay, we 5 minutes over, let's wrap up. Is there anything, what can I say in conclusion?
- FB1: Thank you for giving us the opportunity. Seriously, do you know (unclear).
- Michelle: The only thing I think was overtime. You guys don't get paid for overtime?
- Everyone: [00:25:59] No.
- FB1: [00:26:03] And taking back overtime is quite tricky as well. You get time back but you struggle to get your time back.
- FB3: There is never enough people at work.
- Michelle: They are going to make some facilities a 24 hour thing now – have you heard about that?
- Everyone: No...yes...where?

- Michelle: KDH is on the list I think and we have something new in the GPP concerning that so I think maybe for your own sakes go and read because they going to ask us to comment at some stage. They've just changed the rules basically and said that pharmacists should work...should be available 24 hours.
- FB1: But we are.
- FB10: No they mean on the premises.
- Michelle: On the premises but only at certain facilities in South Africa and they will pay us at the old level 8 which is like kind of just below the production 1 for those extra hours so please guys, be aware, you need to comment on stuff like that when it comes up.
- FB10: How in the near future? (unclear) open for comment?
- Michelle: It will be open for comment at some stage.
- FB1: So in other words we work after hours...
- Michelle: If I find it I will...
- FB10: Send it to me?
- Michelle: You get basically paid after hours ja, it's called an extended hours or after hours pay rate okay and it's part of the OSD agreement that was signed that we will be..
- FB1: Our overtime rate is actually less than our hourly rate.
- Michelle: Correct, it will be and that's what I am just worried about for those guys so are maybe gonna get stuck in these facilities, they gonna be, they just gonna implement it and then you gonna have to run with working extra hours – say for instance working 3 days shifts of 12 hours okay, you can work flexi then it will just be the same amount of hours but sometimes they will require to work more hours than standard but they will pay you at a lower rate okay, so just be aware that when it comes up for comment, it's gonna come up cause 2015 they need to reply on this stuff so somewhere this year.
- FB1: So you actually want to know would we leave the state that would be a reason.
- FB10: Isn't it gonna be pharmacy in general so private hospitals will have to do it...
- Michelle: That's right.
- FB10: ...hospitals, your community pharmacies...
- FB1: But private hospitals pay.
- Michelle: Yes, that is the difference and that's why I am just saying is that the...
- FB1: They did it years ago working 24 hours and they had pharmacists and they used to drug deliveries and things during the night and it worked very well but it wasn't cost effective. It cost them a fortune.
- Michelle: Ja now that's the thing. For us it's not going to cost the state that much but we gonna suffer.
- FB1: No I am not doing it for less pay.
- [End of recording]

APPENDIX Y: TRANSCRIPT FROM INTERVIEW WITH FOCUS GROUP “FC”

PART 1

Michelle: Okay, so all I need you to do for the recorder is just to say your name and just tell me how long you've been at [FACILITY NAME].

FC1: My name is FC1 [surname] and I've been at [facility name] for 13 years.

Michelle: Wow, okay.

FC2: My name is FC2 [surname] and I have been at [facility name] for 10 years.

Michelle: Okay, wow you guys.

FC3: My name is FC3 [surname]. I have been at [facility name] since 2006, so it's 8 years.

Michelle: Okay, so it's long...and you?

FC4: I am FC4 [surname]. I've been in [facility name] for 14 years.

Michelle: 14 years, so it's 14, 13, 10 and 8 – I haven't seen that in a long time.

FC3: god it's time to leave people.

FC1: Are you serious?

Michelle: Ja well, yes I haven't, I am quite amazed at your guys. You know some people go out and they come back in. You guys have stuck it out hey. So why did you choose public sector, you must have done your community service and then why did you decide to...did you stay straight on?

FC2: I think both of us did our internship and community service here.

Michelle: At [FACILITY NAME].

FC3: I did community service here.

Michelle: And then you just stayed on because you were happy or what was the reason?

FC2: Well for me personally we do lots of locums – I used to do locums after hours in retail and it just wasn't something that interested me. I did not like it at all.

FC3: I have also been, well FC2 as well, actually the three of us, we also did sterile training so chemotherapy and IV antibiotics and TPN that was something you didn't get an exposure to anywhere else. For me that was one of the reasons why I came back because I pretty much, almost straight after I finished my comserv I started training in sterile and that for me was an incentive to actually stay on because it was something I was interested in and I do really still enjoy it – I haven't done it for a while but...

Michelle: Ja, obviously rotation is not something that always happens easily as well...

FC3: And children get in the way as well...they come out when you pregnant.

Michelle: That's true, very true. So if you guys...do you think public sector is popular now? People trying to get in?

FC2: I think they are but they actually don't realise that it's a package deal, so they don't actually really know what they getting themselves into. The package does look very appealing for private especially but when they really break it down it's actually not what they want.

Michelle: The cash out is quite a bit less than...

FC2: I think the supervisors in [facility name] historically has just got a bit of a different twist to it cause we were all translated to production and we actually had to fight to get translated into the supervisor post and I think it was quite unique when we had a very big fight with...

Michelle: So just as a question, how long then have you guys been in your supervisor roles? Did you come in cause you didn't? Cause you were production first, so how long were you?

- FC3: They were all principle...I mean they can tell the story but they were all principle pharmacists before the OSD. I was only promoted after the OSD so I am not involved so it's best if you talk about that.
- FC1: So before OSD we would have your normal junior pharmacists then senior pharmacists and then principle pharmacists so we were all principle pharmacists and then after OSD everyone was translated to production. So we were all on the same level with the junior pharmacists.
- FC2: We were actually just in our grades so I only had like 2 years experience, I was Grade 1 production,
- FC1: ...all of us actually were Grade 1 production with the rest of the staff.
- Michelle: That's quite a disaster hey.
- FC1: It was. They didn't take into account that the principle pharmacists before OSD were actually the supervisors so they just translated them straight into production. There were no supervisor posts created with OSD.
- FC2: We had to apply for the post technically.
- FC3: And it took a long time as well, it was like a year and a half...
- Michelle: So to create the post first you first had to convert the production 3 to a supervisor or some of the production posts to supervisor posts and then appoint you in that post, am I right?
- FC3: Ja.
- Michelle: And how did you guys do? How did you fight that? I mean, did you just do all the documentation at HR, I mean who helped you? Was there anyone that helped you with that...that you can remember?
- FC2: A lot of help [name] was quite involved with the...and [name] as well. We had to actually get the other hospitals to also get involved because it was a big thing cause we, I think it wasn't only us that was affected in the hospital, some of the medical doctors as well and it was a big thing cause that was when that strike happened.
- Michelle: That's right ja, I remember that.
- FC3: And it was quite a big...I think for most of you it was quite a big salary difference as well because you were probably, most of you were like pharmacists Grade 2 at that stage or even Grade 1.
- FC2: I was Grade 1.
- FC3: See she is actually a supervisor. If you look on the scale.
- Michelle: It's a major, major difference in salary.
- FC3: And they were still doing the work, it's not like they just became production pharmacists and then you go well...
- Michelle: It the job description basically and you were doing all the key performance stuff.
- FC2: And I think what we did was, we started saying that we were not going to do the job because we were not recognised it fell onto our chiefs and onto our assistant managers so there...
- Michelle: You were basically threatened hey? Ja.
- FC1: It wasn't something that was done through the hospital, it was higher up so we had to go through the union and then they took that to Joburg and...
- Michelle: Bargaining councils...that is hectic.
- FC1: So it did take a very long time.
- Michelle: Ja, and I get that. I totally get that. Okay so then if you were to go, what would make you leave government? If there was something offered to you, what is it more money? Is it a different working environment?
- FC3: Comfort.
- Michelle: Comfort.
- FC2: For me at the moment.

- Michelle: Infrastructure.
- FC2: Personally, I live like down the road from [business name] and the principal there, I mean the rep, the RP there, he approached me and he said do you want to come here, what are you getting now, let me know and I am can fight for you and I was like “Really? I can walk to work”, and I think that for me is more appealing cause you start at 09h00 cause they only open at 09h00 and, I mean its longer hours but at least I can take my kids to school, you get an hour and a half lunch so I can go fetch them and drop them off at home...those things are appealing to me.
- Michelle: Absolutely. Ja, that the thing. And you guys? Anyone?
- FC4: Same as you, as you get older, it’s the family responsibilities that come to count. Finances yes but at the end of the day you can have lots of money but you still need to have to have your support system and everything. So I think just like FC2, I mean the closer you are at home the better.
- FC3: And money can’t buy you time hey.
- Michelle: No, and family is a huge...you need a lot of time.
- FC3: Ja, for me it would be working hours. The money really isn’t, I am comfortable with what I earn and I think I don’t know if I would get a job outside earning what I do now with the hours I earn now but...
- Michelle: It’s comfortable hours obviously because it’s early start...
- FC3: I am happy with early start actually, I prefer it but ja, and as FC4 says also, commuting time because most of us don’t live close. I think out of all of us I live the closest but still, traffic is an issue.
- Michelle: It is huge.
- FC3: And I am on the school run unfortunately so I have...I drive past ten schools.
- Michelle: That is always a nightmare.
- FC3: It takes me half an hour to go 5km, but that’s it aside but for me it’s definitely and FC4’s hit the nail on the head. As you get older you realise what’s important.
- Michelle: Ja, when you younger you can still basically just think work, eat, sleep, work, but being a mom I think is also a big thing because you the mom and that’s a huge thing. So the things that make you stay at this stage?
- FC4: It’s the hours.
- Michelle: It’s the hours, convenience of knowing your job maybe?
- FC4: I think so - the comfort.
- Michelle: The comfort zone hey?
- FC3: I enjoy what I do at the moment. I am happy where I am, the department that I am working in. I know it’s not everyone’s cup of tea and I know that there are people who don’t want to work where I work and that’s fine but, I am happy where I am.
- FC1: And it’s not the working relationship that we have with the nurses and the doctors because you don’t really get that in private. In the teaching hospitals the doctors are learning as well so we learn new things almost every day.
- Michelle: And everyone learns together basically.
- FC1: Exactly.
- Michelle: That’s fantastic yeah. I must say that is a very nice...
- FC3: You don’t get that outside.
- FC1: And I also like the amount of leave days we get...in private you will never get...
- Michelle: Oh yes that is true, you are right.
- FC2: As well as your benefits because I mean if you think of about your maternity leave here as opposed to outside.
- Michelle: Sometimes they can just refuse you and you know I have friends...

- FC3: They can't refuse you the time but they can refuse to pay you.
- Michelle: Ja, that's what I'm saying, you know they tell you take it but it's unpaid leave which is...
- FC3: Well I am pregnant now so...surprise surprise...And ja, so you get 4 months fully paid and one of my friends actually asked me because my first child, he's only, he will be under 2 when my second one is born and my friend said to me, "Do you get maternity leave again?" and I am like "What do you mean?"...
- FC1: You can have maternity leave every year.
- Michelle: Ja, you can have a child every year and have 4 months off.
- FC3: But apparently a lot of private companies have rules that not more than once within a two year period...they'll give it to you again but...
- Michelle: But you've got to take it on your own. That's amazing.
- FC1: And there is a cap on your salary outside if they do pay you, they pay you like a third or two thirds or whatever.
- FC3: Or you've got to claim the rest from UIF...
- Michelle: That's right...
- FC3: It's very complicated. Whereas we basically just get don't come to work and we get our salary paid as normal.
- FC1: And you get your bonus in your bonus month if you are not here so.
- FC3: You don't have to go fill in any forms or, I mean I think for the UIF you've...
- FC2: You have to apply..
- FC3: And you've got to Home..is it the Department of Labour, you've got to go and stand in a queue every month to get your money or something stupid.
- Michelle: Ja, that's it.
- FC3: We just get that sms.
- Michelle: Ja, I must say there is some comfort about being in the state you know, they do look after their people in that way but there is other things...
- FC3: And it's stable as well, even when times were tough, even... I remember, when was it so bad that companies, some companies were closing, they were only working opening three days a week..remember that time?
- FC2: It was where they were actually...
- FC3: You know our jobs are stable.
- Michelle: Ja, that's true.
- FC3: The government is not going to say to us you know, limited hours, we were still working 5 days a week, 8 hours a day.
- Michelle: That's right.
- FC3: You get that stability.
- Michelle: Retail I was just thinking about when they had the whole change with the dispensing fees and I mean, just so many places closed down. Those people were scuffling to find jobs in bigger corporate's and stuff you now. Okay, then the next question, so do you guys have any plans to climb the ladder above supervisor?
- FC1: That, actually, I think, is one of the disadvantages of working the state, there isn't really post above them and there is an assistant manager post but usually one with the facility in that usually...
- FC3: And you've got to wait for someone to leave...
- FC1: So there really isn't anywhere for us to go now.
- FC3: The three people above us, well I don't know about the one but two of them, like they not going in a hurry so we going to be old and grey and by the time that post...I think most of us actually applied when the one came open, just for the experience of interviewing for that level and I must confess when I think about it now, I didn't actually want the job.

- Michelle: It comes with a lot of responsibility.
- FC3: Extra responsibility, a lot of extra time and a lot of extra headaches.
- Michelle: Yes.
- FC4: Unless you change, go to the offices in the district....
- Michelle: Yes, that is what I was thinking as well.
- FC4: ...unless you change...
- Michelle: Ja, in other words actually change over from...
- FC4: ..if it is appealing to you.
- FC3: But I think at this stage of the game it is a little bit scary because we have all been doing what we've been doing for so long and we good at what we do here and to make that change now, we might...
- FC4: I think just the feeling of going through the training phase again, feeling stupid at times.
- FC3: I was actually having a similar discussion with a friend not that long ago. I think it's unique to us being professionals because we studied pharmacy, we knew what we were getting ourselves into, we knew what our jobs would entail, we know what it's like but some other – you know a lot of people we know, they did a BA and when they change a job you know, everything is new again and I think we're just we used to our comfort zones and we not used to that whole idea that if we starting a new job...every time we start a new job, it's a new thing for us.
- Michelle: Yes, and we don't do that often because of the kind of career that we have hey. Ja, cause I mean there is this policy specialist line who is clinical line which there is no positions there.
- FC3: I was gonna say, there isn't a position there so what's the point.
- Michelle: So that doesn't help anything but I mean, eventually one could probably move and there is not many positions there either.
- FC3: I was gonna say, isn't this [name] and who else is it?
- FC2: There is another person.
- FC1: There is [name].
- FC3: Is she also part of the specialist?
- Michelle: But there, there is some positions here that have been opened like in policy, some management positions that have been converted to policy specialist. Like you know your [position name] guys? [position name] guys going be in this now and I think the [position name], [name] and those guys are also here. So you have to also think of that and she has got a staff under her you know and there is always people under them that are assisting them you know, so there are other things so..
- FC3: But then you have to work in town and sit in more traffic.
- Michelle: That's the thing. That's the other thing and get up with the birds and if you've got children and you got to drop them off at carers and all sorts of things that doesn't work either hey. So you have now established, there is nothing above, but I mean if there was something there, I mean you said you guys all applied anyway so the position that did that assistant manager post that did come available. So you would maybe consider it if there was a post hey?
- FC4: I think the JAC, IT... [surname]... [name], she had a post and I think it entailed travelling, sleep over George or whatever...I have a three year old... I'm like, okay, it was appealing before you told me I have to travel and sleep over, where's my child at that time but I do like her job but it's the frills that comes with it. I don't mind travelling, but maybe if it was five years ago or ten years ago I would go for it.
- FC1: It's not the time.

- FC3: I think when you've got family commitments it's a lot harder to accept these jobs that say, I mean, even with our job, we're expected to work you know, it's in our contract, overtime where necessary... that can be a problem. I think most of us are not too bad at the moment but our out-patient department.
- Michelle: It just runs over all the time.
- FC3: It runs over all the time and it's very difficult to manage your other commitments if you have children or you know whatever your other commitments are, even if it's your gym appointment whatever and you keep on having to cancel at short notice or you can't do anything during the week because you never know if you going to get out there before 6 or not...it's difficult.
- Michelle: It just pains me when I hear it. No it does because ag, ja, I've also, I mean I've been in the state and I've been there myself and I know how you guys...
- FC4: That's why I think now probably in these posts mostly (unclear) people and I think the post that I was looking for that the one I am talking about [name], [name] was my intern and now I am being told that he is coming to train me and like no, [name] you cannot train me on (confidential)...
- FC1: Because he will probably know more than you.
- FC4: So I think there are people still with no responsibility...
- FC2: Ja, the experience.
- FC4: Who is the other one, [name], in (confidential)...
- FC3: Was he one of your students as well?
- FC4: No he is not.
- FC2: No he is not but he was like in campus a couple years after us.
- FC3: Well the woman that used to do [position], [name] [surname], she was in my class at varsity. I I was very shocked to hear she had that job but anyway.
- Michelle: I suppose there is probably spinoffs as well like but then that's going out of the state again cause I was thinking you know, with JAC, I mean how many people have they taken from the state when they launched their whole software stuff they took a couple of people.
- FC2: Cause [name] was here as the [position] pharmacist and she actually...
- Michelle: Exactly so I mean, it's just being in the position and around when people come and do things for the state that, you know you the face and they see you and sometimes you get in somewhere else you know. Anyway, so, and then asking you mention money is enough hey?
- FC2: Ja....
- Michelle: Money is enough?
- FC3: I mean obviously more money would be nice but I am not uncomfortable with what I earn, let's put it that way. And when I look at the...when I...cause I don't know about you guys but, cause, it must be because council definitely sells all our details, all those locum e-mails that come out and when I look at what the salaries are I kind of go "Really? Ok". A lot of them are sort of like R30k to R35k – I suppose that is...
- Michelle: R40k at the most.
- FC3: Benefits on top of that though.
- Michelle: Ja you don't know.
- FC3: But you don't know.
- FC1: You may come out with less.
- Michelle: Ja, you will, with quite a bit less.
- FC3: And depending on...most of them are for Joburg anyway.
- FC1: I was just...I noticed that I just mentioned it yesterday I think about the fact that...
- Michelle: There is not much in Cape Town.

- FC1: There are not a lot of things in Cape Town available.
- FC3: But it's the age old thing, everyone wants to live in Cape Town so they sacrifice, they earn a little bit less...they live in smaller houses.
- FC2: We were all translated to grade 1 which technically is similar to our grade 3 pharmacists...
- Michelle: It is actually overlapping.
- FC2: Yeah, overlapping.
- Michelle: I am glad you mentioned that. What do you guys think of that?
- FC2: That's the reason why I think most of us, we were all translated to grade 1. We had no option of actually grading to how much years experience we had so...
- Michelle: So you had to basically work again from scratch to get into grade 2?
- Everyone: Ja.
- Michelle: Are any of you guys in grade 2 now?
- Everyone: No.
- FC3: No, cause they only did the, no but they only did it, when it was like?
- FC1: It's now this year. I think it's after five years. We should all be, cause we all...
- FC3: Are we all?
- FC2: Yeah.
- FC3: No, I am only 2012...
- FC1: Oh, cause you applied after us but all of us that were translated to supervisors we just in the beginning of this year got translated.
- Michelle: Okay so grade 2.
- FC3: But the salary difference is...
- FC1: But it's not..
- Michelle: But at least you can start running on a new scale now apart from being on the same salary scales as production pharmacists.
- FC3: But that's what I am saying, between I think...someone was saying, ja, like a pharmacist grade 3 is the same salary scale as a pharmacist supervisor.
- Michelle: So did you guys not feel a little bit like..
- FC3: And even pharmacist grade 2 is not that much less and if you think about the responsibilities that we have and what we have to do are much much more so...
- Michelle: That's what I am always wondering about.
- FC1: I think initially we were very unhappy and we all sort of threatened that once we actually reached 13 years we will leave...
- FC2: We will translate back to grade 3...
- FC1: Back to grade 3 and have all that responsibilities. But it's so easy nowadays to get someone in a supervisor post so it's not like they will take our threats seriously. They will let you go cause someone else with now 3 years of experience can come in as a supervisor.
- Michelle: Very very interesting you are saying.
- FC1: So you don't have to have a lot of experience to come in as a supervisor now...
- FC3: So they will let you leave as a pharmacy supervisor grade 2 because they know that they will get a pharmacy supervisor grade 1.
- FC1: And you just need your internship, community service and one more year of work to come in as a supervisor.
- Michelle: It's amazing you saying that because as you can see I have put a little sheet of comments in there and I mean, if you see the very first one it says "Ag its very easy to become a supervisor or manager nowadays, you only need 3 years experience in the government". And you guys agree hey? But that puts you out in the sense of okay, if I do wanna go..if I just wanna get out of this..there

is no way of getting out of it cause you thinking..they'll say okay fine, we not really taking you seriously and did you guys plan, you see that little comment there..."I plan to be a supervisor as part of my career goal." Did you guys think you would do this? Eventually, when you started off in production and after your community service – did you start seeing the supervisor as really new?

FC2: I think I saw it in varsity time already

Michelle: That's very interesting. That's nice to hear actually hey. And if you could do it again would you do it again?

FC3: Do pharmacy?

FC2: Not the way we did it.

Everyone: (unclear) [21:09:00]

Michelle: Let's not even go there cause that's another thing. Ja, but ja, that's also a valid thing to say but ja...

FC3: Things you wish you knew when you were 17 / 18.

Michelle: Ja, true.

FC1: I think personally, I would be grade 3 pharmacist.

Michelle: Would you?

FC2: Ja, same!

FC3: Ja probably, ja.

FC1: I think the amount of responsibility is unfortunately that we have as supervisor especially at this hospital because it is so big. It's a lot and we are, they also expect us to do production as well because we so short staffed so we doing production and supervisory...

Michelle: ...and your supervisory. So basically you running between the two, when you get a chance you go and do your paperwork and then you have to run back again when the patients start piling up and start dispensing...

FC3: And when you don't do enough of your supervisory stuff because there is so much production to do then you get kind of well, why you spending so much time on production, why you behind, why hasn't this...why haven't you addressed this e-mail, why haven't you...

Michelle: Ja, I know. I can see...

FC2: And I think it is very quick to get caught up in production especially if you are working in the out-patients department. It's highly pressurized every day and...

Michelle: And it's hard for you to actually say, "Well actually I need to go sit at my desk"...

FC2: Because how do you validate to your staff?

Michelle: Ja, this is the thing. The other production pharmacists will look at you and they start to get bitter about it.

FC2: Because the thing is in the end of it you need to..

FC3: They also very quick to point out "that's not my responsibility".

FC4: But later on the staff, even the management, I mean if there is a call from the super in his office, they don't call the staff in the production, they call in the supervisor "What's happening?" So if you sitting in the office you can't actually (unclear)

Michelle: If you run out of stock then who comes / runs to you hey? Am I right or...

FC2: And the thing is, you supposed to deal with staff satisfaction, you supposed to be dealing with HR, everything...patient satisfaction...

FC4: ...management...

FC2: Management of...there is such a lot that you deal with – you pulled over all of those places and at one stage you wearing many hats, that's basically it.

- Michelle: Well you basically a manager, a real manager. Even though it says supervisor and there is a manager above you, you guys are the floor managers basically hey?
- FC2: Ja, because, the thing is – [facility name]’s situation is a bit unique to other departments whereas in [facility name] or [facility name] they are all under one roof so their assistant manager in the next office whereas our assistant managers sits here or is in a meeting somewhere else or somewhere else. We are [position] and can’t afford... you’re down by 7 people, you need to make things work.
- FC1: And their supervisors are all under one roof so they have support whereas we are each in a different area...(unclear)
- FC2: And dealing with different (unclear)
- FC3: Fighting against each other almost.
- Michelle: Ja, and you got to make things run whether...
- FC2: And we’re competing. That’s basically what it is. You compete for staff, you compete for performance, you compete for everything and that’s why most of the management meetings we sit in...it’s like “No but..aargh”...But why is it that OPD always gets first preference? What about us and...
- Michelle: That’s how everyone basically feels like they in the same boat, they desperate and they’ll do anything just to get things running.
- FC3: And who is gonna fight the loudest.
- FC2: Tooth and nail.
- FC3: Which is sad because we are all actually towards the same goal.
- FC2: Together...and it’s unique to this hospital, you don’t get it anywhere else. Cause there they have good support structure.
- FC3: And also if you’re all under one roof, it’s a lot easier to ask the person who is work by the fridge to go and ask or work by the water cooler but when we’ve got to move people around departments then they are like “Oooh, but oh...” and it take 15 minutes or you ask for help and it arrives 3 hours later and a person actually got there at 08:00 and not at 07:30 so what time must they go home and you close at 16h00 so where must they go to but I mean that get’s sorted out but, ja, there is always a...
- Michelle: Ja, some major hiccup actually.
- FC3: Ja, and although it takes 5 minutes to get between each of the departments...
- FC2: It takes 15 / 20 minutes...
- FC3: It takes 15 to half an hour.
- FC2: And broken telephone is very very, very common here.
- Michelle: They probably just take it off the hook cause they’ve had enough.
- FC2: Yeah no, because the thing is I would say something to her over the phone and the message would get to her in a different way and like, “But I never said that!” But that’s what happens.
- Michelle: Ja, it goes via someone else to you. And you think you guys have been paid fairly as compared to, besides now the internal thing with the production pharmacists, compared to outside, you were looking at some of the salaries, you think you definitely being paid fairly compared to private guys?
- FC3: Well I don’t know because I have never been an RP, so I don’t know exactly what...
- FC1: Someone doing our responsibilities outside would be earning...
- FC3: Exactly. Most of the e-mails that we get, I don’t actually know anyone who works in retail, maybe the rest of you can shed some light but I mean, I certainly don’t know...
- Michelle: Ja, what the kind of salaries are like...
- FC3: Ja, what they are earning.

- Michelle: I also not, I can't highlight that myself so...
- FC3: And I think there is a lot of variability as well cause of course they all want to pay as little as possible but then again the big companies are also alienating their staff so, [business name] and [business name]...
- Michelle: True, very true. Right, I think you know I am not even going to go into anything much more. If there is anything you guys spot there...is there anything you want to talk about? Concerning anything, promotion, you know, this is short so..short and sweet.
- FC3: I think that the biggest thing is that we don't have anywhere to go. We've hit that glass ceiling essentially.
- Michelle: So if you obviously going to get some nice increases coming up cause you all kind of moving into that, but once you get to the top of those 5 years then it's verby, is that what you saying? And you a bit worried about that?
- FC3: It does kind of look like it hey.
- FC1: And I think like in private you get bonuses and...
- Michelle: Incentives.
- FC1: ...and share bonuses and things like that. We don't really have anything to look forward to.
- Michelle: Ja, you only have like a cost of living adjustment every year and that's about it hey.
- FC1: And the portion between the different notches it's basically actually nothing. I think you don't really see it when you...
- Michelle: A few hundred rand.
- FC3: I was gonna say, did my salary go up this year? You know what I mean, cause you get, it all comes in at the same time so you never quite know what was cost of living and what was your notch and everything else. It's not very transparent.
- FC1: Like twice a year you get a profit sharing bonus or something like that.
- Michelle: Ja, that's true.
- FC2: I am concerned about what you said about the grade 2 thing cause I don't remember seeing that?
- FC1: You must just check your...you might not even notice.
- Michelle: If you open your salary slip.
- FC2: It's not the difference in the salary, I don't actually notice the actual grade 2 on top.
- FC1: You must just check.
- Michelle: Ja, no you better. You have to check on HR hey. I know guys, I know most people don't check their salary slips but actually its important. I know, I have seen most people fling them in a pile at home but do do that you know because you got to check up, you actually have to be like you were when you were being getting those new supervisor roles going, you need to be a little bit vigilant and on their case about stuff you know. And what about SPMS? Do you feel that, does everyone get above average performances or are you just getting average? How are you guys getting working that? How is it feeling because I mean that also affects your progression essentially?
- FC3: It's such a bone of contention in SPMS in general. Not just in pharmacy but you know, throughout cause you know we go on courses and somehow whatever the course is about, SPMS always comes up. You noticed? It's funny... and the one department was saying, I can't remember who it was...
- Michelle: You don't need to mention names.
- FC3: ...but no one seemed to know that if you, because it's paperwork to do anything above average, so a lot of departments...
- Michelle: In other words if you want to get (unclear) you got to work...

FC3: ...this department in particular was like “Aargh, just give us all 3 as we don’t care, we don’t care, just can we sign and get it over and done with we’ve got too much else to do”, and also quite frankly the bonus that you get is not, I mean, if you get the big bonus, I think it’s worth it but the normal one, I think by the time tax is taken off and everything else, a lot of people are disillusioned by how much they actually get out. They like “Really? Really, I worked this hard for a whole year and that’s all I got?” So they just didn’t bother and they didn’t realise and no one pointed out to them, I don’t know whose fault that was, no one said but if you don’t get above a 3 then you not eligible for grade progression.

Michelle: That’s right.

FC3: So a lot of them they have now realised, cause it’s 5 years down the line, they’ve realised that actually a year or two ago they could have already been earning this salary.

Michelle: So they could have reduced the 5 to 3 years basically.

FC3: Ja, but still [END OF RECORDING]

PART 2

FC3:will apply even if you get there a year or two earlier, it still you know, what happens after notch 5? There’s nothing.

Michelle: Ja, spot on hey. And also okay, so looking under the comments just quickly...

FC4: Well I think under SPMS from a supervisor’s position, I think it’s in another heading. The situation whereby we’ve got staff below us and when I mean, we actually know that there is end of March that you know you making enemies just for a month or something, people are just not greeting you and it’s an extra unnecessary load of work.

FC2: Yeah, you don’t need that.

Michelle: That is a lot of work and a lot of pain basically.

FC3: And that’s the other thing in private, I think the ratio of management no, like supervisor to the people you are supervising, it’s supposed to be not more than 4 and for most of us, it’s, I mean between the two of us we supervise 15 people hey? 14?

FC4: 14.

FC3: Somewhere around there, which means every quarter, every quarter we have to sit and performance evaluate 14 or 15 people and you can’t. There is a reason it’s 1 to 4 because when you’ve got 1 to 4 if you think about it, you can actually motivate those people. You can pick up on the little things.

Michelle: Absolutely.

FC3: Whereas when you’ve got so many people to supervise...

Michelle: How do you?

FC3: It’s very difficult.

FC2: How do you measure, how do you monitor?

Michelle: You can’t even keep track and just keep track, that’s the thing, every time you...because by the time you get out, you going “What was this person’s thing again?”

FC3: And then you get rapped over the knuckles because you forgot to get a signature on someone’s time sheet and you like “Really?”. I’ve got so much more to do and I don’t need this.

Michelle: A lot of detail hey, nonsense detail.

FC3: So ja, SPMS is a dirty word.

Michelle: I think you guys are...it’s a lot of hard work. I think you guys have got a hard position. Okay, so your skills and stuff when you came into supervisory – did you feel that you were adequate for the job or did it take some time for you to

- feel 'Okay now my skills are there and I am actually coping with my work okay?'"
- FC4: Firstly I don't think there is ever a time that you actually feel that you actually know everything. By the time you think you are comfortable there is an e-mail from management "By the way you have not done this..."
- FC2: ...this and that and you like "What is that now again?"
- FC4: What is this now?
- FC3: But you never told us that we were supposed to do that.
- FC2: At the beginning it was first when got translated, we didn't actually realise how much stuff that they actually expected us to do. They expecting more and more every single time and just...it's like they add on and add on and add on constantly. I remember when we just got translated into the supervisor post I had two kids after each other and I was ill in-between so when I came back it was, everybody was like...there is a management meeting and everybody is discussing it and I am like "I don't even belong here". I felt completely out, I actually went to my head of department and said "I want a demotion, I can't deal with any of the stuff that is going on, I can't remember phone numbers, I can't remember...I mean, regardless of the porridge brain, I couldn't cope with any of the other stuff that was going on either so it took a while for me to get to a point where I felt again that okay, I am getting there and if you put into a high pressurised situation on top of that...
- Michelle: It's just like you fall apart basically, that's normal.
- FC2: Ja, you do.
- Michelle: That's kind of normal, that will happen. I am glad you are honest about that as well you know.
- FC3: I was frustrated as a pharmacist because I just, I knew I could do and a lot of times I was called upon to do things that were supervisory and I felt very frustrated in my job because while I knew I could do what I needed to do and clearly my boss trusted me enough to ask me to do those things and she obviously had her reasons, I found it very difficult because the other staff...you know I was still a pharmacist but now I am doing things...
- Michelle: Things that are kind of above...
- FC3: ...above my station and I found it quite difficult dealing with the staff and I actually almost got to the point where I was like "Well actually no, I don't want to do that because it's actually gonna cause a headache" so I don't think I had all the skills I needed, I don't think any of us felt that but I was ready for the challenge and I think I've learnt a lot and I think we're also in quite a unique situation in that none of us studied to be managers.
- Michelle: No.
- FC3: We studied to be pharmacists and we figured it out along the way you know, elsewhere and other career paths you know you get...
- FC2: Get training..
- FC3: Yes, you get a lot of training and also there are other options like if people have done MBA's, they've done a B.Comm or you know they've majored in management, been a big part of their studies, not their training, but for us obviously our training is focused on the production side and then you kind of – you end up in this job because you been here long enough, you know how things work...
- Michelle: Ja, systems...
- FC3: ...you figured it out and then you're expected to manage...I think the hardest part is managing the people.
- Michelle: Ja, that is...

- FC3: ...and then we don't get – you know there're courses and stuff but we don't really get much in the way of training and I have certainly experienced all the courses I have been on are actually aimed at, I am at the top range of the range that they're aiming it at so let's say it's...
- Michelle: So what do you do, you don't feel like you're improving through any...
- FC2: They are teaching you things that you know already
- FC3: ...exactly but the courses actually...let's put it this way, everyone else on course is with me as a much lower salary level and much less responsibility so and then I feel the course is aimed more at them so I am not...
- Michelle: Benefitting basically.
- FC3: ...I haven't been on any course...
- FC1: I don't even know when was the last time I have been on a course.
- FC3: I only get them because someone else can't go.
- Michelle: Or someone cancelled you got to take their place.
- FC3: I don't think the top management places enough value on up-skilling the junior management.
- Michelle: Okay, good thing to say because I think that that's very...ja, it's just an important point. I think that that's – if you think about it, I mean when you study to be a pharmacist you really don't consider management as any part of your personality even.
- FC3: I mean we all have the course I mean, my university it was called it was [name of course].
- Michelle: Ja, so you do the basics of...
- FC3: Horrible, like who thought of that! But everything went in there. It wasn't just, it wasn't like a management course, it was all the stuff that didn't fit into pharmaceutical, pharmacology or anything else and it was very...nebulous.
- Michelle: Where did you guys study?
- FC2: We all did it at [university].
- Michelle: And you FC4, [university]. I was also at [university] but I know [university] is also a good school, I mean wherever you go now for pharmacy, it's good. They upgrading everything, but ja, that's interesting you saying that so personality wise I don't think any of us thought would we really have to manage people? When you go and do like an MBA you know, you are the personality that's geared for that, so it's like you have a whole personality change when you are in our job, do you guys feel like that? That you've had a personality change, character change?
- FC2: No, no, you've changed. We were talking about that also, how you've changed and become more assertive and...
- Michelle: More assertive...
- FC3: More hard... more ready to fight for...
- Michelle: I just find myself more rude basically.
- FC3: Very, very, very good at saying no.
- Michelle: Well that's a good skill by the way, it's an excellent skill. Ja, and I think, are you feel like you losing touch with any areas of pharmacy now that you in supervisory?
- FC3: A little bit.
- FC4: Me, (sigh), yes...
- FC3: You, ...not so much.
- FC1: I think it depends on the area...'cause I still work in the dispensary so...
- FC2: ...There is patient contact and stuff where we don't have patient contact.
- FC3: And like FC4 does all our orders so if something is new on code or there is a new drug or something then she will know all about it but we...
- FC4: I am losing out on pharmacology...

- Michelle: On face time. You lose face time and they losing your kind of skill you know which is stock and management and stuff.
- FC3: Because we manage the ward stock and so the things that are ward stock are the things that have been around for years and years...
- Michelle: Years and years...the originals...
- FC3: ...and are not expensive (laugh). So we don't you know, sometimes an e-mail will go out and I think "What is this?"...google quickly.
- FC2: What is this now? Do we keep this?!
- Michelle: Where does this sit in our dispensary and I'd like to know on what shelf.
- FC1: I know it's in [department] somewhere...
- FC3: Ja it must be in [department]. Everything is in the in-patient pharmacy but what does it do? Who gets it?
- FC4: If you are sitting in the pharmacy meeting, they talking about the (unclear), and you need to go and read, when they all talking about everything on the pharmacology side of it, ward pharmacist and everything, you think, okay, I need to catch up.
- FC3: Exactly, we do very few clinical queries. And you know we not talking to the doctors, we certainly are more talking to the nursing staff so...
- FC2: Like out of stock situations and stuff...
- FC3: We very rarely get phone calls from doctors and we very rarely have to phone doctors for anything to assist us.
- FC2: It's by accident that they would call us.
- Michelle: So your production guys do a lot of that, am I right? I see what you are saying by that, so you feel like you losing a bit of that – like you said the pharmacology side hey?
- FC3: Ja, but in order to do our jobs effectively we actually...as much as we don't – we have so much supervisory stuff to do we actually do need FC4 highlight it before ready, we need to do that, a bit of that production as well because it's only when you doing the production, it's only when you're sitting in [department] putting through a couple of blue boards that you go, but hang on, this should be ward stock because we spending 2 hours a day issuing this item...you know what I mean? You pick things like that up and as much as you say to people, let me know if something is an issue, people don't because they are focused on production.
- FC2: They don't have the same insight...
- Michelle: Just getting the stuff done and out.
- FC3: On pushing that rock up that hill until 4 o'clock and then letting it roll down overnight and tomorrow we will push it up the hill again whereas we are thinking more about well, can we put that rock halfway up the hill.
- Michelle: Already it's a start so that when you come tomorrow you can push it a bit further and so on. I agree with you.
- FC3: So sometimes you do need to get your hands dirty.
- Michelle: Ja, absolutely. There is a comment there, I don't know why fellow supervisors is moaning... to be a supervisor is to be a supervisor no matter where you work. I mean, what do you think of that comment? Do you think that's true? Do you feel sometimes it's...you guys look like you don't feel like that hey?
- FC3: No, I don't feel like that hey.
- Michelle: You feel like you feel for one another hey?
- Everyone: Yeah.
- FC2: The thing is...
- Michelle: The relationship hey?

- FC2: ...if you take into account the fact that we are expected to do everything that a production does as well as all the supervisory responsibilities...
- FC3: Then we know why you moaning.
- FC2: ...Ja, but it's not that we moaning as about that, the junior, the staff below us or the production pharmacist, they have this sense of that "Ooh this doesn't look like this is something that I can do so the supervisor needs to do it" even though they won't even use their own initiative to do it and...it's clinically based
- FC3: And instead of going, well, maybe I can...
- FC2: It is something they can do and they can actually empower themselves and when certain of the production pharmacists actually do that and they feel that they are empowering themselves, some of the other production pharmacists actually get upset with them because they think that "Why are you doing that?"
- FC3: You are showing us up.
- FC2: So then there is exploitation okay, from our side it looks like to them that we are exploiting some of the staff and from other sides it looks like we are letting other people get away with murder which is not the case because every person is different and you have to deal with staff each a different way. They need to understand that it is for their enrichment, not that we doing it because we want them to take over our responsibilities and our work, we know what our responsibilities are.
- Michelle: And we'll do it if you insist we do it but what we trying to say is, maybe you need to grow a little bit as well.
- FC2: Ja, you need to because you can't expect, you can't expect supervisors to do everything and be everywhere all the time. We not god. We just as human as you are and you need to work with us as opposed to thinking that "Ah, you the supervisor you need to just to do everything and that's not how it works.
- Michelle: I agree with you. Nicely put.
- FC1: What makes it a bit easier for us is that we understand that what's expected of us when you in a certain department because we do rotate so it's not like I can be bitter with FC4 because she works in the bulk store and I work in say out-patients and I have to leave late every day and she never gets a chance to work late because she works in a different department. We rotate so we know what it is like in each department so we each have a turn to be in the bad department.
- Michelle: That's very nice.
- FC3: And when FC4 is saying it's ordering day and I've got one assistant, what am I supposed to do? And then we all go like "Oh, okay right, ja she does need help" but sometimes it's just frustrating because we are all, sometimes multiple departments are short and everyone's moaning and it the case of who moans the loudest which is also not fair.
- Michelle: Which is what you were saying last time, you were fighting on who gets helped.
- FC3: We fighting against each other and we really don't need to be fighting against each other.
- FC2: Sometimes you...
- FC3: But we are all just fighting because we need our department to run, we all feel the same.
- Michelle: Ja, it's true.
- FC3: Where is your staff?
- FC1: I have like...
- FC2: No staff, no staff...

- FC3: I'm winding you up, FC1. I'm winding you up...
- Michelle: Okay well then I think that that's it, overtime how do you guys manage that? How do you actually, do you claim? Can you claim?
- FC3: With a lot of unhappiness because overtime is capped at salary level 8.
- Michelle: Yes, that's the first thing.
- FC3: What is salary level 8? It's like R200 000 a year.
- Michelle: Ja, it's way below production 1 level.
- FC3: So let's say I am the supervisor, let's...
- Michelle: You in at about R90 an hour, I worked it out.
- FC3: Ja, there you go. But as a supervisor we earn what? Like R250 / R300 an hour? Somewhere around there? Close-ish? I don't know, ballpark, I am sucking it out of my thumb. So now I must work my normal day at let's say R300 an hour for argument sake but now I must work overtime at...
- Michelle: R80 or R90 an hour...
- FC3: ...miss my child's bedtime, bath time routine, organise for someone else – my husband works very long hours as well, maybe organise for someone else to take over from the nanny to get paid R100 an hour and get taxed at a stupid rate so I will probably end up with R50 an hour. I'm like, "seriously?"
- Michelle: That's is a big issue.
- FC3: If you gonna pay be my normal salary overtime I will be much less reluctant to do it, let's put it that way, but I really don't think it's fair that...
- Michelle: Cause then you might as well go and locum for that hour somewhere else and actually earn the R300.
- FC2: I think it most of the time we moved to actually taking the time, we using the time as opposed to...
- FC3: It's like R50 for an hour, like I am not gonna work...that's true
- FC1: And then there is also a rule in the hospital, not hospital... I don't think it's a hospital rule, that you not allowed to get the time back.
- Michelle: Ja, you not allowed to get the time back is a state rule. Can you believe it?
- FC1: So for some of us that would like to take the time after and we don't mind working the overtime, we not allowed to take the time after. We're not supposed to...
- Michelle: You know what, you can if you are appointed into a flexi-time post and this is what they will eventually have to do with all the pharmacists, convert your post to flexi-time so that if you, if they know they gonna run late, they can say "Just come in half an hour later and you work the overtime and then what we will do is we will allow you to take the time off on a Monday morning or whatever or Friday afternoon". It doesn't quite work though hey?
- FC3: It's all well and good and it's better in terms of the money but it's not better in terms of organising your life.
- Michelle: That's the other thing. If you do that you need to be organised, that's the other thing, you need to know in advance.
- FC3: If you gonna tell me today "Oh no well can you come in an hour later tomorrow so that you can work an hour later tomorrow" I'll be a bit like "That's a short notice".
- Michelle: As far as I know it should be organised in advance. You on a month's rotation and you know this month that's kind of how you gonna work. You come in a little later and if there is a little bit of overtime you work a bit later and then you get some time off on this Friday and that Monday or whenever. So I mean that is something you can also just say to, I suppose, I mean I think we would all just need to mention to our managers what is happening, are we gonna have some solution to the overtime thing? If it's not going to be, if you can't solve us not working overtime then solve it some other way.

- FC3: We have a lot of discussion about working hours at the moment because our boss is trying to standardise it and she is determined that we must all be here from 08h00 to 16h30 and that already is causing...
- Michelle: Ja, instead of what 07h30 to 16h00?
- FC3: ...grief, some of us ja. And then there is talk of staggering the working hours in another department from like, what was it?
- FC2: 09h00 till 17h30.
- Michelle: You just need to make sure that when your biggest influx is there all the people are there because the problem is if you staggering then your rate of outgoing medicines to the out-patients is at a lower speed anyway. So I mean if you've got a queue already at 07h30 at the pharmacy in the morning at the out-patients you can't really stagger can you? Cause I mean you gonna be making out those folders...
- FC3: One of the other concerns is that I think a lot of us have had is that the later we stay open, the later we get patients because there is no pressure from the clinics and the doctors you know, because at the moment pharmacy, we don't close at 16h00 but we stop accepting in the out-patients at 16h00 so there is a lot of pressure in the clinics, the sisters, the doctors, they all like "No, but the patients got to get down to pharmacy by 16h00" so then we got that time, you need to get down but if they know that there is someone at the pharmacy till 17h30...
- Michelle: Ja, then they will still be sending people in at 17h30.
- FC3: And everyone else has gone home at 16h30 and there is 2 or 3 people working late till 17h30, those people aren't going home at 17h30, but we'll see.
- Michelle: So, to summarise, the biggest things here is going, from what I can see what we talked about, is the fact that you gonna go nowhere when you get to the end of this thing okay, the working hours is an issue, the overtime rate is an issue.
- FC3: Big issue ja.
- Michelle: SPMS is headache. Anything else that we mentioned, can you guys think?
- FC1: The difference in salary between the supervisor and the grade 3's.
- Michelle: ...and the grade 3's okay and the responsibility that comes with the supervisory post. So those are the major things that have kind of come out hey?
- FC3: Ja, cause I mean you can plod along in your job for 13 years and just churn out scripts and you get paid the same as...
- Michelle: As the guys that are taking on responsibility for the next 5 years before they even see any increase in money...
- FC3: And you've got to do...
- Michelle: More and more and more. So I just want to thank you all.
- FC3: Now that I think about it we actually did have someone who came in who, she is a grade 3 and she is like, she came from private and she was a manager in private and she is like "No, I will take the grade 3 job because I am over responsibility, I've had enough and I am gonna earn the same as what I would earn as a supervisor".
- FC1: She was earning actually earning more than us because we were all on grade 1 still so she...
- Michelle: Ja, that's the other thing cause if you grade 3 at the top then you are actually, you're on supervisory level...
- FC2: It's exactly the same.
- Michelle: I know there is a big problem.
- FC2: I think our head of department also tried remedy that by giving us some incentives but the incentives are like not really...minimal.

- Michelle: Was it money or what was it that they gave you?
- FC2: It was the on-call list...
- FC3: Excuse me, I'm still on call.
- FC2: I'm also on call but I just saying, but the thing is...
- FC1: You'll get there eventually
- FC3: Are you off the on-call list yet?
- FC2: No they're both off.
- FC3: Oh, you're both off?
- FC1: Thirteen years and fourteen years...
- FC3: Siss, Eight years, eight years,
- FC2: But you, but remember I am not going to go off it, because I was on contract for long, so she said I am only being started from, I was off contract in 2012, so from 2012, they're counting ten years.
- FC1: So FC2 maybe your supervisor grade started from there because you weren't permanent before...
- FC2: Ja, I think so.
- FC1: ...so it could be, ya, I think so, probably...
- FC2: I think so, probably...I must actually check, and see...
- FC1: It is because it's permanent...
- FC2: I was thinking it could be that but I don't know if it is that.
- FC1: It is that.
- Michelle: Alright ladies, so I will do my analysis. It's going to take a while cause it's transcribing four voices, it take a while and then I will analyse it from there and then you will all get a results from me and then you can comment on that and then off we go from there. That gets added to the pool of other people that have got similar problems. It's got to be in by March next year, but I will make sure that you guys get it much sooner than that.
- FC3: Nice to see the salary scales actually because you've known it for a long time.
- Michelle: I wanted you to have a look at that because it does help you a little bit and that is a brand new one.

APPENDIX Z: TRANSCRIPT FROM INTERVIEW WITH FOCUS GROUP “FD”

PART 1

Michelle: Alright, so let's just talk firstly, if you want to go straight into asking any question about that overlapping thing you can do that, maybe I am pointing out something there or otherwise we can just start by saying why did you guys choose public sector? You can just chat.

FD1: Mainly the hours, the most important factor for me.

FD2: Can we....

Michelle: Ja, you just talk, it's a chat, a conversation. I would agree with you, I was gonna come back in.

FD1: And then also the benefits which I think is better than retail if you consider the salary benefits you get there and the salary benefits you get here.

Michelle: So you actually did your comparison?

FD1: Yes.

Michelle: Okay that's what I wanted to know. And then you say benefits, are you talking about your leave and your pension fund, medical aid scheme? The percentage that they contributing?

FD1: Yes.

Michelle: Okay, so let's just pause this. The big thing was she chose public sector because of the hours really, the package, the benefits.

FD1: Absolutely.

FD3: Me too.

FD2: I worked in retail for many years and for me it was a bit of a change as well and to do something different.

Michelle: So you were bored there basically. That's so true. And you, hours as well?

FD3: Yeah, hours basically and also I had a bit of a lot of retail so I mean there is no room for family when it comes to those to it's over time the whole and it's compulsory over time so you don't have a choice. I started out with a new family so...

Michelle: It was hectic...

FD3: Hectic yeah.

Michelle: So then if you...do you think because of all these things you guys are saying now, do you think public sector is more popular amongst pharmacists now? Have you heard any of your friends that wanna get in?

Everyone: Ja, everyone agrees.

FD2: I think because of the package as well. The package is actually very good.

FD3: A lot of my friends were laughing at me and said you must be crazy going into the public sector and now I promise you, I've got four of my friends that's now, now that they see the way I work and how I work and what I get, all those thing, they suddenly trying it out as well but it's not that easy to come in.

FD1: No it's not. It's not like in the olden days it used to be you don't want to work in state but that's changed, the salaries have changed and getting in people have asked me "oh, don't you know somebody, don't you know a position, don't you know somebody that knows of someone?", so ja.

Michelle: So once you are in it's quite easy to see where the posts are. Do you guys think it's quite hard when you outside, cause you've either got spot the advert...

FD1: You have to know someone.

FD3: It was by a fluke that I got into [facility].

- FD1: I applied for 16 positions before I got mine.
- FD3: I still remember I had a chat with you at [place] and she came in, and I am asking about it because I was so, you know, trying out for all these positions and all that she said to me, it is a process to get in and believe me, I think for about 7 months I was always into tears because...
- Michelle: Rejection.
- FD3: ...this, that and ja, all the paperwork and all those things.
- FD1: It's rewarding once you there.
- Michelle: Yes, that's fantastic, that's fantastic to hear. Anything else you want to say FD2 because, anyone you know that wants to get in?
- FD2: Ja, I have a couple of friends.
- Michelle: And how did you spot to come in? Did you spot an advert somewhere or did you hear something?
- FD2: I said to [name]...
- Michelle: Ah yes, you've a connection...
- FD2: For many years it was sort of just a thought, and I said that if ever there's a post going open, you must let me know, so she then she let me know and I applied, it wasn't that difficult.
- Michelle: Ja, but you also went to the interview and everything...talking about the interview process. Okay, what aspects make you stay? You were talking about it's rewarding, it's great. Is it the work, besides the hours, what in the work is so interesting?
- FD2: It's quite rewarding for me to help the community, the poor, you know the, you feel you do more for the community than retail pharmacy.
- FD1: In retail the people expect the service, they pay for it, so they expect good service and in the public sector, they grateful for what they getting so...the attitude of your patients is totally different.
- FD3: Ja, they are, absolutely, I agree with that.
- Michelle: And you, obviously you doing quite a bit of ward stuff and you as well...I don't know about ...so much at [FACILITY] but, so you get to actually work with sisters and the doctors a bit more, am I right?
- FD2: Ya, interact...
- Everyone: Agrees.
- Michelle: And which you don't get in retail.
- FD1: Yes.
- FD2: Not at all.
- FD3: In retail you actually too scared to phone the doctor and the doctor has this attitude, "just do what I say" you know and where at least you know with like [FACILITY] there was a time that we actually went up to the wards and actually typed inside you know, all the blue boards, and if you've got a query you actually go full frontal to the doctor and you discuss it and just say "okay, let's talk about this, what do you...?" you know, it feels like..."
- FD2: You work as a team.
- Michelle: Exactly.
- FD1: You on the same level.
- FD3: There is obviously politics everywhere but it's much better. You get valued more, where I mean in retail, it's all about the money. I remember, I am not gonna say where I worked but it's like you know, this is law, this is how you supposed to do it...no no no, we know this customer for years, even if it's a Ritalin, ag, don't worry about it, as long as we get the money in you know, that kind of thing where I love public is where okay, [FACILITY] was that from the beginning, this is law, this is how it's done, there's no deviation from this you know. I mean for the first time in my life I was working at a place

- where schedule 6 books actually balances because we keep an eye on it all the time.
- Michelle: Fantastic...such a good feeling hey? I must agree with that. And if you were to go? Would there be any reasons if you thought okay, now I am outta here and you wanna get out of public sector? What would be the reasons? What are the things that irritate you or what would you...?
- FD1: Stock. Especially at the moment. This year it's even worse I mean, for four years I have been working at [facility], this year's the worst that its ever been...with late tenders and contracts that aren't awarded, so there is an immense shortage of stock.
- Michelle: How do you guys handle that?
- FD1: I beg, borrow and steal.
- Michelle: Ja, so you do the same as everyone basically.
- FD1: Or I try to get a replacement or try to order the next best thing. You try and cope as best as you can but you feel your hands are chopped off. It's very frustrating especially if you stand in front of the patients and have to explain why you don't have this and that and three or four things on the script.
- Michelle: I agree.
- FD1: It's a challenge.
- FD2: What I find frustrating is also the language thing. It's quite frustrating if you hand out medicines and the person looks at you, you know that they don't understand and you can't speak their language. So I find that quite frustrating.
- Michelle: Do we get that a lot? Do you find you getting...?
- FD2: Ja, I often think that no matter how you explain you know, you think they walk away and they haven't a clue...
- Michelle: You not sure actually if they gonna to take the meds right. So what's the outcome gonna be?
- FD2: So, the, the compliance, you know.
- Michelle: Ja, the adherence...
- FD2: Adherence...
- FD1: Half of our pharmacy is, it's Xhosa speaking, so you can grab someone.
- Michelle: And do you feel, do you have the same as well?
- FD3: We've got the same but they sent us to a Xhosa course but that was so basic...
- Michelle: Not related maybe.
- FD3: Exactly, like most of the time I just said I want to know how to say "one tablet three times a day" you know. No, it was more about how to change your petrol Xhosa and how to greet...okay, greet is good but ja, it was not really related to...
- Michelle: Too general and not specific enough. That is a problem. So ja, I have lots of people say things like, the infrastructure, like premises sizes is frustrating and IT is frustrating, getting things, sourcing things, labels, whatever it may be.
- FD1: Buying non-pharmaceuticals is also frustrating.
- Michelle: Ja, that's it okay, so that's exactly and you agree hey?
- FD1: Ja, because I am doing the buying.
- FD3: We are very lucky. I mean [FACILITY] is, first of all we've got a fantastic manager that will, he will drive around the world to go get stock so we don't actually really have that big stock issues but like our HR, that's one thing of government I just...can't get. I've had so many struggles and we at the moment struggling with our beneficiaries, for our pension funds. I've done it already three times personally that I stand in front of the guy with the computer, this is my husband's stuff, this is me and they can't get it right.
- FD1: And stores...
- FD2: ...red tape.

- FD3: Registering my kids as well for family responsibility. The one moment I came to claim and the next moment they come to me “where is your child’s birth certificate?” and all that. No, but they changed our staff and this. Well, don’t you have handovers?
- Michelle: Well then you’ve lost everything? Ja, it’s got to be in a file somewhere, so which file is it in?
- FD3: So, that’s the kind of stuff for me that’s frustrating.
- Michelle: And you said the stores hey? Was it just being able to get things?
- FD1: Ja, a good example is a water cooler that we had to have. I’ve ordered it twice now and then they just come back “we don’t have your order” and they don’t know where it is.
- FD2: The way I think it’s incompetence, people who deal with, what do you call it?...
- Michelle: Administrative tasks...
- FD2: To give the certain companies...what do you call it?
- Michelle: Your vendors or your tenders.
- FD2: Tenders, people who decide on tenders.
- Michelle: Okay, so then let’s go onto the next thing. What about these translation tables? What do you guys think of salaries, let’s talk about money.
- FD3: I did some homework.
- Michelle: Oh did you? You did it yourself, oh wow, I am so impressed.
- FD3: Just ask [name]...
- Michelle: No that’s fantastic. So ja, what do you guys think about – are you guys sitting production 1,2,3, are you finding your salaries adequate compared to outside, do you have any complaints about how it’s structured? I know as you can well see, production 3 overlaps with 5, the whole grade basically overlaps with supervisor level 1, so that’s a big thing.
- FD3: You remember what I said to you the other day, is when I got into [facility], obviously by now I am supposed to be actually very high grade 2 but according to, you know they go according to specific day to day whatever to grade me and I wanted to apply for the supervisor post but then I eventually when I got to see the salary I was like, I am not gonna (sorry for the word) take this crap from other people all the time and that responsibility for what a few...
- Michelle: Bucks more...
- FD3: Exactly. So that was for me like...
- Michelle: If any.
- FD3: If any.
- Michelle: If any, cause now if you in production 3 you’ve been with the government for what? Maybe twelve years or thirteen years and you come into that. What do you do?
- FD3: Now you just stick to being a pharmacist.
- Michelle: Do you wanna go to supervisor? I don’t know.
- FD3: No.
- FD2: I am quite happy with my salary and like you said, I wouldn’t like to be a supervisor for a few rand more than we get now.
- FD1: Exactly.
- FD3: Because that opportunity was there and I was like, okay I am gonna do it, no I am not gonna do it and then I thought to myself I’ll be crazy you know, I’ve got two little kids at home. I’d rather have my...
- Michelle: You could always do it later though if you wanted to for other reasons.
- FD3: Exactly ja, if it’s worth it, but it’s not worth it for me now.
- Michelle: And now for you, cause I know you considering it.

- FD1: Ja.
- Michelle: But talk about it truthfully, cause it's important.
- FD1: I feel like I am in a rut at the moment so that's why I applied for a supervisory post.
- Michelle: Do you need the stimulation?
- FD1: Ja, I need a new challenge. But then the same thing for four years and I can do it with my eyes closed so, except for the challenges in the stock situation we have at the moment, there is nothing new.
- Michelle: Which is not your fault.
- FD1: Ja, so I feel...
- FD2: And you're still young.
- Michelle: You ready to move on.
- FD1: Ja, so I feel I have to go up, I can't just, just be a pharmacist and just be that.
- Michelle: And if you were there, I mean, would another reason be that you wanna maybe move even into the next section?
- FD1: Yes.
- Michelle: So you've got a long term kind of idea of where you going.
- FD1: Upward steps, not stagnate in the same place.
- Michelle: Ja, so you see, everyone's got a different...so do you think the overlapping thing is a big deal then or not? Not for you?
- FD2: Not for me.
- FD3: Not too much.
- Michelle: Not too much but you just saying that it is a little bit of a...
- FD2: I think it's unfair if I look at [name], I think what she does as a supervisor pharmacist, she should get much more. It's not that I want the job but I think she should be compensated more for being a supervisor.
- FD1: Ja, if you looking for responsibility.
- Michelle: Okay, well it's interesting that you say that, 'cause that's how they feel...sometimes. And also it depends on the position though FD1, so I don't think you need to stress too much because you'll be out of the situation that maybe that he's in, and you have a long term goal, so it's a different story. But it's interesting you say that. I don't know, if they compensated a bit more and they've shifted it, would you maybe consider?
- FD3: Of course.
- Michelle: Okay, so you would maybe look at it again and say maybe this can work then?
- FD3: Absolutely.
- Michelle: So some are actually swayed by a bit by...
- FD3: Because, I really actually when I was like, yeah, I am now getting into government, obviously struggled a lot to get there and I was like "Whoa, here is a position open as well as a supervisor" and by that time I was sort of like almost knew all the responsibility of that and then like I was saying, when I saw the salary I am like "no". I am not gonna tire myself out during the day for this you know. I will if it's definitely more.
- Michelle: Ja, then you would have considered it.
- FD3: For sure.
- Michelle: Well that's good to hear. Okay, so other career paths – have you guys actually, do you guys actually know about all these other career paths that run alongside?
- FD2: (unclear 16:10:0)
- Michelle: Yes, policy specialist, clinical, management, you obviously know the positions there, there's an assistant manager there as well which is [name] and...[name]...? No, he's a supervisor still.
- FD3: Please explain to me assistant manager and just manager or...

- Michelle: Ja, good question.
- FD3: Cause according to what I know [name] is the manager.
- Michelle: Well if I look here, that's a good question. Do they even have an assistant manager section. So if you look at assistant manager you need five years appropriate experience after registration; for deputy manager you need seven years.
- FD2: In the government sector or just five years as a pharmacist.
- Michelle: Five years appropriate experience ja.
- FD2: Okay.
- Michelle: They tell you, sometimes they break it up, like they'll say there needs to be two years in ummm, but they don't say that in here so...and then there's this manager, standard manager, which is a minimum of nine years appropriate experience after registration and then there's a senior manager but the senior manager is a new OSD post job level so it's something totally different.
- FD2: OSD?
- Michelle: OSD post job level. So I mean, so you would, FD1 would you think to go to get into, do you know if there is any post for assistant manager besides [name]'s post? Kind of in the area?
- FD1: No.
- Michelle: I don't know either.
- FD2: Isn't that the only...
- FD1: [name]'s post is supposed to be assistant manager.
- FD3: What about Karl Bremmer, [name] [surname] is down there isn't she...(unclear 18:02:8) management post there?
- Michelle: Probably one ja, and you were supposed to be...[name] is supposed to be assistant manager.
- FD1: I think his post is supposed to be an assistant manager's post because we also a district hospital.
- Michelle: That's right.
- FD1: But at the moment that's not the case, I don't know why.
- Michelle: Ja, that's actually, that's interesting, they haven't converted his position. I wonder, he will know probably why. So the district hospitals obviously have this assistant manager thing, but I mean like here as well, at [FACILITY] it's not the case, it's supervisor and production pharmacist and it depends on the size and I suppose the amount of beds you've got then they would have more positions created.
- FD1: But I mean [FACILITY] has got, what? 300 beds?
- Michelle: I don't know, I don't think it's that much. 150 hey?
- FD2: Ja, it's less than 300.
- FD1: And [FACILITY]?
- FD3: I've got no idea sorry.
- Michelle: And you guys have got?
- FD1: Maximum 120 and we full.
- Michelle: It's actually quite small in that sense, but technical you see, that's the other story. There a lot of technical clinics or expertise that run out of [facility] so you can't say...I don't think they base it just on beds size, it's what offered as a service probably as well. And then this clinical position?
- FD3: I was wondering about that.
- FD2: What does that involve?
- Michelle: That would involve a degree.
- FD3: That's your Master's degree, because they just, they working at it at the moment and (unclear 19:28:9) [name] ne?

- Michelle: Ja, that's it, [name]'s qualified. It's a difficult thing because, okay, so you've got ward pharmacists, you guys have got a ward pharmacist so it's a production pharmacist but does ward duties.
- FD1: Yes.
- Michelle: Okay, so they not a clinical pharmacist you see, so they get paid like the same as the rest of the production or a little bit higher maybe in the production pharmacists salary.
- FD2: Okay, but what would you do as a clinical, would you still do your normal work and then just sit and laugh at us.
- Michelle: No, I think you would actually run...
- FD2: Sit in the office.
- Michelle: You would run all...you would basically work with all the specialists on the drug side of stuff and connect to the pharmacy.
- FD2: Or do they not set up the code lists and things like that?
- Michelle: You would probably be involved indirectly in that PPTC on a bigger level, on a higher level. That's the reason why no one knows, so it's there but...
- FD3: When [name]'s there, I mean I remember when I typed upstairs he would come up with me and then he would go through those folders and the stuff that he asked me, I am like joh, I feel so incompetent, it's a total different level. It's more going to doctor and he talks to the doctor and then like kidney failure here, looking at the creatinine levels, looking at the...I don't even know how to read those results.
- Michelle: Yeah, he's got a serious understanding of pharmacokinetics and can spot like things.
- FD3: Ja, definitely more studies, but I am very interested in that one.
- Michelle: That is interesting yes, but that's like you said requires qualifications.
- FD3: Exactly.
- Michelle: And policy specialist level? I mean there are positions that go there sometimes. Do you think there is enough positions guys? Let's ask that question.
- FD2: Ja, definitely.
- Michelle: Do you think there is enough positions? To climb the ladder?
- FD2: Oh, actual positions, oh, I though you mean options. No I don't think so.
- Michelle: Cause that's the other thing. I am just asking because how much do we know at base level about what's going on up above us? We don't know and that's the thing, I don't know.
- FD1: I just know what I hear because...
- FD3: It's very hush hush.
- FD2: Isn't it published in the Government Gazette?
- Michelle: Sometimes ja, I am sure it does.
- FD2: So it's our responsibility to check.
- Michelle: I suppose so but the thing is it's...if you get the gazette and you actually go and look at it. So what were you saying about [name]?
- FD1: Ja, that's what we hear is from [name] or from [name] because [name] works with us so we hear it via the grapevine but otherwise not.
- Michelle: Ja I see. It's just difficult cause like, how transparent is our career pathing and where do positions sit? That's why I am always interested to know, does anyone know anything more that what I know and I haven't even looked a lot, I have looked as much as I can.
- FD3: It's very like I say, I mean when I came from retail into government I was like, look this is like a whole new world, I didn't even know that this side exist...I know there is differences between retail and hospital but there is so much more but there, you just don't get info anywhere. I mean we've got now

a CSP that she actually showed me a lot of extra courses that you take via Potch but obviously like Unisa and that kind of thing and she is now doing [institution] clinical stuff and I am like, I am really interested but also by accident she came upon these things.

Michelle: Ja, that's the thing, it's interesting. And technicians, do you guys know anything about that? I am just asking, I am just putting it out there. And then, do you guys feel utilized enough? Do you feel like you utilized to your maximum? I don't think you do anymore cause you bored so you not utilized. Do you feel utilized enough, you used sufficiently? Do you feel like management gives you enough responsibility?

FD3: Yes.

Michelle: And you were like that I suppose in the beginning?

FD1: Yes, especially when JAC started, I mean I was in the middle of that and setting up and...

Michelle: So you felt utilized then?

FD1: Ja, but now, it's old news. Now everybody has got and up and running.

Michelle: So that's why you said you need the next level up. I don't there is much more I need to ask you, is there anything else you guys wanna say?

FD2: What is this about?

Michelle: Ja, just some stimulating things that I put down and I think the big thing was being supervisor was part of my career goals, there's no way I want to do supervisor, you guys have already touched on that. What does my supervisor do all day?

FD1: Sits in meetings.

Michelle: We need the help with dispensing that we busy with something else.

FD3: So no you not part of the action anymore, now you gonna sit in meetings the whole day, do you really wanna do that?

Michelle: Do you agree, do you guys ever feel like that? Like you wondering what they doing? You do?

FD2: I think all the meetings is a waste of time. We need more people to work on the floor than some of those...meetings meetings meetings.

FD3: I feel the same.

Michelle: Is it, do you feel the same?

FD3: Ja. I mean an example for instance, health and safety, I mean I was just now for four months on maternity and I was the chairperson of health and safety and before that I was like, are we gonna talk the same stuff every time? Nothing gets resolved, nothing, it's just paperwork and this and that and nothing nothing and it was interesting to see what we talked about after I came back from maternity and it's still the same stuff and then the meeting is about 3 hours long where every sister of every wards sits there with their check list – the oxygen cylinders are still on the ground, the ventilation is not working, then its...you sit and listen to everybody's nonsense and nothing gets done so you feel the same also if you see the supervisor and managers sit and talk and talk. With us it's the same things, late comings, people not taking, taking longer lunch hours you know, silly, stupid things and the works just...and the rest of us have to...

Michelle: Gotta run. And you don't feel like that.

FD1: I agree to a certain extent. Some meetings are a waste of time and I know that because I am second in charge so when [name]'s not there I have attend the meetings so I know about meetings that are a waste of time and sometimes I just say I am not going to go to that meeting it's wasting my time where I can rather be in the pharmacy and assist.

- FD2: It's also like this [PROGRAM] thing, [PROGRAM], I mean they spend millions on and we've had three meetings, whole day, two day meetings and nobody implements it. I think it's an absolute waste of time.
- Michelle: Ja, I was just looking at that as well.
- FD2: You know it's a wonderful idea, wonderful idea but is it to anyone's benefit?
- Michelle: Ja, I agree with you.
- FD2: There is a lot of things like that.
- Michelle: There's a second part of that that you were going to say that, I think, about there is some things that are very important obviously that supervisor does. So could you touch on some of that? What would you...I mean when do you feel that like okay, actually I am so glad this person is here? What instances?
- FD1: Most of the times when he deals with the doctors, that's when I am glad he is there and it's not me, especially staying to the code list and certain medicines that they want to prescribe, implementing the code list...
- Michelle: And it was probably like very senior doctors? Like specialists and stuff? Or...?
- FD1: Well it's mostly GP's that want to prescribe specialist items, that's what happens. So in that sense if attending a meeting on a Friday morning only if it is to tell the doctors...this and this and this, these are the rules then I am all for it, because we, otherwise it's every 5 minutes you have to call the doctor to explain the situation and it doesn't get heard.
- Michelle: Or you going up to the ward and doing the same thing.
- FD1: So in that sense I feel fine, that's a meeting that is not a waste of time.
- Michelle: Okay, that's something I need to hear because I think a lot of people don't realise sometimes what the supervisor does but then also maybe the supervisor isn't saying to the staff "this is the reason why I cannot always be in the pharmacy with you guys, here's the list of stuff I've gotta get through today" so, but I suppose if you in management you don't wanna have to always be saying to someone.
- FD1: No, you don't have to explain yourself.
- Michelle: Exactly, that's the other thing. So then something else on the list – I wish the older pharmacists would help me more, the older pharmacists have been such great mentors. This is more for younger pharmacists so I don't think you guys fall in that, some of the younger production pharmacists don't know how to move from junior to senior so maybe you guys can be good to them in the future I don't know. Then I am often bored, mentally stimulated in my work. We claim over time, let's talk about over time. How, what's the verdict on that?
- FD1: We don't get paid for over time.
- FD3: That's...are we allowed to say that?
- Michelle: Ja, you can (unclear 29:27:0)
- FD1: But, we are allowed to take the hours, but we are not allowed to get paid for it, so if we work overtime we take the time.
- FD2: But we got paid out for the stock take and I think it's very little. I didn't take stock this year but they were all complaining cause it's, I think they got R80 an hour...they got out.
- Michelle: R80 per hour out.
- FD1: We don't get paid, we get the time.
- Michelle: Okay, so the time is probably not allowed but everyone does it, it's like the silent rule that you have. But what if you couldn't take the time? Is there any time you've not been able to take the time back? You've always been able to organise it? You guys too hey? Ja, okay, and flexi time – does anyone work on flexi hours?

- FD1: Ja, we work flexi hours.
- Michelle: Okay, howz your flexi hours work?
- FD1: If you are on call, you work from 10h00 to 17h00 the Saturday and the Sunday a certain amount of hours plus you on call. Otherwise you do an early shift which is 07h00 to 15h30 or you do the normal shift which is 07h30 to 16h00. So it depends who opens and who closes and who's on call, but we take turns.
- Michelle: How often are you on call?
- FD1: Once a month.
- Michelle: Once a month...and you guys? Once a month? Also once a month?
- FD3: Also once a month.
- FD2: Well a bit more.
- Michelle: It's actually a bit more of every five weeks now or something.
- FD2: Cause we short.
- Michelle: Or are you every three weeks now? It's the other way around.
- FD2: So your total time is still the same.
- FD1: Ja, total amount of hours worked is still the same.
- Michelle: So did you sign into flexi hours on your contract or how did it work?
- FD1: I think the contract just said that you would be required to work flexi hours and over time.
- Michelle: So it did state both?
- FD1: It did say something in that line.
- Michelle: And yours didn't say anything like that?
- FD3: To be honest I haven't signed a contract and I'm already there two years.
- Michelle: Is that an HR issue as well?
- FD1: It's ridiculous.
- FD2: (unclear 31:33:8)
- FD3: Ja...
- Michelle: Are you doing SPMS still?
- FD3: Ja.
- Michelle: They are doing that with you, are they, so that's all on record on hey?
- FD3: Hopefully ja.
- Michelle: Okay because it's very important.
- FD3: Cause I only, I think I can only go up a notch now from there next year.
- Michelle: Ja, it's like a 24 months...
- FD1: 2 years.
- Michelle: 24 months cycle. And has anyone had any accelerated, have you had any accelerated...you have hey? So you got 4's or 5? You've got to do 4's or 5's to get the acceleration. Is that very nice, they've been good? Have you seen any difference in your money?
- FD1: Yes. The increase, the yearly increase pertaining to, cause you go up the level, you go up from level 1 to 2, that is not so much and then you get your little bonus, your SPMS bonus which is also...I think it could be more but still it's better, I think it's better than nothing.
- Michelle: And also if you had to look back a couple of years, you'd actually see then the difference in your salary because you running on that new...
- FD1: This December will be my fourth year. My first year obviously was...didn't count and then from the second year onwards, every year I have received performance bonus and moved up a notch.
- Michelle: Fantastic.
- FD1: So it does make a difference.
- FD2: Purely because, you motivate things?
- Michelle: Ja, it's a good question to ask. Who is it that's...is your manager helping you, are you doing it? It's a very important to establish.

- FD1: It's a combined effort. So he will come to me with the report and say these are your key performance output aspects, do you agree? What can you add, what if you done more? Bring me some evidence and then you would hand that in and he would say yes or no and then give you a score and then you discuss your score. You say you not happy or you happy and it's not even always to say that you going to get it because there is something to do with a bell curve which I don't know what that means but sometimes you can have a 5 and not get your SPMS bonus.
- Michelle: It's got to do with how many people are actually...
- FD2: I think there's a quota...
- Michelle: There is a quota yes.
- FD2: We fall under the doctors, all the staff in the hospital so a tea lady can get it but you won't get it
- Michelle: Right, that's it, you're groups and there is funding into that and then it depends on if that funding is there and if it's there how much is the funding and what percentage of the funding, etc. But at least that's good and you, did you, have you climbed a notch yet, FD2? Is that coming now?
- FD2: I have received something but I didn't know how it works.
- Michelle: And [name] did your SPMS nicely, did she ask you in advance what she wants from you and you went and thought about it, you did all your cases or?
- FD2: Hmm (affirmatory).
- Michelle: Okay, that's good. You? Your SPMS... did [name]?
- FD3: Ja, ja, obviously [name] is excellent with those things you know, he also, he gives you the print out and say look at this or whatever but I really don't know what you supposed to do to get a 5 you know, how exceptional you supposed to be, what...
- FD2: Almost like there is not always opportunity.
- Michelle: A guideline as well.
- FD3: What am I supposed to?...
- Michelle: Exactly.
- FD2: What can you do?
- FD3: It's I mean just silly now, you know like for instance, I thought it was quite a big deal that I was nominated as a chairperson of the health and safety of the whole hospital, that didn't feature at all so I was like why do I go for the nonsense, every time I am getting everybody together...dedededa you know, and it doesn't feature and then I am like no no no, well I am just gonna stand down when the nomination comes now again I am not gonna even volunteer.
- Michelle: Consider...ja.
- FD3: Exactly because it's more stress for me, I can't do the admin because first of all we don't even have internet and you lucky if you have like 5 minutes time just to check what's the e-mails you know, so stuff like that and I sort of stripped myself the other day because this is now something totally different but my...last year for my little boy's second birthday and my Mom made these cute little dolls, she knitted it and all that and there was left overs so I took it to [facility] and every now and again I would hand it out to "kleintjies" you know, it's cute you know, they so grateful for it, that's what I love about public and then my Mom started making a whole thing of this, getting all the old "tannies" in [area] to you know, keep them busy and everybody is happy. I had to when I got there with my bags full of dolls and "beertjies" and what not, I had to ask permission to give it out and that floored me totally. I thought this now is now like...
- Michelle: Sticky.
- FD2: You thought that your whole action was for something that really...

- Michelle: Ja, you wanting to give a gift or a you know, be involved in some sort of...
- FD3: What more do you...now you feel in Afrikaans you would say “ek is nou getemp” you know, I don’t even feel like doing that extra because, what extra do I need to do.
- Michelle: You’ve got to cross so many barriers basically to be able to even have a good heart.
- FD3: I saw [name], I was still laughing cause [name] saw me and he like you know, like I am gonna you a written warning. You haven’t received your permission letter yet...whatever you know.
- FD2: And I think one should also, we sometimes too modest to write things...
- Michelle: Oh ja, ja ja.
- FD3: That’s just actually just shy about yourself.
- Michelle: I think that is the problem, if you want to get a good SPMS you have to brag a bit, okay. So just do it. No one’s going to think anything of you because it’s between you and the person that’s interviewing you.
- FD1: Ja it’s got a lot to do with who is your supervisor as well.
- Michelle: That’s so important you said that FD1, it’s very important, because it is the truth, it’s something that’s come up, has come up often.
- FD1: I don’t think they all grade everybody the same.
- Michelle: Ja and then, so then now that’s ja, there is a human element involved which means that there can’t be any absolute to it so then you not guaranteed.
- FD1: It’s not entirely bias, not entirely.
- Michelle: Ja, exactly.
- FD1: But I do agree that you have to have your evidence. What [name] always says is and he is part of the, he’s part of the committee of SPMS or whatever you call it. He says if you do your job, you do what’s expected of you get a 3.
- Michelle: That’s it.
- FD1: If you do a little bit extra you get a 4. So it has to be exceptional to get a 5.
- Michelle: Ja, so you need to make a big change basically every year. Something...
- FD1: Ja, I don’t know what that would require but I mean it’s...
- FD3: That’s my point you know. Because you know what’s frustrating, like we had this meeting the other day and unfortunately in public you working with all kinds of communities you know, cultures and stuff like that so unfortunately you have to put – we’ve got a roster telling everybody this week you do checking, this week you do typing, this week...you have to spoon feed some people because...but now the frustrating part is for me is I am that kind of person, I can’t sit still and there is always work to be done so now you get the people that okay, I’ll sit there and wait till the stuff comes because all I would do is checking, I won’t help manufacturing...
- Michelle: You can’t do roster..
- FD2: Doing the roster for them...
- FD3: And like [name] said, it is your full right to sit and do nothing if you’ve done your job and if there is nothing more to be done, it’s your full right to sit and do nothing but when it comes to SPMS we will, that will...
- Michelle: Feature basically...
- FD3: ...never there to see what you do or..and I feel like the biggest yats because I often go to him and say “everybody is doing nothing” and I am sitting there stressing because I am supposed to do the manufacturing I can’t get that done and whatever and nobody offers to help you. There is only a few people that is like...and that’s frustrating so then I am thinking I think I am exceptional because I mean literally last Friday I was the only pharmacist in that whole pharmacy do I had to so schedules, ward stock checking, in-patients, out-

- patients, I had to do manufacturing, all those things and I am not gonna get a gold star on my forehead for that, I know.
- Michelle: I know what you saying.
- FD3: I walk out there in tears, I just feel someone (unclear 40:26:3).
- Michelle: You actually need to collaborate with your supervisors, so [name] and actually say to her “[name] you need to give me a project to do aside from my normal duties every year”. You need to discuss and do something special every year because if you are fulfilling your duties and you doing them exceptionally well which you are then it isn’t fair because someone else could be sitting on the side going “Okay, I am gonna make sure I get my SPMS this year, let me use this time while FD3 is running around so I can do all this extra little things” you know.
- FD3: That’s what happens.
- Michelle: Okay, so now you know.
- FD1: It’s also got to do with the attitude of the people you work with because it’s the same there by us. There is one typing and one picking and one dispensing now the one who is dispensing is alone in front says “I am not gonna type cause I am not the typer” and it’s...
- FD3: That attitude.
- FD1: I mean why don’t everybody help everybody.
- Michelle: Okay, so it’s like there’s a flow, the flow is coming to an end now, now I need to run and go in there again so that I can plug the hole there and then when there starts to get a flow again, the flexibility.
- FD1: ...so, it’s got a lot to do with that.
- FD3: And that’s (unclear 41:25:7) I think it’s a cultural thing mostly.
- Michelle: But ja, it’s interesting you saying it because I think it’s – all of us learn about how to manage people at the end of the day because that’s actually the hardest thing and I know that’s the challenge.
- FD3: And that’s why I don’t want to be a supervisor.
- FD1: You have to know how to speak to people.
- FD2: That’s any work position. One of the biggest challenges is staff – you working with other people.
- Michelle: Yes, you can’t be a lone ranger unfortunately, as much as we’d all like to be and be able to just get our stuff done. It doesn’t work that way.
- FD3: Exactly.
- Michelle: Anyway, so basically let’s just summarise. I think the main thing you guys said was you chose public sector for the hours, for the package. You all agree that the package is good. There are some problems with the overlapping if I could say that okay. Things that will make you stay is more interesting work, giving to the community, giving back to the community, stimulation, progressions comes because normally you need something more stimulating like FD1, reasons for going would be infrastructure or whatever else there might be, climbing the ladder, that’s interesting the clinical but not sure about it, policy specialists seems out of reach maybe I don’t know for everyone. Management comes after supervising and management so you need to go through that first. Grade overlapping like you said, most of you don’t have a problem. Getting paid better than outside, feeling utilized - 90% of the time – and that’s it. Does that make sense?
- FD3: Fantastic, ya.
- [End of recording]