



Inclusion of community pharmacies in private practice within primary care

Clearing house briefs series



**World Health
Organization**

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This brief was developed by Gabrielle Appleford, Systems Governance and Stewardship, Special Programme on Primary Health Care, WHO Headquarters with Anna Coccozza, Systems Governance and Stewardship and David Clarke, Systems Governance and Stewardship, Special Programme on Primary Health Care, WHO Headquarters.

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Abstract

This brief explores evidence from the literature on the role of community pharmacies within the delivery of primary care. Community pharmacies are defined as private businesses, either owned by individuals or corporations, which dispense medications and sell other products. In many contexts, these entities are the most utilized primary care providers, enhanced by their ubiquity and convenience. However, community pharmacies may not be formally recognized within the health system or included within primary care models. They may not comply with legal requirements nor adhere to scope-of-practice restrictions. Government oversight of community pharmacies may be under resourced and not responsive to changes in market developments, which can occur without strategic management. Policy response includes recognition of the role of community pharmacies within primary care models; expanding the scope of the pharmacy profession; and, taking a systems-oriented approach to optimize the rational use of medication and encourage entry into the health care systems at an appropriate level of care.

Key messages

- In many low- and middle-income countries – as in higher income contexts – community pharmacies often serve as the first point of contact for individuals seeking care.
- Community pharmacies are responsive to consumer preferences and changing health needs however, they may not be formally recognized within the health system or included within primary care models.
- System and organizational reforms are needed alongside remuneration models that reflect expanded service roles for community pharmacies and pharmacists to facilitate interdisciplinary coordination, integrated care, preventative services, self-care, and self-management.
- The WHO recognises the role of community pharmacies within primary care models as these offer client service delivery advantages and a unique opportunity for countries to achieve universal health coverage.

Counseling ปรึกษา

เภสัชประจำครอบครัว

สุขภาพ

สุขภาพจิตและสุขภาพใจ

นายแพทย์
เวลาปรึกษา
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Pharmacy and health workers /
healthcare providers – Thailand
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Background

Clearing House briefs are intended to provide short descriptive and comparative analysis of country implementation experience in relation to specific health governance and service delivery issues. As such, Clearing House briefs seek to contribute insights on *“how, why, for whom, in what contexts and to what extent health systems, programmes and/or policies function”* (1) to inform governance practice.

This brief explores evidence from the literature on the role of community pharmacies and over the counter licensed drug sellers in private practice within the delivery of primary care. The brief does not consider informal providers of medicines and related products. Informal providers are defined as unqualified providers and those without a license or registration to sell medicines, such as unlicensed drug sellers and shops (as distinct from those that are recognized and accredited). The brief has a specific focus on community pharmacists within LMICs, however it draws on experience from other contexts (e.g. higher and middle-income countries). More information on the methodology used to develop Clearing House briefs is available in Annex 1. The literature reviewed for the country case examples is included [here](#).

Community pharmacies within primary care: what are they?

Community pharmacies are defined as private businesses, either owned by individuals or corporations, which dispense medications and sell other products (2). In many contexts, they are the most accessible care provider and one of the most cost-effective primary care professionals (3) (4). A review carried out using the best available evidence, largely from higher income countries, estimated that community pharmacists see their clients/patients between 1.5 and 10 times more frequently than primary care physicians (3). When stratified for age, the frequency of contact with community pharmacies was higher for older patients and for some chronic conditions.

In many low- and middle-income countries (LMICs) – as in higher income contexts – community pharmacies often serve as the first point of contact for individuals seeking care. However, they may not be formally recognized within the health system or included within primary care models. This situation exists despite shifting consumer preferences towards over-the-counter services, changing health needs, as well as opportunities afforded through new technologies and therapies (2) (5). These developments highlight the potential for community pharmacies to play a greater role as primary care providers within integrated models of care. This is particularly important in contexts where individuals may not have a clear entry point into the health system due to lack of designated primary care provider, such as a general practitioner.

Community pharmacies within primary care: what is the governance problem?

Summary of potential governance problems in LMICs

- Limited recognition of role within primary care
- Little information on activities
- Limited regulation
- Limited consumer protection
- Large contribution to OOP expenditure
- Large contribution to AMR

As the literature indicates, while community pharmacies play a major role in primary care, enhanced by their ubiquity and accessibility, information on their activities is often lacking. For example, in Brazil, community pharmacists represent one of the largest occupations in the country; however, there is little information on activities provided by community pharmacies on behalf of municipal, state and federal authorities, apart from data on special controlled medications (6).

Community pharmacies, despite being considered one of the most accessible healthcare providers (2), may contribute to unnecessary care and high out-of-pocket expenditure. In India, community pharmacies are widely used by the poor and are considered more accessible and convenient than the public sector. However reliance on community pharmacies and informal care contribute to high outpatient costs, which comprise 70% of India's healthcare-related out-of-pocket (OOP) expenditure (7).

Community pharmacies may not comply with legal requirements nor adhere to scope-of-practice restrictions. Their operations may lack regulatory oversight or self-regulation, due to consumer pressures and commercial demands (7) (8) (9). For example, weak regulation of the pharmaceutical sector in India has contributed to the country's large and growing problem of antimicrobial resistance (AMR). This was attributed to the ready sale of antibiotics without prescriptions and poor awareness among consumers about AMR risks (7). Another study from India found that prioritizing positive customer experience often takes precedence over aligning with public health priorities (8). In India and other contexts, bribery may also be widespread, undermining efforts to control illegal pharmacy activity and protect consumers (9) (10).

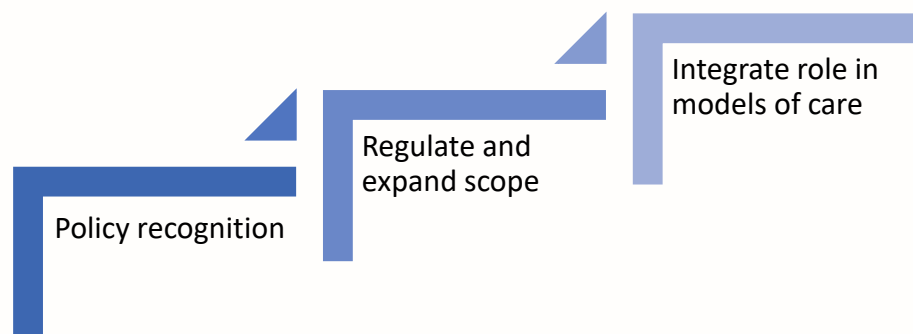
Government oversight of community pharmacies may be under resourced and not responsive to changes in market developments, which can occur without strategic management (11). For example, pharmacy chains are

increasingly capturing a large proportion of market share in the sector (8). In Argentina, more than 90% of pharmacies are chain-based, and have a negative public perception due to concerns of price collusion (12). In India, pharmacy chains account for 4% of community pharmacies but are growing at a rate of 25% per annum (8). In Mexico, doctors' offices adjacent to community pharmacies has increased the number of medicines prescribed and OOP expenditure relative to other service delivery points, counteracting national UHC policies (13). These developments, as highlighted in the literature, require governments to guard against the potential risks posed to consumers due to changing market conditions and to strengthen regulatory frameworks accordingly.

Strategy: what is the policy response to community pharmacies in primary care?

Models of care that encourage people to access care at the appropriate level and entry point of the healthcare system are a major area of interest and reform in many countries. Within the literature, three policy considerations were identified for community pharmacies within such reforms.

Figure 1. Strategies for community pharmacies

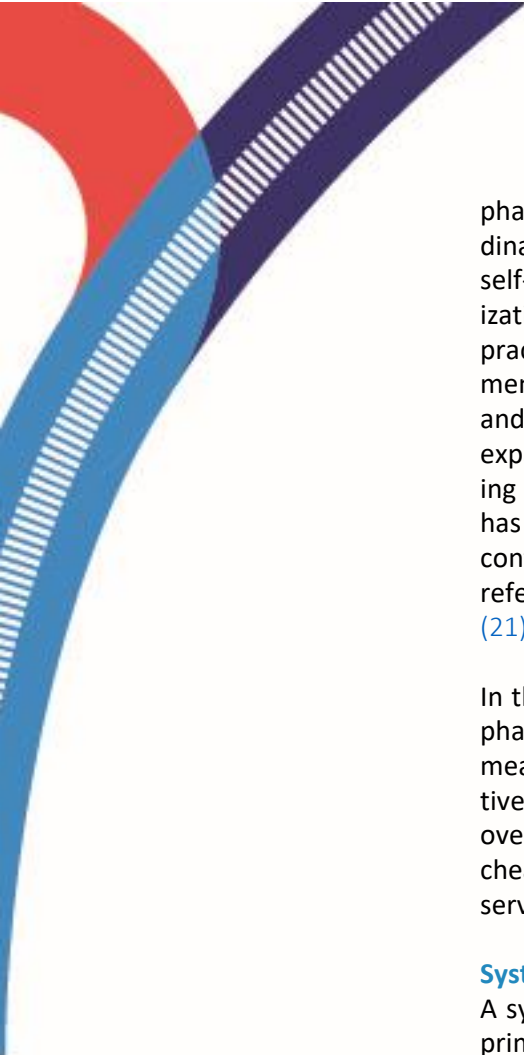


Policy – recognize role

The WHO recognises the role of community pharmacies within primary care models as these offer client service delivery advantages and a unique opportunity for countries to achieve universal health coverage (UHC) (5). Advantages include convenience, such as location and operating hours, greater availability and consistency in stock and ability to source commodities relative to public sector supply chains. When included within insurance and other medical benefit schemes, they may offer financial savings and improve patient retention in care (5). Greater recognition of the role of community pharmacies has been initiated in a range of contexts as part of efforts to ensure timely, equitable, and safe interdisciplinary care within a coordinated primary health care system (14) (15) (16).

Scope – regulate and expand practice

As part of reforms to remodel care, there is growing interest from health authorities and professional organizations in expanding the scope of the



pharmacy profession. These changes in scope include interdisciplinary coordination and integrated care, as well as preventative services, self-care, and self-management (2). Integration includes both vertical (systemic and organizational) and horizontal (service delivery) dimensions (2). A broader scope of practice varies depending on context. It may include services for minor ailments, immunization and vaccination, disease screening, medication reviews and medication management as well as outbreak response (3). In some cases, expansion in scope may be externally supported, by donors and implementing partners, focused on specific interventions and conditions. In LMICs, this has included the provision of family planning services, including injectable contraceptives (17) (18), malaria rapid diagnostic testing (19), TB screening, referral and treatment monitoring (20), and pre-exposure prophylaxis for HIV (21), amongst others.

In this regard, it is important to note that the increasing role of community pharmacies in the provision of health services needs to be accompanied by measures to align the incentives of retail pharmacies with the reform objectives. For example, adopting a retail model may encourage pharmacies to over sell expensive curative products at the expense of cost-effective, cheaper preventative products and services. Thus, the provision of preventive services needs to be incentivized and rewarded.

System – integrate within models of care

A systems-oriented approach to medicine access is recognized within some primary care (re)modelling reforms, moving beyond transactional interactions between consumers and pharmacists (7). This approach is intended to encourage entry into the health care systems ‘at an appropriate level of care and optimize the rational use of medication’ (2). Integration within models of care occurs along a continuum, as illustrated within the literature (Box 2). Examples reflect the recognition of community pharmacies within primary care policy, their regulation and expanded scope of practice, and financial reforms to reflect their broader service roles.

Box 2. Continuum of system integration

In Brazil, the role of community pharmacies within the health system is limited to dispensing medicines, despite recognition of clinical activities by the federal professional association (6).

In Jordan, where integration has spurred promising pharmacy practice, the establishment of an evidence base for services such as medication management review is lagging (22).

In Spain, 'philosophical debates' on the provision of clinical services through community pharmacies has resulted in the development of nationally agreed 'classifications, definitions and protocolized services.' However, these have not resulted in a change in the remuneration model for pharmacies (16).

In Thailand, a strong evidence base has been established for the management of diabetic and hypertensive patients, supporting the feasibility of incorporating community pharmacies into the national health insurance system (23).

In Australia, incentive payments linked to quality measures have been proposed, in recognition of pharmacist's contributions to primary care networks. These include both expanded service roles and the retention of medicines-supply roles (15).

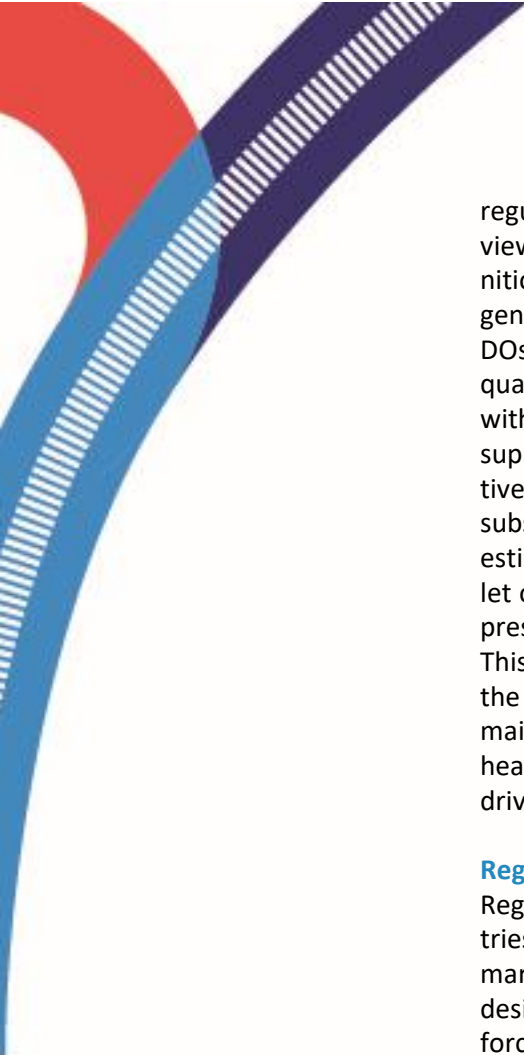
Tools: what policy tools are deployed to facilitate community pharmacy integration in primary care?

Policy tools are how strategy – or policy response – is implemented. Table 1 provides examples from the literature of tools that have been used for the integration of community pharmacies within primary care models. In some instances these have been partner-led through donor initiatives.

Table 1. Policy tools and examples

Policy tools	Examples
Accreditation	Accreditation of drug dispensing outlets
Regulation	Optimization of pharmacy chains and e-pharmacy, use of e-regulation and self-regulation
Remuneration models	Contracting, financial incentives

Accreditation in contexts where the availability of community pharmacies is limited, governments may opt to accredit lower-tier drug outlets. A review of



regulations in 32 countries found that many countries (17 out of the 32 reviewed) have sanctioned such outlets with variations in the degree of recognition, accreditation and regulation (10). Tanzania was one of the more stringent in this country cohort, where Accredited Drug Dispensing Outlets (ADDOs) were introduced in the early 2000s to improve access to affordable, quality medicines and pharmaceutical services in rural and peri-urban areas with few or no registered pharmacies (24). The ADDO strategy was externally supported by a donor initiative and entailed the provision of training, incentives, supervision, and regulation as well as consumer education. ADDOs were subsequently institutionalized as part of the formal health system, and were estimated to include 9,000 outlets in 2016 (25). From the perspective of outlet owners, the primary business incentive was the ability to dispense select prescription-only-medicines, including antimicrobials and antimalarials (25). This model has been adapted to other contexts and has reportedly reduced the sale of prescription drugs of questionable quality (24). However, there remain challenges with prescribing and dispensing practices within public health facilities and ADDOs, with ‘improper patient demand’ continuing to drive inappropriate medicines use (25).

Regulation

Regulations for community pharmacies and drug outlets vary across countries, addressing aspects such as premises, personnel, services, products, marketing, and enforcement. These responsibilities are often managed by designated government authorities and/or professional associations (10). Enforcement of regulations is highly dependent on the availability of technical, human, and financial resources which are often inadequate in LMICs. In these contexts, some donor initiatives have focused on specific services and technologies and may not address wider regulatory reforms, including supervision and inspection systems (5). There is limited evidence of the effects of regulatory compliance through inspections (9). Some countries are experimenting with self-regulation, e-regulation, consumer education, online platforms and other digital tools. There is also opportunity afforded through pharmacy chains to improve regulation of the sector by optimizing economies of scale and chain operational architecture (9). Recent developments in e-pharmacy also presents opportunity for greater regulation through ‘consolidation in the sector, and the traceability and transparency that online records’ afford (26).

Remuneration

A significant barrier to the contribution of community pharmacies within primary care models lies in existing remuneration models. This situation exists both in higher income and LMIC contexts (15) (14). Agreements are often set with representative organizations and are reflected in scope of practice and roles for community pharmacies. These models must provide the ‘right incentives’ to facilitate effective integration within primary care teams (15). Financial incentives may also be used to enable community pharmacies to obtain medicines inexpensively making these more affordable to consumers (5). Governments may also incentivize the provision of products and services of high public benefit in settings where demand is insufficient. In some cases, contracts may also be issued through national health insurance schemes but ‘offering sufficient remuneration not only for medicines but also for any related and additional clinical service is still a hard balance to strike’. Such models need to be calibrated to evolving requirements and market contexts (5).

Conclusion

Primary care is foundational to health service delivery and is the point of first contact with health services. Primary care may involve 'traditional' forms of physical interaction between a patient/consumer and healthcare provider and 'virtual' care through digital innovations such as telemedicine and e-pharmacy. There is growing recognition of the role of community pharmacies within primary care in response to changing consumer preferences, changing health needs, as well as opportunities afforded through new technologies and therapies. System and organizational reforms are needed alongside remuneration models that reflect expanded service roles for community pharmacies and pharmacists to facilitate interdisciplinary coordination, integrated care, preventative services, self-care, and self-management. Ideally community pharmacies should be staffed by a licensed professional to dispense medications according to the national legislative, regulatory and policy framework. The WHO has developed guidance on health practitioner regulation to inform the development of such frameworks (27).

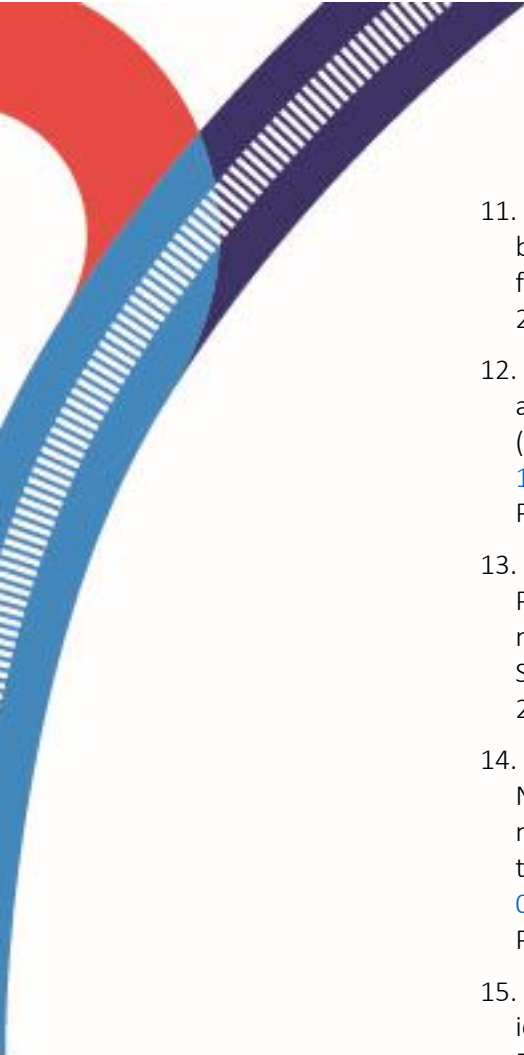
About the Clearing House

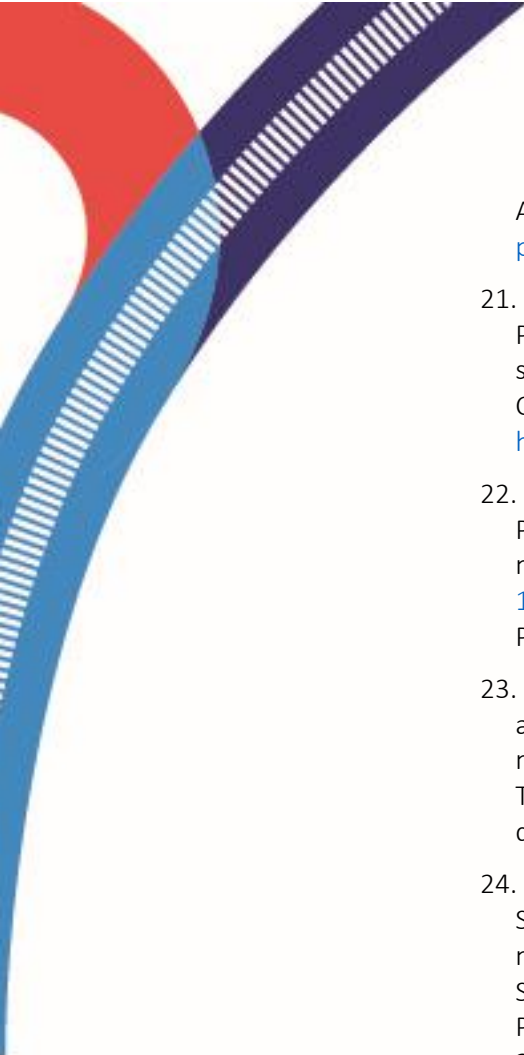
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