Pharmacist-led common ailments schemes

A global intelligence report

2023

fip International Pharmaceutical Federation

Colophon

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International Pharmaceutical Federation (FIP)
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Recommended citation
International Pharmaceutical Federation (FIP). Pharmacist-led common ailments schemes: A global intelligence report. The Netherlands: International Pharmaceutical Federation; 2023

Cover image
Gorodenkoff | shutterstock.com

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Acknowledgements

FIP thanks Courtney Awalt, FIP intern and pharmacy candidate, University of Health Science and Pharmacy, United States of America, for the work developed in the literature review chapter of this report.

FIP thanks Dr Sarah Dineen-Griffin, Vice President of the FIP Community Pharmacy Section and lecturer, University of Newcastle, Australia, for all the support in the insight board chapter of this report.

FIP thanks all respondents to the survey and case studies as they provided valuable insights from their countries and jurisdictions that support the advancement of pharmacy practice.

Executive summary

The escalating global demand for health care, primarily attributed to ageing populations and the surge in chronic, long-term non-communicable diseases, stresses the importance of managing common ailments within primary healthcare settings, and highlights the essential role that pharmacists can play in the prevention and management of such ailments. With limited access to general practitioners and emergency departments, patients increasingly rely on the accessibility and competence of community pharmacists as their initial healthcare touchpoint. In response, countries such as the United Kingdom and Canada initiated common ailment schemes (CAS) in the early 2000s, delivering evident clinical and economic advantages, as well as improved convenience and access to care, by easing general practice burdens.

This report seeks to provide a holistic understanding of the role of pharmacists in CAS, amalgamating best practices and advancing patient care internationally. A comprehensive search of the existing literature laid the groundwork for this report. Simultaneously, a short survey and a compilation of case studies targeted at partaking FIP member organisations (MOs) were conducted, followed by an insight board (focus group) discussion with the topic experts from selected MOs.

Collating data from 24 countries (n=25 MOs), supported by case studies from nine countries (n=10 MOs, i.e., those that reported having CAS in their survey response) and additional qualitative input from 10 countries via an insight board discussion (n=11 MOs, the same countries that submitted case studies, plus Portugal), the report findings highlighted the diverse coverage of eligible conditions, ranging from common ailments to some specialised treatments such as emergency hormonal contraception and COVID-19 antivirals. Clinically, CAS enhanced patient quality of life and convenience of access to care, and reduced general practitioner (GP) workloads while, economically, it presented cost-effective alternatives. However, operational challenges persisted, particularly in inconsistencies in service requirements and stakeholder engagement.

While most nations and MOs supporting the implementation of CAS had professional standards in place, the specifics of these standards and remuneration frameworks varied considerably. This variability included the establishment of a CAS formulary (i.e., a list of eligible medicines), the geographical extent of CAS and the presence of distinct remuneration pathways. Public funding emerged as the predominant source of remuneration for CAS pharmacists, and additional training was mandated in two-thirds of the nations with CAS. A notable difference across respondents also lies in the existence of collaborative arrangements with GPs.

In conclusion, the principal findings provided a cross-sectional view of CAS across various countries, showcasing the diversity of professional standards, legislative frameworks and remuneration mechanisms. These findings also highlighted the unique drivers and challenges faced by pharmacists when implementing CAS.

Successful CAS implementation can be seen to require a multifactoral strategy, with important key areas for pharmacists' engagement: public confidence-building, stakeholder engagement and a robust evidence-backed evaluation framework. Alongside this, fostering a collaborative ethos between other members of the primary healthcare team and pharmacists remained crucial.

Foreword

In today's dynamic healthcare landscape, the International Pharmaceutical Federation (FIP) stands at the forefront of supporting both excellence and accessibility in primary health care. Pharmacists, with their unique blend of expertise and accessibility, play a pivotal role in health systems across the globe. FIP takes pride in endorsing the progression of common ailment schemes (CAS) worldwide as a contributor to improved access to health care and stronger healthcare systems.

In alignment with the WHO Declaration of Astana on Primary Healthcare, this FIP report highlights the important role that CAS can have in providing access to health care and supporting universal health coverage, leaving no one behind. We believe that pharmacists and pharmaceutical scientists worldwide can support equitable access to health care and work in a collaborative manner and put patients at the centre of care, while empowering them to make better health choices in every single encounter.

We are committed to providing the necessary tools and support to pharmacy professionals and their organisations to ensure they can offer pharmacy-backed self-care solutions effectively within their local communities. The FIP Development Goals, particularly DG18 (Access to medicines, devices and services) and DG21 (Sustainability in pharmacy) resonate profoundly with the principles of CAS. By integrating these goals with CAS, we are working to ensure that early interventions by pharmacists are not just an ideal, but rather an integral part of primary healthcare worldwide. This harmonisation not only supports the well-being of patients but also aids in alleviating pressures on emergency departments and primary care facilities and paves the way for a more sustainable and efficient health ecosystem.

Over the years, FIP has diligently gathered global insights concerning the diverse roles of pharmacists in community settings and their evolving position within the primary healthcare team. With the involvement of a dedicated team of pharmacists from all corners of the world and at varying stages of their professional journeys, this report represents the cornerstone for collective efforts we have committed to the development and successful implementation of CAS. In this report, we endeavour to explore deeply the role of pharmacists within the framework of common ailment schemes. We gathered data, identified best practices, challenges and enablers, and pinpointed crucial advocacy messages by employing qualitative methodologies, including a comprehensive survey, in-depth case studies and an insight board discussion.

I believe this report will present both a foundation and a catalyst — a foundation on which FIP and our member organisations can base our initial strategies, and a catalyst to drive us to seek even more diverse and comprehensive insights in the future. By equipping pharmacists with the tools and knowledge they need, we strive to ensure that patients have access to timely, informed and personalised care. I urge our member organisations to integrate the roles outlined in this report into daily pharmacy operations and champion their adoption among peers in your region, as part of formal and adequately funded common ailment schemes.

Together we can advance pharmacy worldwide.

Paul Sinclair
President
International Pharmaceutical Federation (FIP)

1 Introduction

The increasing demand for healthcare services has been one of the long-term challenges across many regions, due to an ageing population and the growing prevalence of long-term non-communicable diseases.[1] As a result, triaging common or minor ailments in primary healthcare settings has been hailed as an important driver in identifying any undiagnosed or underlying complications and alleviating the pressure on high-order healthcare settings.[2,3] However, access to primary health practitioners is often restricted due to factors such as waiting lists, geographical distance and limited socioeconomic resources.[4] Consequently, patients and the public in the community frequently turn to pharmacists in the first instance for healthcare advice and support.[5,6] This effectively positions community pharmacies as the primary and preferred healthcare point for patients seeking assistance with common or minor ailments within the community setting.[7]

In recognition of the increasing strain on healthcare resources and the growing consensus in favour of leveraging the pharmacy workforce in this particular context, countries such as the United Kingdom and Canada have emerged as pioneers in the implementation of national programmes aimed at assisting patients in managing common or minor ailments.[7–9] These initiatives, broadly referred to as common ailment schemes (CAS), minor ailment schemes (MAS), or pharmacist prescribing for minor ailments programmes (PPMA), are community pharmacy-based programmes where eligible patients can receive clinical advice and treatment for a range of common, self-limiting health conditions, generally without the need for an appointment.

The positive impacts of common ailment schemes (CAS) have been evident across various domains, particularly in terms of clinical and socioeconomic outcomes. The economic benefits of CAS have been demonstrated in several cost evaluation studies. A Canadian cost evaluation study reported that the PPMA programme in Saskatchewan (a Canadian province) led to significant healthcare savings, showing exponential growth over a five-year implementation period.[10] A cluster randomised controlled trial conducted in Australia also concluded that there is a significant benefit of MAS implementation, compared to the control group in terms of symptom resolution and quality-adjusted life years.[11]

Moreover, the implementation of CAS has demonstrated the alleviation of the burden on general practice resources,[12] subsequently providing an alternative to effectively utilise and integrate pharmacists as essential members of the primary healthcare team.[13] Conversely, the negative consequences of underutilisation of pharmacists' skills and expertise could lead to suboptimal utilisation of public health budgets and patient outcomes. Overall, the implementation of CAS could optimise the contributions of pharmacists, leading to improved patient care and enhanced overall healthcare delivery.

However, there are few comprehensive studies or reports that have thoroughly examined the global landscape and intelligence surrounding CAS,[14] highlighting the urgency for additional research and analysis to bridge this knowledge gap in other countries and regions. Expanding the scope of the investigation to encompass a broader range of countries will facilitate a more comprehensive understanding of CAS implementation and outcomes worldwide.

This report aims to investigate and describe the responsibilities of pharmacists globally in the effective management of common, self-limiting ailments, specifically within the framework of common ailment schemes. By examining the current understanding of the role of community pharmacists within the context of these schemes using the data obtained from FIP member organisations and individual members, the authors aim to consolidate international best practices and to convey crucial advocacy messages to interested member organisations, pursuing avenues for optimising pharmacists' involvement in patient care.

To gain background intelligence regarding the role of pharmacists within the context of CAS internationally, a systematic search was conducted. Concurrently, a short survey was undertaken, as detailed in Chapter 3, and case studies from FIP member organisations were compiled (see Chapter 4). This was succeeded by an insight board discussion, presented in Chapter 5, with topic experts from various countries worldwide.

2 Review of the literature and existing data

A quasi-scoping review of the recent literature was conducted to collate the evidence of the roles of pharmacists providing professional services to patients as a part of common or minor ailment schemes. This review also focused on collating the information on the scope of practice and remuneration models of these schemes in each country along with identifying any published data on health and economic outcomes.

2.1 Search strategy and inclusion criteria

The review inclusion criteria were:

- Population: Pharmacists or pharmacies within primary healthcare settings;
- Phenomena of interest: Pharmacists' roles, practice standards and remuneration mechanisms;
- Context: Common or minor ailment schemes;
- Study types: Recent literature (2013–2023) with full-texts available via open-access; and
- Studies published in English, Spanish, Portuguese or French.

The search was conducted in June 2023, utilising two comprehensive databases: PubMed and Google Scholar. To ensure comprehensive coverage, a dual strategy was employed: through a targeted search in PubMed, using controlled vocabulary and relevant indexing terms and through a customised search in Google Scholar, using free keywords to capture additional grey literature and any potentially missed studies from the PubMed search. The details of the two search strategies are outlined in Table 1. Only articles published in English, Spanish, Portuguese or French were included due to resource constraints for all-language translation. All study types, including primary studies, reviews and meta-analyses, were incorporated where full texts were available via open access.

Common ailment schemes (CAS) were defined as pharmacists providing professional consultations with or without medicines supplied at no cost to patients as a part of a national or regional clinical programme, based on Scotland's model of CAS.[15] Priority was given to those studies that explored the practice standards or policy details of CAS. Any studies that investigated the roles of prescribing pharmacists that went beyond the usual scope of common ailments were excluded but discussed briefly in Section 2.2.7.

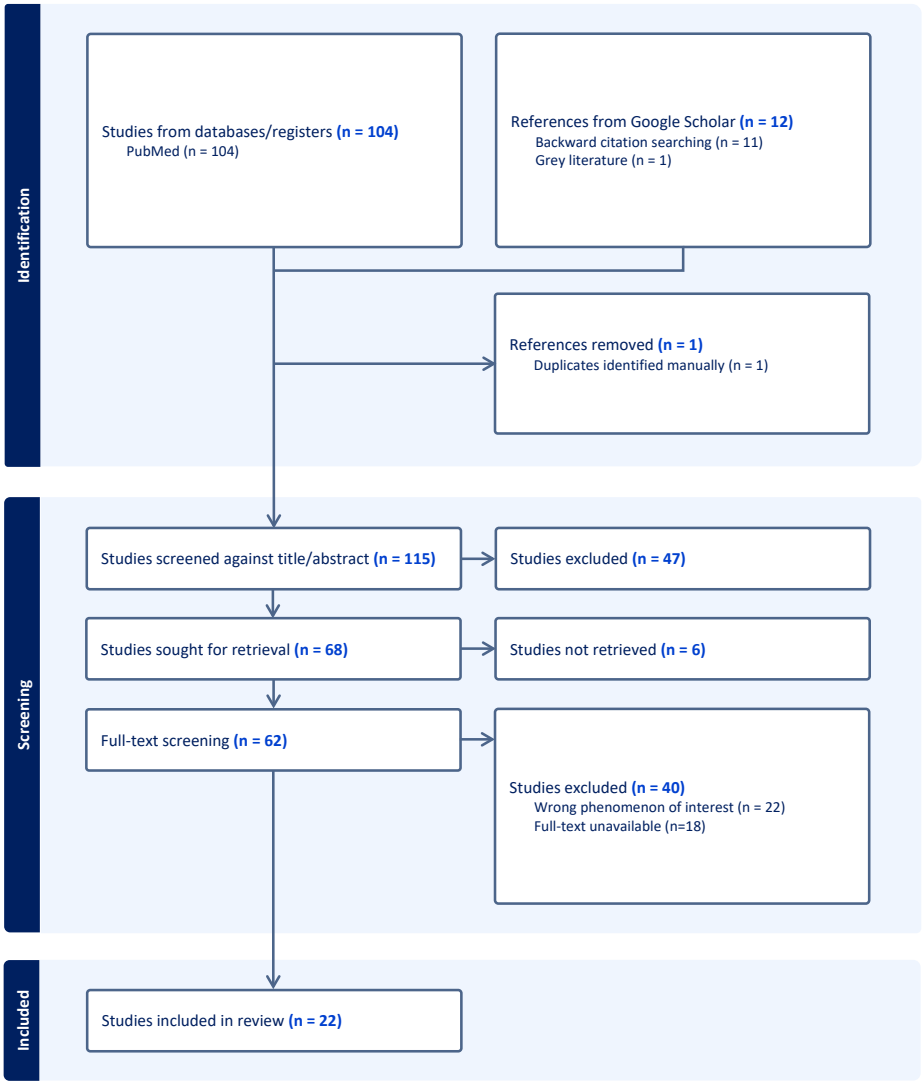
Common ailment schemes (CAS) were defined as pharmacists providing professional consultations with or without medicines supplied at no cost to patients as a part of a national or regional clinical programme.

Table 1. Search Strategies in PubMed and Google Scholar

Database (up to 1 June 2023)	Search terms and keywords		Citations retrieved
PubMed	#1	"pharmacists"[MeSH Terms]	21,587
	#2	"minor ailment*" OR "common ailment*" OR "pharmacist prescrib*"	1,169
	#3	pharmacies[MeSH Terms] or "primary health care"[MeSH Terms] OR "community pharmacy services"[MeSH Terms]	204,348
	#4	#1 and #2 and #3	132
	#5	#1 and #2 and #3 Filters: from 2013/6/1 - 2023/6/1	107
	#6	1 and #2 and #3 Filters: Full text, from 2013/6/1 - 2023/6/1	104
Google Scholar	pharmacy OR pharmacist OR pharmacies	AND minor ailment OR common ailment	12

We identified 116 articles in our initial search and one article was excluded due to duplication. The remaining 115 articles were screened for inclusion criteria and were reviewed for relevant titles or abstracts, of which 67 were excluded. The remaining 62 studies were closely reviewed, and a final 22 articles were included in the literature review. The screening process is presented in Figure 1 along with the summary of included studies in Table 2.

Figure 1. Screening process mapped to the PRISMA Flowchart[16]



2.2 Data extraction and analysis

2.2.1 Scope of common ailments managed by pharmacists

The range of common ailments addressed in the included studies varied across geographical regions and economic contexts. Yusuff et al conducted a systematic review encompassing South America, the Middle East and African countries where the most frequent common ailments reported were respiratory, gastrointestinal and musculoskeletal conditions. The most commonly described medicines were cough and cold preparations, oral rehydration preparations and analgesics.[17] In a study conducted in Malaysia, the most commonly encountered minor ailments were productive cough (7.3%) followed by fever (6.3%) and dermatitis (6.1%).[18]

In comparison, a review by Aly et al reported that, in the United Kingdom, the most consulted upon common ailments were vaginal thrush, followed by hay fever and sore throat. The same study also identified that in Canada, the most common minor ailments encountered by pharmacists were vaginal thrush, allergic rhinitis, haemorrhoids and canker sores (aphthous ulcers).[14]

In the context of the eligible common ailments covered by each country's schemes, some studies explored the roles of pharmacists beyond the usual range of common ailments. For example, Hall et al in the UK examined the role of pharmacists in managing extended common ailments such as acute otitis media and acute

bacterial conjunctivitis.[19] In a Spanish study by Hernández et al the specialised roles of pharmacists in oropharyngeal conditions such as ailments affecting the throat, voice, mouth, lips and tongue were explored.[20]

2.2.2 Funding and remuneration models of common ailment schemes

Remuneration is an important feature in the implementation of CAS that ensures the consulting pharmacists receive appropriate compensation for their professional contribution and service to patients. A well-designed remuneration process is critical for the sustainability of CAS, ensuring the scheme is viable on a long-term basis.

A small number of studies conducted in the UK, Canada and the United States described the funding source and remuneration fees for pharmacy consultations. In a review by Houle et al that explored 60 pharmacist services internationally, although not CAS-specific, the majority (73%) of professional services were paid for by government agencies, with the remainder funded by private insurance plans, which was mainly the case in the United States.[21]

In their review, Paudyal et al observed that the UK government implemented a remuneration system for pharmacies participating in CAS. Pharmacies were reimbursed based on a fee per consultation, ranging from GBP 1.50 (EUR 1.76) to GPB 7.85 (EUR 9.20), which also covered the cost of medicinal items supplied. These fee structures were reflective of the years 1999 to 2009.[22] Additionally, in the time-dependent model, Canadian pharmacists providing CAS services were reimbursed in 30-minute increments, resulting in an average hourly rate of CAD 93.60 (EUR 64.86).[21]

It was noted that in certain cases, remuneration fees were higher when the consultation included the dispensing of medicines at no cost to the patient. This practice was observed in the UK and Canada, where the schemes were nationally funded in most states or jurisdictions. As a result, pharmacists were able to offer consultations and provide medicines free of charge to patients.[23] Pharmacists in Costa Rica were also reported to be seeking to establish a similar remuneration model within the existing CAS framework, as highlighted by Pereira-Céspedes et al.[24]

2.2.3 Health-related outcomes

The overall impact of the common ailment schemes on patients' quality of life was assessed in a cluster randomised trial by Amador-Fernández et al, which reported a gain in quality-adjusted life year (QALY) compared with the non-CAS group.[25] Similar observations were made in another cluster-randomised trial by Dineen-Griffin et al, where minor ailment service patients were 1.5 times more likely to receive appropriate referral and achieved a greater degree of symptom resolution at follow-up.[26]

Patients who received CAS services from pharmacists were found to be more likely to follow up with medical practitioners to seek complete resolution of their symptoms. A systematic review by Paudyal et al reported a significant increase (from 2.4% to 23.4%) in reconsultation rates compared with non-users of minor ailment schemes [27] Reconsultations or follow-up appointments with a medical practitioner were regarded as positive impacts of CAS, as pharmacists were able to intervene early, effectively triage patients and minimise the need for emergency or tertiary care admissions.

Qualitative responses from patients in the included studies also highlighted the positive impact of pharmacist consultations on symptom control. In a study by Hall et al, the majority of patients (85% of 408 participants) were successfully treated at the first instance following the pharmacist consultation, with only 15% needing a reconsultation with a GP.[19] In a Canadian study by Mansell et al, the majority of participants who received CAS services before consulting a doctor (96.8% of 125 participants) reported significant or complete improvement in their conditions after their first visit to a pharmacist (80.8%).[28]

2.2.4 Economic outcomes at a patient or national level

The studies examining pharmacists' involvement in addressing common ailments demonstrated the potential for cost savings across different healthcare settings. A systematic review by Aly et al collated the recent studies conducted in the UK which observed a much lower cost of consultations charged by a pharmacist,

compared with a visit to a GP or an emergency department. On average, a pharmacy-based consultation was priced at GBP 29.30 (EUR 34.33) while a GP visit cost GBP 82.34 (EUR 96.48), and an emergency department visit amounted to GBP 147.09 (EUR 173.29). Similar cost differences were observed in Canada, with community pharmacies offering the most cost-effective treatment at CAD 18 (EUR 12.44), compared with CAD 66.40 (EUR 45.90) for a GP visit and CAD 138 (EUR 95.40) for an emergency department visit. The review also revealed that the minor ailment scheme (MAS) in Birmingham, UK, resulted in cost savings of GBP 2 million (EUR 2.3 million) in 2014, with predicted savings ranging from GBP 12 to GBP 56 million (EUR 14 to 65 million).[29]

In a cost-utility study conducted in Spain by Amador-Fernández et al, it was found that patients enrolled in a MAS presented a positive impact on the incremental cost-utility ratio (ICUR). For patients presenting with symptoms only, the ICUR was EUR 24,733/QALY with a 47.4% probability of cost-effectiveness. When factoring in patients seeking a direct product request, MAS emerged as the dominant strategy, with a 93.69% probability of cost-effectiveness.[25]

2.2.5 Reduced workload in general practice settings

A few studies showed a decreased burden on GP workload involving the treatment of minor ailments. Kim et al conducted a study that projected cumulative reductions in visits to the emergency department, family physicians and walk-in clinics by implementing the pharmacist prescribing for minor ailments (PPMA) model. The reductions were estimated to be 799, 3,677, and 5,090 visits, respectively.[30] These findings were also consistent with the observations in a systematic review by Paudyal et al, which demonstrated a decrease in GP consultations and out-of-hours services for common ailments following CAS implementation.[27]

These reductions in GP workload indicated that involving community pharmacists in the care of common ailments could free up GPs' time to address more complex disease states. By allocating the management of minor ailments to pharmacists, CAS could not only improve access to healthcare but also foster collaborations between GPs and pharmacists, benefiting patient care overall.

2.2.6 Drivers and barriers to common ailment schemes: stakeholders' perspectives

Studies on patient perceptions of CAS consistently indicated positive attitudes internationally. Patients in Canada and New Zealand prioritised trust and convenience, often choosing pharmacists over physicians for CAS.[28, 31]

Pharmacists in Malaysia perceived several barriers to implementing CAS, such as lack of access to patient medical information, absence of dispensing separation and inadequate support from other healthcare professionals.[18] Barriers to implementing CAS included inadequate remuneration, time constraints, a lack of collaborative relationships with GPs and low public awareness.[9, 32]

Protocol-based prescribing was favoured by a majority of pharmacists in Malta,[33] while simplifying pharmacist-patient consultations and data collection processes were regarded as important implementation factors in Australia.[34]

Several studies emphasised the prospects and guidelines for the successful implementation of CAS. It was suggested that future research should focus on a comprehensive review of the health and economic outcomes of CAS, accompanied by a multi-pronged approach such as raising public confidence, engaging stakeholders and relevant advisory groups, and establishing a robust evaluation framework.[9, 32, 35]

2.2.7 Expanding the scope of CAS: emerging areas

Several studies were excluded from this analysis because they fell outside the scope of CAS for this report. For instance, recent studies conducted in the USA examined the roles of pharmacists in prescribing hormonal contraceptives.[36–38] Additionally, a UK study focused on the roles of pharmacists in providing outreach services to the homeless population within the context of CAS.[39] These studies, while relevant to the broader field of pharmacy practice, were not directly aligned with the specific investigation of CAS in this report.

Table 2. Summary of included literature

Authors, year	Aim/objectives	Study type, participants	Study location	Investigated conditions	Relevant key findings
Aly et al. 2018[14]	To explore the features of international MAS, including their similarities and differences, and consider the essential elements to design a MAS model.	Systematic review	Various	Various	A total of 147 publications were included in the review. Key service elements identified included eligibility, accessibility, staff involvement and reimbursement systems. Several factors need to be considered when designing a MAS model; including contextualisation of MAS to the market. Stakeholder engagement, service planning, governance, implementation and review have emerged as key aspects involved with a design model.
Aly et al. 2021[29]	To explore the views and experiences of health professional stakeholders such as community pharmacists, intern pharmacists, medicines counter assistants and general medical practitioners with regard to minor ailments services education, training and assessment practices and preferences.	Primary; qualitative Community pharmacists, pharmacy assistants, intern pharmacists and GPs	Australia	Not specified (primarily an exploratory study on views of stakeholders)	Stakeholders reported considerations for the diverse roles in service delivery and fit-for-purpose tailored training.
Amador-Fernandez et al. 2021[25]	To evaluate the clinical, humanistic and economic outcomes of a minor ailment service in community pharmacy compared with usual care.	Cluster randomised controlled trial Patients	Spain	Dermatological problems: cold sore, foot fungi Gastrointestinal disturbance: diarrhoea, flatulence, heartburn or vomiting, Pain: dysmenorrhea, headache, sore throat	MAS patients gained an additional 0.0003 QALYs (p = 0.053). When considering only MAS patients presenting with symptoms, the ICUR was EUR 24,733/QALY with a 47.4% probability of cost-effectiveness (willingness to pay of EUR 25,000/QALY). However, when considering patients presenting for a direct product request, MAS was the dominant strategy with a 93.69% probability of cost-effectiveness.

Authors, year	Aim/objectives	Study type, participants	Study location	Investigated conditions	Relevant key findings
				Upper respiratory tract: cough, cold or nasal congestion.	
Amador-Fernandez et al. 2022[40]	To evaluate the patient-related outcomes of a community pharmacy minor ailment service compared with usual pharmacist care.	Cluster randomised controlled trial Patients	Spain	Dermatological, gastrointestinal, pain and upper respiratory tract problems	Patients visiting MAS pharmacies had higher odds for being referred to a physician (OR = 2.343, CI95% = [1.146–4.792]) and higher reconsultation rates (OR = 1.833, CI95% = [1.151–2.919]) compared with usual pharmacist care. The use of management protocols through the MAS strengthened the identification of referral criteria such as red flags in patients suffering minor ailments.
Attard Pizzuto et al. 2019[33]	To investigate the perception of Maltese pharmacists to prescribe a selected number of antibiotics.	Mixed-method 209 pharmacists	Malta	Bacterial infections, e.g., bacterial conjunctivitis, mild skin infections, mild–moderate acne, uncomplicated urinary tract infection in women. Mild upper respiratory tract infection, chlamydia	Most pharmacists (77%) agreed with pharmacists prescribing a selected number of antibacterials. Protocol-based prescribing was the preferred model for prescribing by 60% of pharmacists. Half of the respondents (50%) felt competent to prescribe. Co-amoxiclav for an uncomplicated upper respiratory tract infection was the antibacterial that most pharmacists (51%) felt confident prescribing.
Bhatia et al. 2017[8]	To describe pharmacists' scopes of practice relevant to prescribing within various jurisdictions of Canada, using the prescribing model in Alberta as the reference point.	Cross-sectional survey, exploratory 13 pharmacists	Canada	Various	Pharmacist prescribing authority in Canada differs state by state. Specifically, prescribing rights in the context of minor ailments schemes exist in most of the provinces (except British Columbia, Alberta and Ontario).
Dineen-Griffin et al. 2021[34]	To co-design and test the feasibility of an Australian Minor Ailment Scheme for minor ailment presentations.	Qualitative; quasi-experimental pilot Various stakeholders	Australia	Reflux, primary dysmenorrhoea, headache (tension and migraine), common cold, cough and low back pain.	The developed service included the following components: (i) an in-pharmacy consultation between the patient and pharmacist, (ii) treatment pathways accessible to pharmacists on the internet to guide consultations, (iii) existing digital communication systems used by the general practice to exchange patient information, (iv) training, and (v) change facilitation. The main implementation factors

Authors, year	Aim/objectives	Study type, participants	Study location	Investigated conditions	Relevant key findings
		across the two phases, e.g., pharmacists, GPs, patients, local health network representatives			identified were a simplification of the pharmacist-patient consultation and data collection processes.
Hall et al. 2019[19]	To evaluate a new community pharmacy model of service for patients with ear, nose and throat and eye conditions who would otherwise have had to seek primary care appointments or emergency care.	Evaluation study 408 patients	United Kingdom	Sore throat, acute otitis media, acute bacterial conjunctivitis	Most patients (61%) received a Pharmacist Only Medicine. The number of patients successfully followed up was 309 (76%), of whom 264 (85%) had not seen another health professional for the same symptoms. Patient satisfacation survey was completed by 259 patients, of whom 96% reported being very satisfied or satisfied with the service.
Hernández et al. 2021[20]	To characterise the pharmacists' professional practice in oropharyngeal conditions in terms of patients' requests and pharmacists' interventions performed.	Cross-sectional multicentre observational study Patients	Spain	Oropharyngeal conditions — defined by authors as any disorder located in the mouth, pharynx or larynx, e.g., throat, voice, mouth, lips, tongue etc.	The most frequently requested professional service was the dispensing service (44.7%), mainly for treating throat symptoms (70.8%). The most common pharmacist intervention was "selection of pharmacological treatment", followed by "dispensing the requested medicine".
Houle et al. 2014[21]	To update a previous systematic review by identifying remunerated pharmacist clinical care programmes worldwide and reporting on the uptake and patient care outcomes observed as a result.	Systematic review	Not applicable	Various	Sixty new remunerated programmes were identified across Canada, the United States, Europe, Australia and New Zealand. In North America, the average fee provided for a medication review is CAD 68.86 (EUR 47.98) with CAD 23.37 (EUR 16.28) offered for a follow-up visit and CAD 15.16 (EUR 10.56) for prescription adaptations. Time-dependent fees were reimbursed at CAD 93.60 (EUR 65.21) per hour on average.
Kim et al. 2021[30]	To use a decision-analytic model to examine the potential economic impact of establishing a remunerated programme for	Feasibility study	Ontario, Canada	Respiratory tract infections, contact dermatitis and conjunctivitis	At a service uptake rate of 38% for the prescription-detached scenario, the PPMA model led to savings of CAD 7.51 (EUR 5.23), CAD 4.08 (EUR 2.84) and CAD 5.15 (EUR 3.59) per patient for upper respiratory tract infections, contact dermatitis and conjunctivitis, respectively. Per 30,000 patients, the

Authors, year	Aim/objectives	Study type, participants	Study location	Investigated conditions	Relevant key findings
	pharmacists prescribing for minor ailments (PPMA) in Ontario, Canada.				PPMA model for these minor ailments was projected to lead to cumulative reductions in visits to the emergency department, family physician and walk-in clinics by 799, 3,677 and 5,090, respectively.
Mansell et al. 2015[28]	To determine whether patients prescribed medications for minor ailments by a pharmacist symptomatically improve within a set time frame.	Qualitative 125 patients across 90 pharmacies	Saskatchewan, Canada	Allergic rhinitis, diaper dermatitis, cold sores, canker sores, insect bites, mild acne, thrush	Conditions significantly or completely improved in 80.8%; only 4% experienced bothersome side effects. Satisfaction with the pharmacist and service was strong; trust in pharmacists and convenience were the most common reasons for choosing a pharmacist over a physician.
Mantzourani et al. 2016[9]	To explore the perceptions of stakeholders on a national pilot of a new service, the "Choose Pharmacy" CAS in Wales.	Qualitative 7 pharmacists, 2 general practice managers and 2 representatives from the local health board and the government sector	Wales, United Kingdom	Not specified. Primarily a qualitative study; however, it could be derived that the participants referred to any eligible conditions listed under the All-Wales Common Ailments Scheme.	The scheme was welcomed by stakeholders in terms of improved public image of community pharmacies and a societal shift towards self-care for minor ailments. It was highlighted that engagement in the early stages of the scheme increased the sense of ownership among stakeholders.
Nakhla and Shiamptanis 2021[32]	To describe the process utilised by Ontario, which incorporates data analysis, broad stakeholder engagement, patient involvement, implementation science and an evaluation framework.	Review paper	Canada	Various	Key differences and similarities among existing minor ailment programmes. A multi-pronged approach was utilised by Ontario such as broad stakeholder engagement, implementation science and an evaluation framework.
Officer et al. 2021[35]	To explore factors underlying consumer satisfaction with primary health care nurse practitioner and pharmacist prescriber services.	Qualitative (realist evaluation study) 21 consumers, 15 GPs, 9 pharmacist prescribers, 16	New Zealand	Not specified	Study findings emphasise the importance of consumer confidence in the provider as a mechanism for establishing advanced practitioner roles.

Authors, year	Aim/objectives	Study type, participants	Study location	Investigated conditions	Relevant key findings
		nurse practitioners			
Paudyal et al. 2013[27]	To explore the effect of pharmacy-based minor ailment schemes (PMAS) on patient health and cost-related outcomes and to quantify the extent to which existing PMAS have achieved the aim of shifting demand from high-cost services.	Systematic review	Not applicable (most included studies were conducted in the UK)	Various	Low re-consultation and high symptom resolution rates suggest that minor ailments are being dealt with appropriately by PMAS. PMAS consultations are less expensive than consultations with GPs.
Paudyal et al. 2014[22]	To explore community pharmacists' views on the potential utility of e-MAS performance data as a source of feedback on the quality of their own practice.	Qualitative 20 community pharmacists	Scotland, United Kingdom	Not specified (however it could be derived that the participants referred to the Minor Ailment Scheme in Scotland.	Pharmacists highlighted the potential for feedback to support practice in areas related to medicines supply, patient registration and the impact of the new guidelines on their practice. Issues of confidentiality and participants' disinterest in the feedback were potential barriers to the use of the e-MAS data.
Pereira-Céspedes et al. 2021[24]	To evaluate the criteria associated with the referral to a physician or with dispensing medicines in those consultations in Costa Rica.	Descriptive cross-sectional multicentre exploratory study 30 community pharmacies	Costa Rica	Various (e.g., influenza, cough and cold, diarrhoea, irritable bowel syndrome, toothache, muscle contracture and limb pains.	In Costa Rica, MAS is a common and basic service for almost every private community pharmacy but has no established MAS protocol. Private sector services must be paid directly by the patient where a potential for MAS lies.
Raghunandan 2022[31]	To determine New Zealand public preferences for pharmacist prescribing services in primary care in NZ.	Quantitative (discrete choice experiment) 924 members of the public	New Zealand	Not specified	Respondents preferred pharmacist prescribing services with the following characteristics: optimisation of medicines and changes to only current medicine service types, lower consultation costs, shorter waiting times, longer operating hours and consultation by appointment. These results suggest the NZ public sees pharmacists as part of the primary care prescribing team and is willing to utilise them if these services are implemented.
Selvaraj et al. 2020[18]	To evaluate community pharmacists' views towards pharmacist-led minor ailment services. .	Quantitative (cross-sectional survey)	Malaysia	Not specified	Most respondents had positive perceptions and attitudes towards pharmacist-led minor ailment services. The most common perceived barriers were lack of patient's medical

Authors, year	Aim/objectives	Study type, participants	Study location	Investigated conditions	Relevant key findings
		305 community pharmacists			information, absence of dispensing separation and lack of support from other healthcare professionals.
Tan 2020[41]	To evaluate the management of the minor ailment using non-prescription medicines among Malaysian community pharmacists.	Cross-sectional, descriptive 173 community pharmacists	Malaysia	Productive cough, fever, dermatitis	The median duration of treatment was 5 days and the cost of treatment involved medicines cost only (median: MYR 13.40/EUR 2.65) without any consultation fee. Most of the consumers (75.5%) sought help from pharmacists first without consulting doctors.
Yusuff et al. 2021[17]	To conduct a systematic review of the management of minor ailments by community pharmacists in developing countries, and to identify the specific minor ailments encountered, the medicines recommended or requested and the information gathering and counselling practices.	Systematic review	Not applicable	Various	Minor ailment-induced encounters by patients with community pharmacists are generally unstructuredand involve mainly verbal requests for specific medicines by name (60%). The most frequent minor ailments reported were respiratory, gastrointestinal and musculoskeletal conditions, and the most common medicines recommended or requested for were cough/cold preparations, antimotility and oral rehydration preparation, and analgesic/antipyretic products. Community pharmacists encountered 11–30 customers with minor ailments per day, with an average of about 4.8 (1.3–20.5) minutes per encounter.

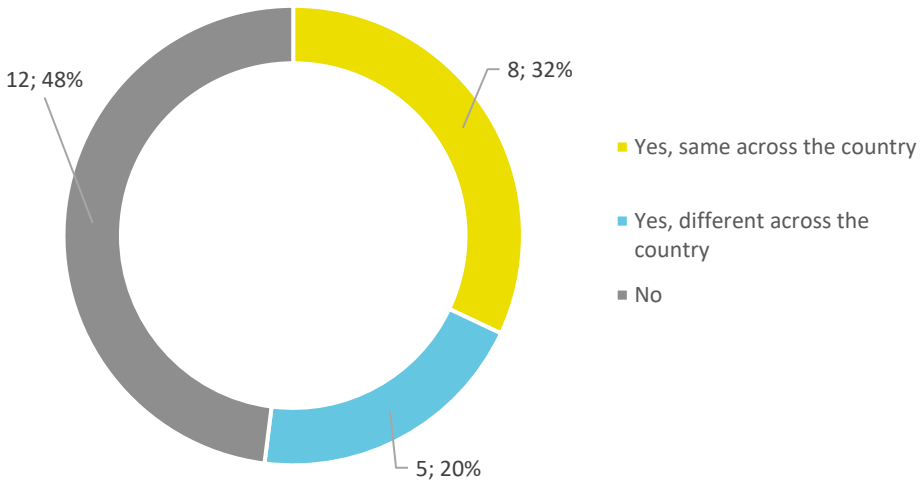
3 Assessing the pharmacy team's involvement and needs in supporting common ailment schemes — findings from a brief international survey

A survey containing eight questions was sent to FIP member organisations (see Appendix 1). The questions highlighted different aspects of common ailment schemes (CAS) and served as a first step to understand which countries could have these practices in place.

Twenty-five responses were received from Australia, Belgium, Bulgaria, Canada, Denmark, England, Finland, France, Germany, Ireland, Israel, New Zealand, Nigeria, North Macedonia, Norway, Portugal, Romania, Scotland, Slovenia, South Africa, Spain, Switzerland, The Netherlands, Uruguay, and the United States.

Regarding the first question, as seen in Figure 2, "Are pharmacists in your country delivering interventions in some of the areas pointed out above under the framework of a structured CAS?", eight countries indicated pharmacists are delivering interventions under a structured CAS (i.e., France, Ireland, Nigeria, North Macedonia, Scotland, South Africa, Spain and Switzerland). Furthermore, five countries added that they had CAS but only in some parts of the country or that it differed across subnational jurisdictions (i.e., Australia, Canada, England, New Zealand and the USA). For the remaining 12 nations — Belgium, Bulgaria, Denmark, Finland, Germany, Israel, Norway, Portugal, Romania, Slovenia, The Netherlands and Uruguay — the survey was pre-emptively concluded due to the absence of CAS within their healthcare systems. It is worth noting that around half of the survey respondents do not have CAS interventions in their jurisdictions and a fifth of them do not have the same structure across the country.

Figure 2. Are pharmacists in your country delivering interventions in some of the areas pointed out above under the framework of a structured CAS? (n=25)



The second question was "Which ailments or clinical areas are covered by the CAS?" Survey respondents were asked to indicate which clinical areas were eligible under their CAS. Various common ailments were listed as choices, and the responses received were categorised based on their broader clinical areas (i.e., infectious, respiratory etc.), as shown in Table 3. The most frequently covered ailments identified were headlice, diarrhoea and eczema (n=11 each), appearing across different countries. The frequent CAS coverage of those conditions

may indicate their high occurrence in community settings. Therefore, focusing public engagement efforts on these specific areas could have a more immediate and substantial impact.

Table 3. Clinical areas covered by the common ailment schemes in each country.(n=13)

Conditions	Countries
Infectious diseases:	
Head lice	Canada, England, New Zealand, Nigeria, North Macedonia, Scotland, South Africa, Spain, USA
Vaginal candidiasis/thrush	Canada, England, Nigeria, North Macedonia, Scotland, South Africa, Spain, Switzerland
Threadworm	Canada, England, Nigeria, Scotland, South Africa
Conjunctivitis	Canada, England, New Zealand, Nigeria, North Macedonia, Scotland, South Africa, Switzerland
Upper respiratory tract infection	England, Nigeria, North Macedonia, South Africa, Switzerland, USA
Scabies	England, New Zealand, Nigeria, Scotland, South Africa
Chickenpox	France, Nigeria, North Macedonia, Scotland, South Africa, Switzerland
Uncomplicated urinary tract infection	Australia, Canada, France, Nigeria, North Macedonia, Scotland, South Africa, Switzerland
Gastrointestinal disorders:	
Diarrhoea	Canada, England, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Constipation	New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Indigestion	Canada, England, Nigeria, Scotland, South Africa, Spain, USA
Gripe/colic/wind	Nigeria, Scotland, South Africa, Spain
Respiratory conditions:	
Sore throat	Canada, England, France, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Cough	Canada, Nigeria, Scotland, South Africa, Spain, USA
Hay fever	Canada, England, France, Scotland, South Africa, Switzerland, USA
Nasal congestion	Canada, Nigeria, Scotland, South Africa, Spain, USA
Asthma	Canada, South Africa, Switzerland
Pain and inflammation:	
Headache	Canada, England, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Earache	Nigeria, Scotland, South Africa, Spain, Switzerland, USA

Conditions	Countries
Toothache	Nigeria, Scotland, South Africa, Spain, USA
Non-specific pain	Canada, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Minor burn	New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Musculoskeletal disorders	Canada, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Soft tissue injury	Nigeria, Scotland, South Africa, Spain, USA
Dermatological conditions:	
Bites and stings	Canada, England, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Athlete's foot	Canada, England, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Mouth ulcers	Canada, England, Nigeria, Scotland, South Africa, Spain
Nappy rash	Canada, England, New Zealand, Nigeria, South Africa, Spain, USA
Haemorrhoids	Canada, Nigeria, Scotland, South Africa, Spain, USA
Cold sores	Canada, Nigeria, Scotland, South Africa, Spain, USA
Warts/verrucae	Canada, Scotland, South Africa, Spain, USA
Non-specific/other fungal infections	Canada, England, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Eczema/allergic dermatitis	Canada, England, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Acne	Canada, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Non-specific dermatitis	Canada, England, New Zealand, Scotland, South Africa, Spain, Switzerland, USA
Psoriasis	Canada, New Zealand, South Africa, USA
Oral thrush	Canada, England, Nigeria, Scotland, South Africa, Spain, Switzerland
Allergic conjunctivitis	Canada, France, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Dry eyes	Canada, England, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Ear wax	Scotland, South Africa, Spain, USA
Others:	
Teething	England, Nigeria, Scotland, South Africa, Spain, USA
Emergency hormonal contraception	Canada, England, Ireland, Nigeria, Scotland, South Africa, Spain, Switzerland, USA
Travel sickness	Canada, Nigeria, Scotland, South Africa, USA

Conditions	Countries
Post-vaccination pyrexia	Nigeria, Scotland, South Africa, USA
Laceration	New Zealand, Scotland, South Africa, Spain, USA

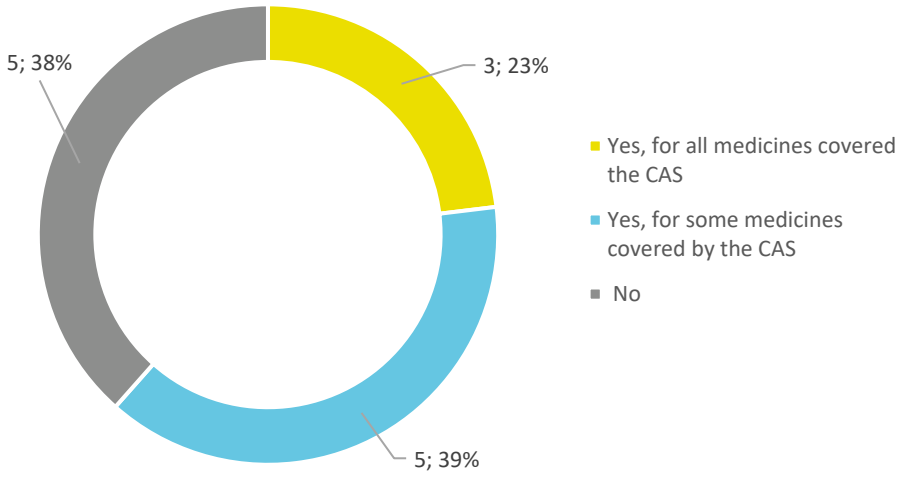
The third question was "How are pharmacists remunerated for CAS interventions?" (Table 4). In countries such as Canada, England, France, Ireland, New Zealand and Scotland, the public health system and corresponding third-party payers handled the reimbursement. South Africa indicated that reimbursements come from private health insurance companies and third-party payers. North Macedonia, Spain and the US reported no financial compensation for CAS interventions. In Nigeria, the costs are covered by patients themselves, whereas in Australia, the reimbursement model varies by jurisdiction (Queensland: paid by patients; New South Wales: public health system-funded consultation; Victoria: starting October 2023, public health system-funded consultations). Also, in Switzerland, for some patients, it is paid for by their health insurance, but for the vast majority of patients, they had to pay out of pocket. Meanwhile, in North Macedonia, Spain and the US, pharmacists were not financially reimbursed for their participation in CAS. The finding that public funding supports pharmacist remuneration in nearly half of the cases is a positive indicator of government commitment and scheme sustainability. While the lack of financial incentives in some regions highlights room for improvement, it also presents an opportunity to enhance CAS services universally. On the other hand, having around a quarter of the countries with no remuneration for these services indicates that this important intervention pharmacists are already providing — possibly also in other countries not included in this survey — is not being recognised by healthcare systems and policy makers.

Table 4. How are pharmacists remunerated for CAS interventions? (n=13)

Remuneration	N	%	Countries
They are reimbursed by public health systems/third-party payers	6	46	Canada, England, France, Ireland, New Zealand, and Scotland
They are reimbursed by private health insurance companies/ third-party payers	1	8	South Africa
They receive no remuneration for CAS interventions	3	23	North Macedonia, Spain, and the US
Paid out of pocket by patients	1	8	Nigeria
Other	2	15	Australia, Switzerland

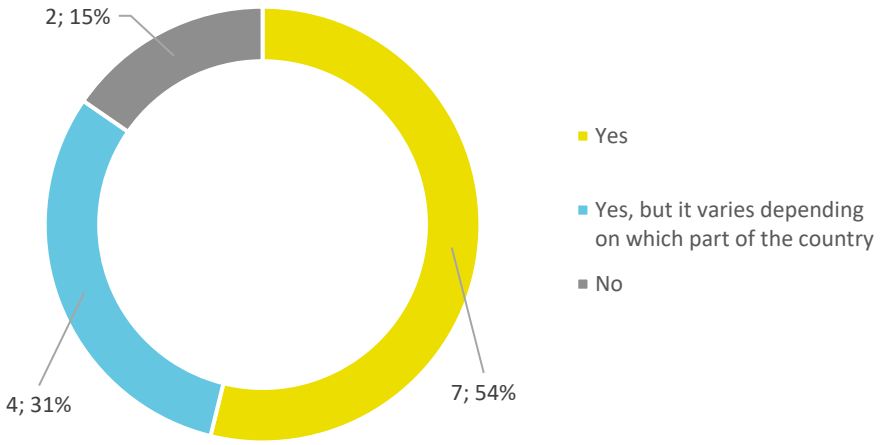
The fourth question was "Are medicines dispensed under the CAS reimbursed by third-party payers?" Three countries (France, New Zealand and Scotland) indicated that they were reimbursed for all medicines provided under CAS. Five countries (Australia, Canada, Ireland, North Macedonia and South Africa) indicated that they were reimbursed for some medicines, but not all. In contrast, five countries (England, Nigeria, Spain, Switzerland and the USA) indicated that there was no reimbursement for medicines provided under CAS (see Figure 3). Overall, the extent of reimbursement for medicines provided under CAS varied across different countries, with more than half of them with all or some of their medicines covered under CAS. This difference may potentially affect the cost-benefit analysis of CAS, and hence the interests of stakeholders in implementing CAS. Further, covering only some of the medicines covered by the CAS might hinder the full potential of these schemes as it can pose an economic barrier for patients, as seen in five of the countries that responded to this question.

Figure 3. Are medicines dispensed under the CAS reimbursed by third-party payers? (n=13)



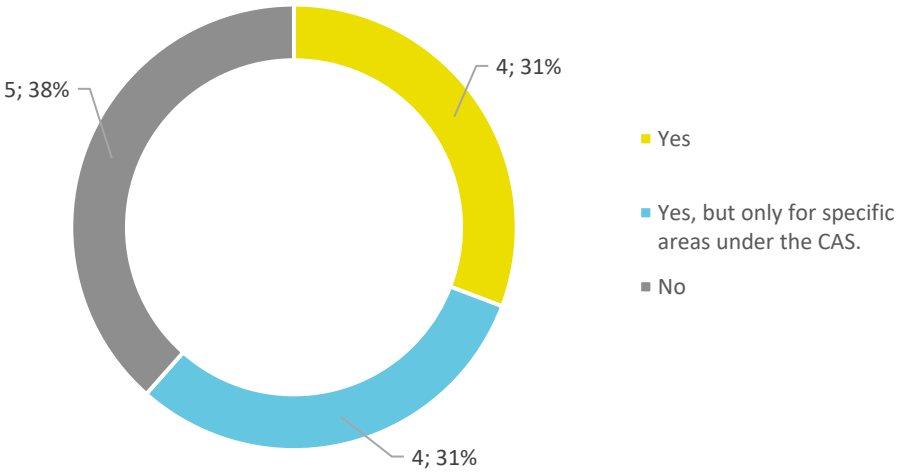
The fifth question was "Are there specific professional regulations, standards or requirements in place for CAS?" Seven countries (Canada, France, Ireland, New Zealand, Scotland, South Africa and Switzerland) mentioned that there are specific professional regulations, standards or requirements for these schemes and four additional countries (England, Nigeria, North Macedonia, and Spain) indicated that while they do maintain professional standards for CAS, the applicability of these standards varies by region within each country. For Australia and the USA these professional requirements did not exist (Figure 4). The presence of professional regulations, standards or requirements is essential to ensure the quality of CAS and increase the likelihood these schemes will be sustainable in a long-term perspective. Having only two countries without requirements is a good indicator that the regulatory bodies are involved in the development of these services, and this can be an enabler for future pharmacy practice change.

Figure 4. Are there specific professional regulations, standards or requirements in place for these services?



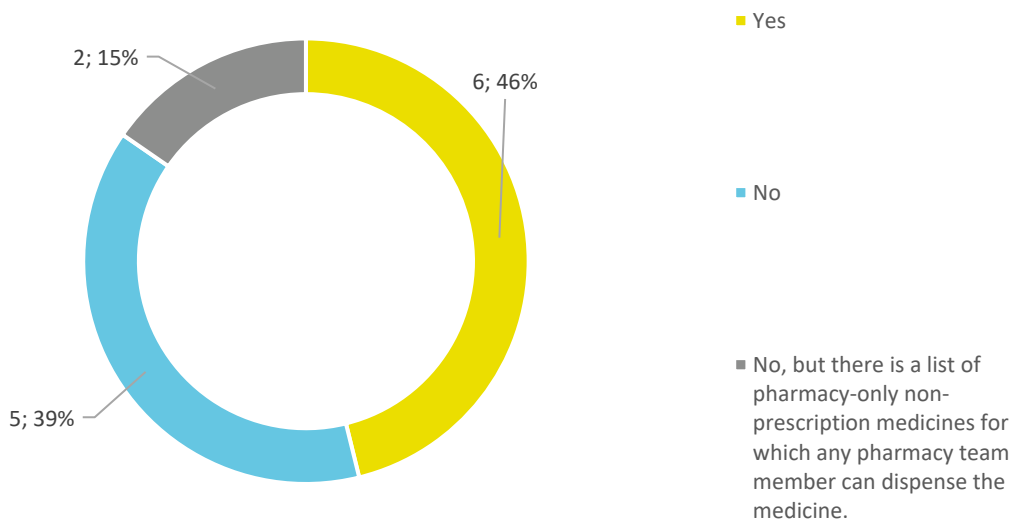
The sixth question was "Are pharmacists providing interventions under a CAS required to undergo additional education or training?" Four countries (Australia, Ireland, Scotland and Switzerland) indicated that pharmacists need to enrol in additional training or education. Meanwhile four additional countries (England, New Zealand, Spain and the USA) stated that such educational requirements exist, but only for specific areas within the CAS framework. In comparison, five countries (Canada, France, Nigeria, North Macedonia and South Africa) have no such requirements for additional training (see Figure 5). Training strategies for pharmacists are another important factor that supports the development of CAS, as more trained and skilled pharmacists will provide these services with more comfort and more efficiency. The provision of continuous professional development that covers areas under the CAS can be one way to develop competencies related to these schemes.

Figure 5. Are pharmacists providing interventions under a CAS required to undergo additional education or training? (n=13)



The final question was "Is there a list of pharmacist-only non-prescription medicines in your country/territory that requires a pharmacist to do a clinical assessment and decide on the dispensing of the medicine?" Five countries (Canada, England, Nigeria, North Macedonia and the USA) do not have pharmacist-only list while two other countries (France and Spain) do not have such a list but there is a list of pharmacy-only medicines for which any pharmacy team member can dispense the medicine. In contrast, six countries (Australia, Ireland, New Zealand, Scotland, South Africa and Switzerland) do have a formulary of pharmacist-only non-prescription medicines. Among these six countries, South Africa and Switzerland specified that they charge a dispensing fee for pharmacist-only medicines, whereas Australia, Ireland, New Zealand and Scotland do not levy a particular fee for such medicines. (see Figure 6). The existence of pharmacist-only medicine lists in some countries adds a layer of professional standards to CAS. Furthermore, these lists could serve as a tool to standardise the scope of services, offering clarity for pharmacists, patients and other primary care practitioners.

Figure 6 - Is there a list of pharmacist-only non-prescription medicines in your country/territory that requires a pharmacist to do a clinical assessment and decide on the dispensing of the medicine? (n=13)



The survey responses highlighted various aspects of CAS frameworks and snapshots of remuneration mechanisms. These differences signify several key implications in relation to CAS development such as the benefits of public funding for seamless integration into primary health care, standardised medicine lists and opportunities to improve pharmacist reimbursement.

In Chapter 4, case studies offer a more comprehensive understanding of key elements of CAS frameworks such as professional standards, remuneration models and details of implementation processes.

4 Case studies

FIP invited those respondents who reported that pharmacists in their country delivering interventions under the framework of a structured CAS to submit a case study expanding on the information that they had provided. The case studies contained similar topics to the short survey but had open-ended questions where participants could detail the information about the case studies and include links for further reading. We received nine responses from eight countries:

- Canada;
- England, United Kingdom;
- Ireland;
- New Zealand;
- Scotland, United Kingdom;
- South Africa;
- Spain;
- Switzerland; and
- United States of America.

4.1 Canada

Member organisation:	Canadian Pharmacists Association (CPhA)
Case study authors:	Robyn Locke, Lindsay Rodwell, Kelsey Skromeda

[Section A] Coverage and workflow of CAS

1. **Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.**

The list of ailments which community pharmacists may assess and prescribe for varies across provincial/territorial jurisdiction. We have compiled a scan of the ailments pharmacists are able to prescribe for in each jurisdiction: National Scope of Practice Summary Infographic (current as of 20 July 2023)

The complete list for each jurisdiction is below:

- British Columbia (BC), Alberta (AB — all schedule 1 drugs and blood products), Saskatchewan (SK), Manitoba (MB), Ontario (ON), Quebec (QC), New Brunswick (NB), Nova Scotia (NS), Newfoundland and Labrador (NL) + expanded scope 2023, Prince Edward Island (PEI), Yukon (YT)
- Northwest Territories (NWT) — Pharmacist Minor Ailment Prescribing not authorised
- Nunavut (NU) — Pharmacist Minor Ailment Prescribing not authorised

2. Standard workflow of CAS and how these are structured in the country/territory.

Standard workflow and requirements for documentation vary across jurisdictions. Please see below for a general workflow process based on the Model Standards of Practice for Canadian Pharmacists and the provincial/territorial pharmacists' standards of practice.

- Initiation/request for minor ailment prescribing by patient or pharmacist;
- Attainment of patient consent for pharmacist prescribing;
- Assessment by pharmacist- —including physical assessment, medical history, cost effectiveness and patient preference, as applicable;
- Provision of prescription medicine, over the counter medicine, non-pharmaceutical advice and/or referral to another healthcare professional by the pharmacist;
- Documentation of pertinent patient and prescription details;
- Notification of primary care provider or specialist (if applicable);
- Billing of service to public funding body or patient (ailment and jurisdiction dependent); and
- Establish, document and carry out follow-up monitoring plan.

[Section B] Regulatory and remuneration frameworks for CAS

3. Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.	
a. Practice guidelines and quality assurance	Standards of Practice by Province/Territory: BC, AB (Standard 14), SK, MB (Standard 9), ON Ontario has adopted the Model Standards of Practice for Canadian Pharmacists produced by the National Association of Pharmacy Regulatory Authorities QC (Section 2), NB (Section 21), NB Minor Ailments, NS, NL (Section 5.1), PEI (Sections 4–6), YK (Standard 20), (NWT and NU excluded)
b. Education and qualification(s)	Many, but not all, jurisdictions require formal training and/or authorisation from the regulator to assess and prescribe for common ailments. See below for the links to the educational and qualification requirements by province/territory: BC (Policy 70) Pharmacists must complete the Pharmacist Prescribing for Minor Ailments and Contraception (PPMAC): Regulatory Education Module and must record self-declaration of training completion. AB (Standard 16) Pharmacists must have obtained additional prescribing authorisation from the regulator. SK It is mandatory for all Saskatchewan pharmacists to complete Level I Prescriptive Authority training (including Minor Ailment Part 1 training if practising in a self-care environment). MB (Standard 9) Successful completion of the Self-Limiting Conditions Independent Study Programme, a completed application for authorisation to prescribe a drug included in Schedule 3 to the Pharmaceutical Regulation for Self-Limiting Conditions (not including smoking cessation) and a certificate of authorisation to prescribe a drug for self-limiting conditions from the College of Pharmacists of Manitoba are required before pharmacists can prescribe for the conditions and the drugs (not including smoking cessation) listed in Schedule 3 to the Manitoba Pharmaceutical Regulations.

	ON The Ontario College of Pharmacists has developed a mandatory Orientation for Minor Ailments Prescribing module. Part A pharmacists (practicing pharmacists who provide patient care) must complete the module before prescribing for minor ailments. QC (Section 2) The standards of practice have been defined in four parts: 1) Maintaining competence, professional development and activities to promote advancement of the profession; 2) Monitoring drug therapy in partnership with the patient; 3) Medication management and 4) Organisation and safety of care and pharmaceutical services. NB All pharmacists currently practising, and those transferring into the province, must read and understand this document or view the recorded educational module on minor ailments and notify the New Brunswick College of Pharmacists of such before performing such activities. NS No additional education/training required NL (Section 4) Pharmacists must first apply to the Newfoundland and Labrador Pharmacy Board for authorisation; and demonstrate completion of the required orientation programme, as approved by the board. PEI (Section 1) No additional training required YK (Standard 20) Pharmacists must apply to add initial prescribing as an endorsement to their Yukon licence NWT and NU excluded
c. Requirements for CAS provision	Requirements for minor ailment prescribing vary by province or jurisdiction. Any additional requirements for provision of minor ailment prescribing are outlined in the appropriate provincial/territorial standards of practice or guidelines above. These may include the expectation of a collaborative practice environment, no prescribing for family, themselves or others with whom they have a close relationship, etc.
4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.	
Billing policies and renumeration vary by province/jurisdiction, condition and service type. Most provinces (except Manitoba) now provide payment for all pharmacists to assess and prescribe for common ailments or for those participating in pharmacy walk-in clinics. In most provinces, payment is tied to the assessment and not to the act of prescribing, i.e., pharmacists will receive payment whether or not a prescription is issued. Where the billing policies are available, links have been provided below. BC, AB — through Alberta Blue Cross, SK (Section 10), MB, ON, QC, NB, NS, NL, PEI, YK, (NWT and NU excluded)	

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

- Health care provider shortages
- Patient access to primary care providers (e.g., family physicians, nurses)
- Communication between healthcare providers
- Return on investment
- Patient outcomes

Minor Ailments Advisory Group (MAAG)

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.

Date	Event(s)
2007–2008	Alberta grants 15 pharmacists expanded authority to prescribe
2011	Nova Scotia and Saskatchewan implement minor ailment prescribing
2012	Saskatchewan implements government funding for minor ailment prescribing
2014–2015	Manitoba, Quebec, New Brunswick, Prince Edward Island and Newfoundland authorise minor ailments prescribing
2012–present	Implementation of public funding for pharmacist prescribing (province and condition dependent) Much of the public funding for minor ailments across Canada has occurred within the past three years. Expansion of the ailments for which pharmacists can prescribe (province dependent)
2022–2023	British Columbia and Ontario authorise minor ailments prescribing by pharmacists

7. Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.

☒ Yes ☐ No

☒ Summary or links to study findings:

- Pharmacist-led minor ailment programs: a Canadian perspective (2016)
- Provincial Comparison of Pharmacist Prescribing in Canada Using Alberta's Model as the Reference Point (2017)
- Pharmacist Prescribing for Minor Ailments Service Development: The Experience in Ontario (2021)
- Community Pharmacy Primary Care Clinics (NS – ongoing)

[Section D] Mobilisation and ongoing engagement

8. Engaging stakeholders:

a. With/from other healthcare professional groups	• Formation of a Minor Ailments Advisory Group by Ontario College of Pharmacists (OCP) • Collaborative care agreements between practitioners and pharmacists (province dependent) • Surveys
b. With/from policymakers	• Formation of a Minor Ailments Advisory Group by OCP • Partnerships between provincial colleges of pharmacy • Cost-effectiveness and health benefit analyses pre and post implementation

c. With/from the public	• Formation of a Minor Ailments Advisory Group by OCP • Provincial-led marketing (e.g., social media campaigns) • Pilot programmes providing free health care from pharmacists • Surveys and focus groups
d. With/from pharmacists	• Formation of a Minor Ailments Advisory Group by OCP • Partnerships between provincial colleges of pharmacy • Surveys of pharmacist satisfaction and thoughts • Implementing public funding for services (province dependent)

9. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

- Lack of public funding and low uptake where patients are required to pay out of pocket
- Significant push back from physicians and nurse practitioners
- College requirements to develop additional pharmacist training programmes
- Inability of pharmacists to access health records needed to adequately assess certain patients
- Lack of uniform policies and regulations across provincial/territorial jurisdictions
- Hesitancy from some pharmacists to take on expanded scope of practice

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

The authority and funding provided to pharmacists for common ailments assessments and prescribing have increased significantly since COVID-19 and the resulting health care labour crisis. Governments are now less concerned about pushback from physicians given labour shortages and a crisis in access to emergency clinics and hospitals. The pressure on these access points to the healthcare system has led to inconceivably long waits, substandard conditions and emergency department closures. Governments, which historically have been somewhat indifferent to pharmacist prescribing for minor ailments, have now been pushing regulators to expand scopes of practice wherever possible and are now willing to provide more funding for pharmacy services to help keep patients out of clinics and emergency rooms. Capitalising on these external factors, pharmacists' increasing role in primary care, patient needs and their trust in pharmacists are essential to continued support and funding for pharmacy.

4.2 England

Member organisation:	Pharmacists' Defence Association
Case study author:	Bharat Nathwani

[Section A] Coverage and workflow of CAS

1. Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.

Proposed in 2023 — details to be finalised

Pharmacies will take on the prescribing of drugs for seven common ailments:

- Earache
- Sore throat
- Sinusitis
- Impetigo
- Shingles
- Infected insect bites
- Uncomplicated urinary tract infections in women

2. Standard workflow of CAS and how these are structured in the country/territory.

Details around training and practical aspects for the scheme are not finalised. There are numerous local common ailment schemes, set up by local health systems, but they are not centrally funded and not guaranteed. Therefore, many schemes appear and disappear in short timescales.

[Section B] Regulatory and remuneration frameworks for CAS

3. **Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.**	
a. Practice guidelines and quality assurance	Pharmacy First, Community Pharmacy West Yorkshire Manchester services, Greater Manchester LPC The documents above relate to local schemes within England — they provide examples of possible standards/requirements for the national England scheme which is to be launched in 2023.
b. Education and qualification(s)	Follow links in the above documents
c. Requirements for CAS provision	See specification in above links

4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.

See criteria detailed in the links provided in Question 3

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

England scheme (Scotland has its own scheme)

Top line:
Launch Pharmacy First nationally in England so that by end of 2023 community pharmacies can supply medicines including prescription-only medicines for seven common conditions. The government believes that alongside oral contraception and blood pressure services expansion, it could save 10 million appointments in general practice a year once scaled, subject to consultation.

Investment promised of up to GBP 645 million over the next two years to expand community pharmacy services, subject to consultation.

Detail as known:
Community pharmacy is an essential part of primary care and offers people easy access to health services in the heart of their communities. 80% of people in England live within a 20-minute walk of a pharmacy and there are twice as many pharmacies in areas of deprivation. They give expert clinical advice and 90% of people feel comfortable consulting a community pharmacist for a minor illness. Over 90% who have done so say they received good advice.

Pharmacy First will launch before the end of 2023, learning from areas that have implemented similar models, subject to a Department of Health and Social Care led consultation with Community Pharmacy England. This service will enable pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles and uncomplicated urinary tract infections in women) without the need to visit a GP.

Delivery plan for recovering access to primary care, NHS England

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.	
Date	**Event(s)**
July 2023	Government announcement — England
Early 2024	CAS ailment scheme expected to start — England

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

The scheme has not started but we anticipate challenges around:

- Trained support staff;
- Paid training time for pharmacists;
- Marketing — public expectation may exceed what is possible within the scope of the CAS scheme; and
- IT connectivity with GPs — present systems rely on paper or unwieldy and clunky systems.

8. Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.

☐ Yes☒ No

[Section D] Mobilisation and ongoing engagement

9. Engaging stakeholders:	
a. With/from other healthcare professional groups	GP (doctors) were supportive of the scheme as it would reduce their workload — doctor funding should be unaffected.
b. With/from policymakers	Tied in with government plan to increase access to primary care — to increase access to care locally and divert patients away from emergency or urgent care
c. With/from the public	Many media announcements already made — unsure what the engagement strategy will be but concerns around managing patient expectation of the scope of the scheme.
d. With/from pharmacists	Details not known.

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

It is essential that pharmacist membership bodies are consulted and are part of the design process for any CAS. In the UK the four national health systems (England, Scotland, Wales and Northern Ireland systems) negotiate with the owners of the pharmacy businesses. The professional bodies and pharmacist member organisations are excluded from the negotiations.

It is also essential that health systems learn from the experiences in implementing and monitoring of their schemes so that CAS operate on best current evidence basis.

4.3 Ireland

Member organisation:	Irish Pharmacy Union
Case study authors:	Susan O'Donnell, Susan O'Dwyer

[Section A] Coverage and workflow of CAS

1. Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.

Two nationally funded schemes exist in Ireland for accessing emergency hormonal contraception (EHC). There is also a scheme available to patients to access EHC and pay privately. EHC is funded nationally for patients who hold a general medical service (GMS) card. Ireland has also recently introduced a free contraception scheme for females aged 17 to 26 years of age. This scheme includes free access to EHC. Patients not covered under either national scheme can present to pharmacy for EHC and pay for it privately. Outside of EHC there is no nationally funded scheme for common ailments.

2. Standard workflow of CAS and how these are structured in the country/territory.

- EHC consultation is initiated by the patient presenting in the pharmacy;
- The medicine is classified as an over-the-counter medicine, the patient cannot self-select this medicine;
- Pharmacist carries out a consultation with the patient;
- The pharmacist makes a clinical decision as to whether supply is appropriate or not and where it is appropriate a decision is made as to which medicine to supply (levonorgestrel or ulipristal acetate);
- Where supply is not recommended, the patient is referred to other services as appropriate;
- Pharmacist counsels patient on the medicine;
- Pharmacist counsels the patient in relation to safe sexual practices and discusses ongoing contraception needs and sexually transmitted infections testing as appropriate;
- A record of the supply is maintained on the patient record for GMS and National Free Contraception Scheme patients and for private patients it can be maintained on the patient record as part of good pharmacy practice, but it is not a legislative requirement;
- Where the patient is eligible for a national scheme reimbursement is applied for through a portal for the free contraception scheme or through a routine dispensing process on dispensary system for those who hold a GMS card;
- Under the GMS scheme and the National Free Contraception Scheme remuneration is provided for the consultation (whether supply is made or not) and reimbursement is provided for any medicine supplied;
- Private patient pays a fee directly to the pharmacy.

[Section B] Regulatory and remuneration frameworks for CAS

3. Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.

a. Practice guidelines and quality assurance	The regulator, the Pharmaceutical Society of Ireland (PSI), publishes practice guidance which is used by pharmacists as the basis for the relevant governance structures for this service. The guidance the PSI has in place is as follows: Guidance for Pharmacists on the Safe Supply of Non-Prescription Levonorgestrel 1500mcg for Emergency Hormonal Contraception Guidance for Pharmacists on the Safe Supply of Non-Prescription Ulipristal Acetate 30mg (ellaOne®) for Emergency Hormonal Contraception An inspector from the PSI may also carry out a visit to review the policies and procedures that are in place to ensure they meet requirements and comply with the guidance they have issued.

	Where the service is being reimbursed under a national programme, probity requirements must be adhered to. The pharmacy must have a consultation room to enable the patient consultation to take place in private.
b. Education and qualification(s)	Training in relation to the delivery of emergency contraception services is incorporated into the undergraduate MPharm programme.
c. Requirements for CAS provision	The service must be provided in accordance with the PSI guidance documents on the safe supply of EHC. It is a requirement that the pharmacist carries out the consultation in relation to the supply of EHC and the consultation must take place in a consultation room which must meet certain standards as outlined in the PSI Guidance on Patient Consultation Areas. To receive remuneration and reimbursement under the GMS and National Free Contraception Scheme pharmacies must comply with the requirements of the Health Service Executive Primary Care Reimbursement Service.

4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.

Under the GMS scheme and the National Free Contraception Scheme remuneration is provided for the consultation (whether supply is made or not) and reimbursement is provided for any medicine supplied.

Reimbursement details can be found within the following circulars issued to community pharmacists about the nationally funded schemes by the Health Service Executive:

Arrangement with Community Pharmacy Contractors in relation to Free Contraception Service

Arrangement with Community Pharmacy Contractors in Context of the Roll Out of Free Contraception Service

Emergency Hormonal Contraception (EHC)

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

Patient need — prior to the reclassification of EHC as an OTC treatment, patients had difficulty accessing emergency contraception services in certain areas of the country (more rural areas in particular) especially over the weekend and out of hours. The introduction of pharmacy-based services addressed this access gap.

Timely access to care — emergency contraception is most effective the sooner it is taken so increasing access to service was very important in this regard.

Equity of access — The GMS scheme was introduced to ensure equity of access for all service users

National policy — policy to ensure improved access to reproductive healthcare for all women laid the foundation for the introduction of the National Free Contraception Scheme

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.

Date	Event(s)

March 2010	Classification change for medicine from prescription only medicine to pharmacy only
July 2017	Product(s) received a reimbursement code from the Health Services Executive
April 2019	Minister establishes a Working Group on Access to Contraception
October 2019	Report of the Working Group on Access to Contraception issued
September 2022	Free contraception scheme announced

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

- Public engagement was mainly word of mouth but was immediate and significant as it addressed a healthcare need of women
- Limited financial resources were a possible reason for the delayed introduction of the GMS scheme but ultimately these were addressed with a view to ensuring equity of access to services
- Implementation in practice was supported by professional organisations and the regulator

8. Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.

☐ Yes ☒ No

[Section D] Mobilisation and ongoing engagement

9. Engaging stakeholders:	
a. With/from other healthcare professional groups	• Close collaboration between professional organisations and the regulator to ensure safe standards of practice • Collaboration and shared messaging with the Health Service Executive Sexual Health and Crisis Pregnancy Programme
b. With/from policymakers	• Identify objectives • Meetings with Department of Health to establish policy in relation to pharmacy involvement in national schemes and associated remuneration/reimbursement. • Collaboration with the Health Service Executive on ways of working and operational aspects of service delivery.
c. With/from the public	• Including pharmacy in publicity • Individual pharmacy promoting the service
d. With/from pharmacists	• Direct communication to members from the IPU. • Creation of a contraception hub on the IPU website. • Providing guidance and support materials such as a standard operating procedure and frequently asked questions guide.

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

A multi-disciplinary approach, focus on citizens' health needs and access to shared learning among organisations.

4.4 New Zealand

Member organisations:	Pharmaceutical Society of New Zealand (joint response with Te Whatu Ora — Health New Zealand – not a member organisation of FIP)
Case study authors:	Elizabeth Johnstone (PSNZ), Billy Allan (Te Whatu Ora – Health New Zealand)

[Section A] Coverage and workflow of CAS

1. Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.

- Skin infections (scabies, headlice, fungal, minor infections)
- Skin (eczema/dermatitis)
- Eyes (infection, inflammation, allergy)
- Dehydration (acute diarrhoea and vomiting)
- Uncomplicated lower urinary tract infection (requires specific pharmacist accreditation for this service)
- Paediatric analgesia/fever
- Analgesia/fever

All of these are province specific and uncomplicated UTI treatment is only offered in one province as part of this CAS. The CAS in New Zealand is not yet nationwide (in 10 of 20 districts).

2. Standard workflow of CAS and how these are structured in the country/territory.

Assess, treat or refer

1. CAS is initiated by either patient or pharmacist.
2. Patient eligibility confirmed.
3. Consultation — patient assessed, and patient history taken. Some pharmacies have electronic access to patient medical records if required.
4. Consultation outcome — patient either referred to primary/secondary care, treated in the pharmacy if required, or counselled on how to manage the condition without supply of a medicine. Pharmacists are paid for the consultation if a medicine is provided or not.
5. Treatment — treatment selected from a set range of government-funded options. If the patient needs or wants a product that is not funded, then the consultation is funded but not the product.
6. Product is dispensed through the pharmacy management system (payment for product and dispensing fee) and consultation claim through a standardised web portal.
7. Patient counselled on any medicine including how to use, common side effects, when and where to seek further help. Information provided on condition, including prevention and self-care measures.

[Section B] Regulatory and remuneration frameworks for CAS

3. Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.

a. Practice guidelines and quality assurance	Because this service sits within the New Zealand Pharmacist Scope of Practice, there are no current professional standards/QA required other than: • Competence Standards for NZ Pharmacists, and • Pharmacy Services Standard (defines the quality and safety requirements for the provision of community and hospital-based pharmacy services and clinical pharmacy services not provided from a pharmacy).

b. Education and qualification(s)	Generally, there are no specific training or CE requirements to deliver the minor ailments service. However, it is recommended pharmacy teams attend the online webinar that covers detailed information on service delivery, funding and clinical support. The exception is for the assessment and provision of treatment for uncomplicated UTIs which require specific individual pharmacist accreditation. The Pharmaceutical Society of New Zealand provided support and information about the service specifications and the included conditions and their treatment.
c. Requirements for CAS provision	The pharmacy must have a suitably sized consultation room, ensuring privacy and confidentiality is maintained. Staff are recommended to review/complete staff training, online material, or refresher courses available to optimise consumers' experiences in accessing treatment and care for minor ailments.

4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.

Pharmacies are reimbursed separately for the consultation and product. The product(s) is dispensed through the pharmacy management system (payment for product and dispensing fee) and consultation claim through standardised web portal.

Pharmacists are paid for the consultation if a medicine is provided or not.

There is no charge to eligible patients. Ineligible patients cannot access the service. Ineligible patients can purchase the service privately.

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

The New Zealand initiative aims to improve access for people who are unable to access care or afford care for these minor ailments. Consistent with the health sector principle in section 7(e)(i) of the Pae Ora (Healthy Futures) Act 2023, MAS also promotes people's health and wellbeing by helping to prevent, reduce, or delay the onset of health needs.

The current service was prioritised using eligibility criteria in areas that had been identified with high pressures on their public health systems, based on hospital emergency department capacity and pressure. MAS are limited to the geographical and patient flow catchment for the priority hospitals (priority areas).

Eligibility criteria includes a person eligible for publicly funded health services in New Zealand, and one of the following:

- A child under 14 years of age;
- A *whānau* (family) member (any age) of a child under 14 years of age, with the same symptoms;
- A holder of a Community Service Card (income support), or the dependent child of a CSC holder and is 14 to 17 years of age; or
- A Māori and Pacific person.

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.

Date	Event(s)

December 2022	CAS first implemented as single district pilot (Hutt Valley)
16 March 2023	Planning for multi district implementation of service (eight of 20 districts)
12 June 2023	Multi-region CAS implemented as a proof-of-concept
30 September 2023	Proof-of-concept closes; evaluation to be completed; future direction to be agreed

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

- Lack of cost benefit analysis of CAS in the New Zealand health system, limiting the programme's wholesale implementation, and restricting it to a four-month proof-of-concept period.
- Acceptance by pharmacy providers in the non-priority areas that the CAS is a proof of concept and will not be extended to other non-priority areas.
- Limited funding for four months only, and limited conditions covered.
- The limited eligibility criteria, other groups wanting to be eligible for funded access to CAS (e.g., immigrant ethnic communities).
- Working with the national pharmaceutical management agency (Pharmac) to ensure all medicines utilised in the CAS are consistent with the New Zealand medicine funding rules.
- What to call the programme. "Ailment" is an archaic word in New Zealand and not well understood. For public messaging, we settled on "minor health condition service".
- Early indications are that there are several unmet needs that the CAS is filling, , even if the menu of conditions covered is limited.
- Pharmacy engagement has been very positive, and welcoming.

8. Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.

☒ Yes ☐ No

Summary or links to study findings: The CAS currently running is a proof of concept (12 July to 30 September 2023). The programme will be evaluated before determining any future investment and the scope of that investment.

[Section D] Mobilisation and ongoing engagement

9. Engaging stakeholders:	
a. With/from other healthcare professional groups	The suggestion of a CAS to relieve some of the system pressures/ winter pressure on public hospital emergency departments was suggested by an interdisciplinary group of pharmacists, general practitioners, representative bodies (e.g., the Pharmaceutical Society of New Zealand), funders (Te Whatu Ora — Health New Zealand). The proof-of-concept CAS is one of 24 interventions.
b. With/from policymakers	As above, policy makers and funders were involved in the initial decision making/triaging of ideas. Building in an evaluation phase to the proof of concept, including consumer feedback.
c. With/from the public	A public communications campaign targeted at the priority areas and target eligibility populations.
d. With/from pharmacists	The CAS was co-designed with the community pharmacy sector, lead pharmacy organisations, with pharmacists leading the service specification/model of care and funding workstreams.

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

Further information is available:
Community Pharmacy Minor Ailments Service, Te Whatu Ora, Health New Zealand

4.5 Scotland

Member organisation:	Pharmacists' Defence Association
Case study author:	Maurice Hickey

[Section A] Coverage and workflow of CAS

1. **Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.**

- Gastrointestinal system (dyspepsia and reflux, GI smooth muscle spasm, irritable bowel syndrome, acute diarrhoea, constipation, haemorrhoids)
- Respiratory (allergy, cough, nasal congestion, nasal allergy)
- Central nervous system (travel sickness, analgesics and antipyretics, migraine)
- Musculoskeletal and joint
- Infections (vaginal candidiasis, fungal skin infections [not nail], warts and verrucae, cold sores, threadworm, head lice, scabies and pubic lice, impetigo, shingles, bacterial skin infections)
- Urinary tract disorders (urinary tract infection [UTI], cystitis)
- Eye (eye infection, dry eye management, allergic eye conditions)
- Ear (removal of ear wax, otitis externa)
- Mouth (oral ulceration and inflammation, oral thrush)
- Skin (eczema and allergy, emollients, bath and shower additives, antimicrobial bath and shower preparations, nappy rash, allergic itch, scalp disorders, boils)

Associated with the above services are several services which are available in the same way as the medicines offered under Pharmacy First, these include public health services like nicotine replacement therapy, unscheduled or emergency supply of most drugs, for example when the patient loses or travels away from home and forgets their drugs, gluten free food services, bridging contraception and emergency hormonal contraception.

Pharmacy First is accessible nationwide from every pharmacy in Scotland and is underpinned by a national formulary.

2. **Standard workflow of CAS and how these are structured in the country/territory.**

The CAS scheme in Scotland is known as Pharmacy First and has been widely publicised by NHS Scotland and the Scottish government. The present scheme has been in place since 2020, when it was updated to replace the simpler CAS known as the Minor Ailments Scheme (MAS) which commenced in 2005. It should be noted though that the original pilot of MAS commenced in 2001.

A Pharmacy First consultation can be initiated on the request of a patient, and no appointment is necessary. Equally, any pharmacist on duty can offer a consultation if they thought it to be appropriate.

A consultation leads to one of three outcomes: advice, treatment or referral. The consultation is recorded on the pharmacy patient medication record system, details of the consultation are logged, a claim is made for payment, and paperwork if necessary is generated to share with the patient's doctor.

Initial versions of MAS offered all OTC and pharmacy-only medicines which were available for sale, which led to some overuse of medicines. Subsequently a MAS formulary was developed (see the approved list) and a limited list of medicines was made available. Patient group directions were put in place to enable prescription-only medicine (POM) antibiotics to be supplied for eye infections and UTIs. The formulary is

continually reviewed and updated every six months. MAS was renamed Pharmacy First in 2020, and since 2021 an expanding range of POM antibiotics, antifungals and antivirals has been added to the scheme.

Unfortunately, there is limited access to patient records, and usually one pharmacist per pharmacy can access the Emergency Care Summary (ECS) if the appropriate permissions are in place. The ECS is a national system and enables enhanced and efficient patient care and it is expected that there will be further roll-out to more pharmacists.

The Scottish government has developed a digital strategy that should lead to all health professionals gaining appropriate read-and-write access to a single patient record.

If the consultation takes place at the patient's regular pharmacy, and most do, the pharmacy's patient management records are currently of most use.

In most consultations the patient does not sign paperwork. However in instances where the pharmacist is required to contact the surgery or other health professionals, then the patient must sign appropriate paperwork.

There is no billing for the CAS that involves patients; medicines in Scotland are delivered free at the point of need. Payment is levied through taxation and payments to the pharmacy contractor in respect of Pharmacy First is made by the Pharmacy Services Division, which is a government-created payment agency.

[Section B] Regulatory and remuneration frameworks for CAS

3. Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.	
a. Practice guidelines and quality assurance	This is the document from the Scottish government to establish Pharmacy First. This is the leaflet for patients explaining how it works for them.
b. Education and qualification(s)	A Pharmacy First consultation may be made by any pharmacist working in a Scottish community pharmacy. There is a requirement for education for every part of the scheme and many pharmacists record these as part of their CPD requirements for the regulator. Each pharmacist on completion of the relevant national patient group direction must inform any NHS Health Board on whose territory the service will be provided that the relevant training has been undertaken. The details are contained here in this example for treatment of skin infection. The declaration made by the pharmacist states that it is the responsibility of each professional to practise only within the bounds of their own competence and in accordance with the General Pharmaceutical Council (GPhC) Standards for Pharmacy Professionals. Pharmacists are also encouraged to record their training on an online platform, such as NHS Education for Scotland's Turas platform. It is possible to undertake the training direct from this online platform.
c. Requirements for CAS provision	Each pharmacy must have a private consultation area or room where patient privacy and confidentiality can be assured. There is no specific directive about minimum levels of equipment, and it can be variable depending on the pharmacy owner. The condition of all pharmacy premises is regulated by the GPhC.
4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.	

There is no billing that involves patients as medicines in Scotland are supplied from pharmacies free at the point of need.

Payment is levied through taxation, and payment to the pharmacy contractor is made by the Pharmacy Services Division. The pharmacist receives no payment in respect of the CAS; provision of Pharmacy First is normally considered a part of their contract of employment. Pharmacy owners are paid a base payment of GBP 8,000 (EUR 9,372) per annum. They are also remunerated for the drugs supplied, and can access other fees for volume of consultations undertaken. Essentially the more consultations they undertake the more they are paid.

Contractors also receive payments of the order of GBP 5,000 (EUR 5,857) per annum to enable training for their pharmacists and accompanying teams, although it is debatable how much money trickles down to employees. There is no protected learning time, and most staff and locum pharmacists must undertake the training away from work and in their own time.

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

The rationale that drove the development of the Scottish CAS was that many patients, as much as 37%, who visited doctors were suffering minor illnesses which could be treated with medicines that were available in community pharmacies. Many were patients who could not afford to buy common medicines available in pharmacies, but who did not pay if they were given a doctor's prescription.

The CAS was designed so that if a patient has a minor illness, a pharmacy is the first place they should go for advice. Patients do not need an appointment and can go to any pharmacy, anywhere in Scotland.

Patients can access the service if they are registered with a doctor in Scotland, or if they live in Scotland.

Government advertising states that pharmacists and their teams are experts in medicines and can help with minor health concerns and are best placed to give patients and carers advice and treatment for minor illnesses.

This has quantifiably led to less pressure on medical services and on minor injury and accident and emergency services. Significant numbers of patients have been treated, without appointment and at weekends in their communities.

It was said that pharmacy should become the gateway to all other health services; this proved to be true during the COVID-19 pandemic, when pharmacies remained open without appointment to patients

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.

Date	Event(s)
2001	First MAS pilot commenced, a second followed some months later
2005	Expansion of national MAS across all Scotland
2017	Major review of scheme and introduction of patient group directions using treatments with POMs
2020	Introduction of new Pharmacy First scheme
2021+	Ongoing extension of conditions and services have been enabled under Pharmacy First, starting with skin infections and shingles in 2021.

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

The major challenge encountered was the popularity of the service. A review was undertaken in 2017 and the main conclusions were:

- On 31 March 2017, 16.4% of the population of Scotland (around 884,000 people) were registered for the MAS. All but one community pharmacy in Scotland had patients registered for the service. The number of registrations had been increasing over previous years, however since July 2016 the number of registrations has continuously decreased. Registrations decreased by 6.6% (from around 947,000 people) between March 2016 and March 2017.
- Between 2007/08 and 2015/16 the number of items supplied under the MAS increased each year. However, in 2016/17 there has been a decrease, with 5.6% fewer items supplied compared with 2015/16, with a corresponding decrease in cost.
- The service supplied over two million items in 2016/17 with a total cost of GBP 4.9 million (EUR 5.7 million). This accounted for 2.0% of all items supplied by community pharmacies in Scotland.
- The most common drug supplied was paracetamol, which accounted for 20.7% of items.
- For patients aged under 16 registered for the MAS in 2016/17, those who lived in the most deprived Scottish Index of Multiple Deprivation quintile received the greatest number of items per 1,000 MAS registrations (2,927 items) while those who lived in the least deprived quintile received the least (2,318 items).

The review of MAS in 2017 led to the development in 2020 of Pharmacy First.

It was reported that in the two years after the launch of Pharmacy First in July 2020 there had been more than three million consultations.

It has been well received by patients and is very popular.

8. **Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.**
☒ Yes ☐ No
Summary or links to study findings: URL: Prescribing and Medicines: Minor Ailments Service (MAS) Outcomes: see above at (7) for summary

[Section D] Mobilisation and ongoing engagement

9. **Engaging stakeholders:**	
a. With/from other healthcare professional groups	The Pharmacy and Medicines Directorate within the Office of the Chief Medical Advisor to the Scottish government commissioned the pilot schemes from 2001 onwards in negotiation with pharmacist and doctor contractual representatives. The original driver was to relieve pressure on doctor-led services by making better use of pharmacy services, thus allowing doctors to concentrate on chronically ill patients while enabling pharmacists to treat those with self-limiting and minor acute illnesses.
b. With/from policymakers	It coincided with a policy shift that led to a proposal that pharmacists should paid not for the volume of prescriptions dispensed, but instead by a hybrid model whereby they were paid less for dispensing but were also paid for the number and quality of other services they could offer.
c. With/from the public	Public Health Scotland engaged in a marketing campaign which raised public awareness of the new services. This took place in all sectors of the media, while information on the new services was pushed out via every NHS health outlet in the country.
d. With/from pharmacists	Regular communications from the government, health boards and the pharmacy contractors' body were disseminated to pharmacists from the outset. Training has been continual from the early days of the MAS and all pharmacists are now used to it, doing it as a matter of course. Training for

	all aspects of the CAS among pharmacy graduates in Scotland is a significant part of the foundation year worked before they sit the examination to join the pharmacy register.

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

The CAS operated as Pharmacy First in Scotland is fairly advanced, and the proposal is to now move to a higher level which is being trialled as "Pharmacy First Plus". This incorporates pharmacist independent prescribers (PIP) and allows pharmacists who have undergone relevant training to prescribe for common clinical conditions, at a level beyond the scope of the standard Pharmacy First service.

Once again, the proposal is designed to ensure the patient receives the most appropriate and expedient care, reducing the pressures on general practice and urgent care colleagues and systems. Conditions may include (but are not limited to):

- Urinary tract infection
- Respiratory infections
- Ear, nose, and throat
- Dermatological presentations
- Allergies
- Eye infections (in conjunction with local optometry services)

All pharmacists entering the pharmacy register from 2026 onwards will have qualified as an independent prescriber, and all existing registrants are being offered the chance to train as prescribers.

My advice to any organisation planning to implement a comprehensive CAS is that is not something which will happen overnight. It will take planning and engagement by pharmacists, other health professionals and patients; the training requirements for the pharmacists involved are not inconsiderable, but such schemes have the advantage that they build on the unique skills pharmacists already have.

In the United Kingdom there are four separate health services, one for each constituent nation. Scotland started work on the first UK CAS in 2001, introduced it nationally in 2005 and has continued to refine and expand it ever since. Northern Ireland followed in 2009 and Wales in 2011, they are all national services and are developing as variations of the original Scottish blueprint. In England, there have been regional initiatives that were limited in time. The present English Department of Health and Social Care have announced that they would be rolling out a national CAS scheme in the next few months.

In summary, I believe that as an example of best practice and good pharmaceutical care in the community, a well organised and run common ailments scheme must rank amongst the best patient-based services that pharmacy as a profession can offer.

4.6 South Africa

Member organisation:	Pharmaceutical Society of South Africa (PSSA)
Case study authors:	Mariet Eksteen, Jackie Maimin, Sham Moodley

[Section A] Coverage and workflow of CAS

1. Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.

The following common ailments can be treated by pharmacists nationally without medical prescriptions, referred to a pharmacist-initiated therapy (PIT):

Dental and oral conditions

- Oral candidiasis (thrush)
- Uncomplicated gingivitis
- Periodontitis
- Herpes simplex infections of the mouth and lips
- Aphthous ulcers
- Infant teething
- Toothache

Gastro-intestinal conditions

- Abdominal cramps in adults
- Dyspepsia, heartburn and indigestion in adults
- Gastro-oesophageal reflux/disease in infants
- Nausea and vomiting, non-specific
- Travel sickness
- Anal fissures
- Haemorrhoids
- Constipation
- Diarrhoea
- Ascariasis
- Irritable bowel syndrome
- Indigestion
- Gripe/colic/wind

Nutrition and anaemia

- Anaemia, iron deficiency
- Uncomplicated severe acute malnutrition / moderate acute malnutrition / failure to thrive
- Vitamin deficiencies
- Mineral deficiencies (calcium, magnesium, potassium)

Skin conditions

- Dry skin
- Itching (pruritus)
- Acne vulgaris (mild)
- Candidiasis, skin
- Athlete's foot (tinea pedis)
- Pityriasis versicolor (tinea versicolor)
- Head, body and pubic lice
- Scabies
- Eczema, atopic
- Dermatitis, seborrheic
- Allergic contact dermatitis
- Furuncle (unspecified)
- Local infection of skin and subcutaneous tissue (unspecified)
- Nappy rash (diaper dermatitis)
- Urticaria
- Papular urticaria
- Pityriasis rosea
- Common, plane and plantar warts
- Albinism
- Pressure ulcers/sores
- Threadworm

Obstetrics and gynaecology

- Antenatal supplements
- Cracked nipples during breastfeeding
- Vaginal candidiasis/thrush
- Bacterial vaginosis

- Vaginal dryness
- Dysmenorrhoea

Family planning
- Contraception, barrier methods
- Contraception, emergency

Infections and related conditions
- Chickenpox
- Fever
- Mumps
- Rubella (German measles)
- Uncomplicated urinary tract infections

Immunisation
- Hexavalent (DTaP-IPV0HB-Hib) vaccine
- Tetanus and diphtheria vaccine
- Oral polio vaccine
- Rotavirus vaccine
- Pneumococcal conjugated vaccine
- Measles/Measles-mumps-rubella/Measles-mumps-rubella-varicella vaccine
- Papilloma virus types 6 and 11
- Hepatitis B
- Influenza vaccine
- Meningococcal vaccine
- Typhoid vaccine

Musculoskeletal conditions
- Arthralgia
- Rheumatoid arthritis
- Acute gout
- Osteoarthrosis (osteoarthritis)
- Traumatic arthropathy
- Disorder of muscle, unspecified

Central nervous system conditions
- Headache, mild, non-specific
- Post-vaccination pyrexia
- Migraine
- Sleep disorder, unspecified

Respiratory conditions
- Influenza
- Acute nasopharyngitis (common cold or coryza)
- Acute pharyngitis (sore throat)
- Upper respiratory tract infections (mild/uncomplicated)
- Cough
- Allergic rhinitis (hay fever)
- Acute sinusitis
- Nasal congestion
- Asthma (mild, uncomplicated)

Eye conditions
- Allergic conjunctivitis
- Viral conjunctivitis (pink eye)
- Hordeolum and other deep inflammation of eyelid (stye)
- Other disorders of lacrimal gland (dry eyes)

Ear, nose and throat conditions
- Earache
- Swimmer's ears
- Mouth ulcers
- Impacted cerumen

Pain
- Acute pain

Emergencies and injuries
- Nosebleed (epistaxis)
- Insect bites and stings
- Minor burns

General
- Malaria prophylaxis

Reference: Primary Health Care Standard Treatment Guidelines and Essential Medicines List, published by the National Department of Health (NDoH).

2. Standard workflow of CAS and how these are structured in the country/territory.

Provision of PIT for CAS follows the same pattern as for dispensing of a prescription, as described in Good Pharmacy Practice Rule 2.7 published by the South African Pharmacy Council.

1. Patient approaches pharmacy/pharmacist with a request or health-related issue;
2. Pharmacist takes a patient medical history, including current signs and symptoms;
3. Pharmacist considers possible differential diagnoses;
4. Pharmacist asks further clarity-seeking questions, and performs appropriate screening tests with consent, to rule out/confirm possible diagnosis, and patient provides information and/or participates;
5. Pharmacist counsels the patient and may recommend a symptomatic treatment plan (including over-the-counter medicines, which the patient may agree or disagree to take, or if pharmacist thinks the patient's need is not a common ailment, refer to a general practitioner for intervention;
6. Pharmacist dispenses medicines according to record-keeping legislation as included in the General Regulations (regulation 35) to the Medicines and Related Substances Act (internal patient recordings, not full patient health records);
7. Patient signs a copy of pharmacist-initiated prescription; and
8. Patient makes payment through selected payment option (third party payer, cash).

[Section B] Regulatory and remuneration frameworks for CAS

3. Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.

a. Practice guidelines and quality assurance	Provision of PIT as part of the scope of practice of a pharmacist is included in the Regulations relating to the scope of practice, Regulation 3(1)(e) and 4 published by the National Department of Health. Minimum standard for provision of PIT as a service to patients, as per the Good Pharmacy Practice rules, number 2.12, p31 published by the South African Pharmacy Council. Medicines and related substances, as included in Schedule 1 and Schedule 2 in the Medicines and Related Substances Act, 101 of 1965, may be dispensed by pharmacists without a prescription from a medical

	practitioner, as allowed in Section 22A(4)(a) and (5)(a) as published by the National Department of Health.
b. Education and qualification(s)	The BPharm degree equips graduates with the skills for PIT, enabling pharmacists to treat common ailments as included in the 2018 Competence Standards for Pharmacists in South Africa, number 2.6 on page 23 published by the South African Pharmacy Council. CPD has been compulsory since 2020 for pharmacists in any field of the competency standards, following the publication of the regulations relating to continuing professional development published by the National Department of Health.
c. Requirements for CAS provision	With regard to consultation rooms, minimum equipment, staffing etc, minimum standards for pharmacy premises, facilities and equipment, Good Pharmacy Practice rules number 1.2, p35 as published by the South African Pharmacy Council. Premises inspections are conducted in every pharmacy to ensure adherence to minimum standards.

4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.

Pharmacist may levy a fee to charge for certain services and the rules relating those fees are outlined under service code 0028 This is the fee for the service, however, the implementation of this fee is not compulsory, nor is it a maximum or minimum fee. The fee is not enforced to be remunerated by third party payers.

A dispensing fee for pharmacists is calculated for each item dispensed based on the single exit price of each product. The dispensing fee is the only professional remuneration a pharmacist receives for dispensing medicines. This fee is a maximum fee, and not compulsory to charge. Unfortunately, the 2023 fee is not yet published, only a draft fee.

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

Two important considerations are the move to universal health coverage and the adoption of self-care. Pharmacists can assist the government to achieve both if a proper reimbursement model is included in future plans.

To this end two submissions, one to the Green Paper on National Health Insurance (NHI) in parliament, and a second to the Council For Medical Schemes, both outline a process to make it compulsory for PIT to be included in the legislative programme.

The priority areas include all of the above in Question 1 and further the newly introduced Pharmacist-Initiated Management of Antiretroviral Therapy programme.

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.

Date	Event(s)
Aug/Sep 2023	Liaison with Council for Medical Schemes for inclusion of CAS in the scheme rules for 2024
Ongoing	Liaison with government for inclusion of CAS in the NHI plans for South Africa

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

In South Africa, we have difficulty convincing payers to pay for PIT. Payers normally only pay for the medicines dispensed. Pharmacists themselves are reluctant to charge for this service which the South African Pharmacy Council has regulated.

Secondly, there are no proper guidelines or a scientific basket of products that pharmacists can easily refer to ensure standardisation.

We do not have a central data base to accumulate the intervention data. Also, it is difficult to show outcomes and savings from the intervention because of the lack of data.

8. **Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.**
☐ Yes ☒ No

[Section D] Mobilisation and ongoing engagement

9. **Engaging stakeholders:**	
a. With/from other healthcare professional groups	No engagement
b. With/from policymakers	Presentation on relevant Green/White Paper when invited for comment Presentations to Payers in Government Medical Scheme Presentation to Parliament of South Africa
c. With/from the public	Ask Your Pharmacist Campaign Adcock Ingram's Sponsors of Brave Campaign Variety of TV and radio interviews
d. With/from pharmacists	Presentations at conferences Regular input in newsletters

10. **Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?**
1. Clearly define the common ailments that your pharmacists are qualified to deal with; 2. Design algorithms with scientific protocols; 3. Design a basket of cost-effective medicines to use; 4. Get evidence-based data on possible cost savings to your health systems; and 5. Present to payers/government.

4.7 Spain

Member organisation:	General Pharmaceutical Council of Spain
Case study authors:	Juan Iniesta Meco, Álvaro Salcedo Gómez, Tamara Peiró Zorrilla

[Section A] Coverage and workflow of CAS

1. **Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.**

According to the consensus document of the Ministry of Health in 2001, the Minor Ailment Service (MAS) is the service provided by a community pharmacist when a patient seeks their advice about a possible treatment for a health problem. In other words, the patient asks, "what can you give me for . . . ?" This always involves those self-limited symptoms or syndromes for which the legislation allows dispensing a medicine without a prescription. It may also involve referral to a doctor if necessary.

In Spain, a minor symptom is any condition that meets the following criteria: mild in nature, easily recognisable, short in duration, unrelated to the clinical manifestations of other health problems suffered by the patient or to the effects of the medicines taken, not requiring a medical diagnosis and responding to or relieved by mild symptomatic treatment that does not require a medical prescription. These minor symptoms include more than 30 symptoms such as: heartburn, headache, nasal congestion, diarrhoea, dysmenorrhoea, sore throat, constipation, fever, haemorrhoids, dry eye, flatulence, colds, etc.

2. Standard workflow of CAS and how these are structured in the country/territory.

In 2009, in Spain, a collaborative working group called Pharmaceutical Care Forum in Community Pharmacy was created with the objective of defining and proceeding with the Clinical Professional Pharmacy Service (CPPS). Regarding the MAS, it is defined as "the professional service provided upon the request of a patient or user attending the pharmacy without knowing which medicine to buy and asks the pharmacist for the most appropriate remedy for a specific health problem". Therefore the service is initiated upon a patient's request for a consultation about a minor symptom, and follows the procedure outlined below. The patient does not need to sign any informed consent because the consultation can be done anonymously.

Interviewing the patient

- Who is conducting the consultation?
- What is the reason for the consultation?
- Timing of consultation

Previous actions taken

- Other medicines used for other diseases

Known allergies and intolerances

- Concomitant diseases, pregnancy, lactation, or other special physiological conditions

Evaluation of the information

- The information obtained is evaluated, identifying whether there are criteria for referral to a doctor or whether medication-related incidents have been identified.

Action or intervention, in the event of an incident

- If an incident is detected, the pharmacist will make the appropriate intervention: provide personalised information about the medicine, offer health education, refer to another CPPS, among others.
- Depending on the information obtained at this point, the pharmacist may act in different ways: providing a pharmacological treatment that does not require a prescription, a non-pharmacological treatment, providing hygienic-dietary measures, referring to the primary care physician, to another health professional or to another CPPS. Several actions can be followed.

Registration and evaluation of the service process

- The pharmacist will register and document the interventions and actions carried out. This record is not mandatory for the pharmacist and the patient does not have access to it.

The pharmacist does not have access to the patient's medical record, so it is essential to ask the patient about all their diseases and the medicines they have been prescribed so as not to give an

indication that interferes with the patient's underlying conditions or, for example, to detect that it is an adverse drug reaction to a medicine the patient is taking.

[Section B] Regulatory and remuneration frameworks for CAS

3. Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.	
a. Practice guidelines and quality assurance	According to the Medicines Guarantees and Rational Use Law, Article 19 establishes conditions for the dispensing of non-prescription medicines: The Spanish Agency of Medicines and Medical Devices may classify as non-prescription medicines those medicines intended for processes or conditions that do not require a precise diagnosis and whose toxicological or clinical evaluation data or their use and route of administration do not require a medical prescription, so that these medicines may be used for self-care, by dispensing them at the pharmacy by a pharmacist, who will inform, advise and instruct on their correct use.
b. Education and qualification(s)	To work as a pharmacist, a degree or graduate qualification is required, although no additional training is necessary to practise as a pharmacist. At the national level, the Medicines Guarantees and Rational Use Law mentions that: (i) The presence and professional performance of the pharmacist as an essential condition and requirement for the dispensing of medicinal products to the public, considering the number of pharmacists necessary according to the activity of the office — Article 85 (b) (ii) The public administrations shall ensure the continuous training of pharmacists and the appropriate qualifications and training of pharmacy assistants and technical pharmacy assistants — Article 86.5.
c. Requirements for CAS provision	The CAS is a CPPS with no requirements for the provision of the service, except that it must be performed in a community pharmacy. The pharmacy may have a personalised care area where this service can be provided to patients in a more private environment, if required, but this is not a requirement for the provision of this service.
4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.	
For the time being, CAS in Spain is not remunerated either by the administration or by patients and, therefore, there is no financial reimbursement or billing policy applied to the provision of this service. The pharmacist will be paid the margin for the non-prescription medicine dispensed, but there is no specific fee for the service from the government at the level of the administration.	

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

The CAS is one of the services provided by community pharmacists in Spain since the beginning of the profession, as the legislation gradually established it as a service to be provided by a pharmacist.

The implementation of CAS has several benefits for both the patient and the health system.

- Optimising the use of medicines in self-limiting processes.
- Providing a great relief for the health system, freeing up primary care consultations, while not reducing the quality of patient care. As a result, it promotes accessibility to primary care for patients and medical care for complex and chronic patients.
- The pharmacy provides correct information on non-prescription medicines for their appropriate use. These medicines in Spain cannot be found in any other establishment and are not available to the public; they must always be provided to the patient by the pharmacist in a community pharmacy.

In relation to the healthcare system, the CAS increases the capacity of primary care by transferring consultations to community pharmacies, optimizes healthcare costs, promotes collaboration between healthcare professionals and balances health inequalities. In conclusion, it contributes to the sustainability of the health system.

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.

In Spain, the CAS is a CPPS provided since inception of the pharmacy profession and does not require training or specialisation. It is a service provided daily in all pharmacies throughout the country.

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

The main barriers identified during the delivery of CAS were:

- Pharmacy owner's perception of the benefits of CAS;
- Motivation of the pharmacy team; and
- Time for CAS to be carried out and communication of the team.

All these barriers are mainly related to remuneration, as pharmacists, especially owners, will perceive less benefit from the service because they do not receive a fee for service. Likewise, the main challenge of the MAS is to demonstrate to the administrations the benefits for the patients and, therefore, to increase their capacity to manage and control a growing number of health problems (not only minor symptoms) from the community pharmacy.

The main limitation of the service is that the community pharmacy does not have access to patients' clinical records. It would help them carry out the service better and more quickly and effectively if all the diseases and medicines used by patients were available to them.

8. Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.

☒ Yes ☐ No

Summary or links to study findings:
In Spain, some research has been conducted to measure the impact and implementation of the MAS in the context of community pharmacy.

Outcomes:

- The provision of CAS enabled a significant increase in the detection of referral criteria and was demonstrated to increase the safety of patients presenting with minor symptoms.

- Patients who consulted a community pharmacy obtained greater resolution of minor symptoms than those who went to a health centre.
- The number of treatments received by patients to alleviate a minor symptom was reduced.
- The estimated savings in community pharmacy from the implementation of the service were between EUR 30 million and EUR 121 million per year through the transfer of minor symptom consultations from health centres to community pharmacies, including the corresponding remuneration to the pharmacy.

[Section D] Mobilisation and ongoing engagement

9. **Engaging stakeholders:**	
a. With/from other healthcare professional groups	This CPPS is one of the most favourable means of communication between healthcare professionals, specifically with GPs. This is because they often identify incidences such as, for instance, a health problem that is not a minor symptom and therefore requires a referral to a doctor. Collaboration strategies between these health professionals include meetings with multidisciplinary teams or referral protocols for doctors validated by scientific societies are some of the examples.
b. With/from policymakers	Pharmacy representatives bodies hold regular meetings with the Ministry of Health to highlight the role of pharmacists in this service, and provincial pharmacy chambers meet with regional authorities in each autonomous community.
c. With/from the public	Patient-facing campaigns, workshops and courses are carried out by pharmacists with patients, as well as multidisciplinary webinars aimed at the population with minor symptoms. In this way, patients can be made aware of the situations in which they can consult a pharmacy before consulting a doctor for the treatment of a minor symptom, avoid self-medication and, in the case of non-prescription medicines, promote greater knowledge of the correct use of the recommended treatment by the pharmacist.
d. With/from pharmacists	For pharmacists, there are campaigns designed to raise awareness of minor symptoms such as dry eye, sunburn, etc. In addition, the General Pharmaceutical Council of Spain provides continuing education courses that update pharmacists' knowledge of minor conditions. It also provides a registration platform to document the CAS and have alerts on interactions, contraindications, etc., as well as non-prescription medicines that could be indicated in each case.

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

It is necessary to establish a procedure to provide the service in a proper and standardised manner for all pharmacies, thus giving equal access to all pharmacies. In addition, pharmacies should be provided with training and a registration platform to encourage the use of this procedure.

It is also necessary to encourage coordination and collaboration sessions with GPs and jointly draw up referral procedures and criteria to be observed by the pharmacy, as this will favour the relationship between both professionals.

Carrying out the CAS in community pharmacy results in a greater resolution of minor symptoms than where patients go directly to a health centre, as well as reducing the number of treatments received by the patient to relieve a minor symptom. When carrying out the service, it is advisable to have a space for personalised patient care in the community pharmacy.

In conclusion, community pharmacies can promote the rational use of medicines and contribute to the sustainability of the healthcare system.

4.8 Switzerland

Member organisation:	PharmaSuisse, the Swiss association of pharmacists
Case study author:	Martine Ruggli

[Section A] Coverage and workflow of CAS

1. Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.

- Acne
- Allergic rhinitis
- Atopic dermatitis
- Back pain
- Burns
- Conjunctivitis
- Cystitis
- Diarrhoea
- Dyspepsia
- Eczema
- Emergency contraception
- Follow-up of asthma
- Headache
- Herpes zoster
- Impetigo
- Mycosis on hands and feet and skin
- Obstipation
- Pharyngitis
- Sinusitis
- Thrush
- Tick bite
- Tinea versicolor
- Vulvo-vaginitis
- Warts

The CAS is nationwide but not all pharmacies are offering it.

Also, it is possible to extend a prescription of a physician for one year.

2. Standard workflow of CAS and how these are structured in the country/territory.

- Initiation on demand of the patient or by the pharmacist
- Counselling with documentation in consultation room
- Possibility of providing OTC medicines, prescription only-medicines that pharmacists can now prescribe themselves or also, in special cases, all prescription-only medicines (also antibiotics) but not narcotics.
- Documentation in the pharmacy, possibility to transmit the information to the physician.
- Patient must sign paperwork.
- Billing: some healthcare insurance plans pay for the counselling but not for the medicines, and for the other cases the patient must pay for everything
- Pharmacists have the right to prescribe in Switzerland

[Section B] Regulatory and remuneration frameworks for CAS

3. Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.	
a. Practice guidelines and quality assurance	There are no regulatory requirements. The algorithms are developed and validated with physicians. They are digitalised. There is interprofessional collaboration in certain cases still today: back up from telehealth centres or from healthcare insurance centres, sometimes also from physicians or from hospitals.
b. Education and qualification(s)	In Switzerland there is a postgraduate certificate for CAS. It is not mandatory but if the healthcare insurance is paying for the service, they can ask for it.
c. Requirements for CAS provision	Consultation rooms are mandatory. A first assessment can be done by technicians and then the patient is taken into a consultation room where a pharmacist will take over.

4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.
Reimbursement depends on the healthcare insurance. If not paid by the healthcare insurance, the patient that must pay. Insurance pays for the service but not for the medicines.

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.
We implemented the service 11 years ago with the support of a telemedicine centre if the patient needed it (the patient had a consultation with a tele physician who afterwards also spoke with the pharmacists and gave treatment recommendation). We wanted to develop new services for pharmacists and for the healthcare system and have a new collaborative service with physicians.

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.
No data provided.

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.
• Change of the work process in the pharmacy; • Pharmacists' lack of confidence; • Megative reaction from doctors, who even threatened pharmacists who wanted to offer the service; • Service had to be paid for by the patient (no insurance coverage at the beginning); and • Extensive training required.

8. Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.
☒ Yes ☐ No

Summary or links to study findings:
URL: netCare, a new collaborative primary health care service based in Swiss community pharmacies

Outcomes:
Pharmacists from 162 pharmacies performed 4,118 triages over a period of 21 months. A backup consultation was needed for 17% of the cases. In follow-up calls, 84% of the patients who were seen only by pharmacists reported complete relief or symptom reduction.

Conclusions: netCare (the name of the CAS programme) is a low-threshold service by which pharmacists can manage common medical conditions with physician backup, if needed. This study showed that a pharmacist could resolve a large proportion of the cases. However, to be efficient and sustainable, this service must be fully integrated into the healthcare system.

[Section D] Mobilisation and ongoing engagement

9. Engaging stakeholders:	
a. With/from other healthcare professional groups	We had a close collaboration with Switzerland's biggest telemedicine centre. We developed all the algorithms and the education concept together, and trained the pharmacists together. The physicians of the centre also had training on how to work with the pharmacists. The pharmacists visited the centre to meet the physicians with whom they would be working together
b. With/from policymakers	We established the programme without approval of the government, which did not want to extend pharmacist competencies at that time. But as we were able to demonstrate the added value of the new service, the government changed the law to give us prescription rights.
c. With/from the public	The collaboration with the telemedicine centre and to be able to have a physician consultation via video in the pharmacy was revolutionary 11 years ago. We had impressive media coverage
d. With/from pharmacists	There was intensive collaboration with the pharmacists involved. Training programmes were many times improved and adapted for the needs of pharmacists. We also offered a half a day's coaching in the pharmacy if wanted.

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

CAS is a great service. Try it!
We helped the implementation of the service in France, in collaboration with Pharmasystème Qualité and it was able to launch the programme as a pilot project in Brittany based on the netCare CAS from Switzerland. It is a huge success in France, and it is fully remunerated.

4.9 United States of America

Member organisation:	American Pharmacists Association
Case study authors:	Michael Murphy, Brigid Groves

[Section A] Coverage and workflow of CAS

1. Clinical area(s) or common ailment(s) currently covered by the CAS or an equivalent scheme, and whether the list applies nationwide or is state/province-specific.

Nationwide (9 September 2021–11 May 2023)

- COVID-19

State-specific

- Influenza
- Group A streptococcus pharyngitis
- COVID-19
- Lice
- Skin conditions, including ringworm and athlete's foot
- Hormonal contraceptives
- Emergency contraceptives
- HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)
- Tobacco cessation
- Opioid antagonists

2. Standard workflow of CAS and how these are structured in the country/territory.

Workflows are typically dictated through state regulatory agencies and are either adopted as official regulations of the state or are official protocols endorsed by the state. Workflows commonly include the following:

- Requirements for pharmacists to participate (licensure, education, training, etc);
- Steps to assess if a medicine is appropriate for the patient;
- Steps to prescribe a prescription or over-the-counter medicine, including necessary lab work;
- Steps to refer a patient to another care provider;
- Patient education requirements;
- Patient follow-up requirements; and
- Documentation requirements.

In response to these workflow categories, we provide the following. It is important to note that the specifics of workflow for all programmes are variable between disease-state protocols and between states.

(1) CAS Initiation by patient/pharmacist

Initiation of the workflow is variable across states, and may be initiated by patients, by pharmacists, or through a referral from another healthcare professional. In some instances, a referral may be required not only to initiate the service, but also to subsequently bill a government-funded or privatised health insurance plan for the cognitive services provided by the pharmacist.

Initiation of the workflow typically begins with an assessment of the patient to determine if they meet inclusion or exclusion criteria to receive the service. Inclusion and exclusion criteria may include the result of a lab or point-of-care-test, patient's age, potential exposure to a bacterial or viral infection, patient's symptoms, patient's medication list, patient's past medical history, and other considerations or specific risk factors.

(2) Counselling

Protocols may or may not include specific patient education or counselling requirements. If patient education or counselling requirements are included in protocols, they may include the following:

- Proper storage and use of the medicine;
- Medication adherence recommendations;
- Signs and symptoms of bacterial or viral infection;
- Follow up instruction with other healthcare professionals; and
- How to administer the medicine if not orally administered, and proper disposal.

(3) Providing over-the-counter or prescription-only medicines

Protocols may include over-the-counter or prescription-only medicines. This depends on the specific protocol, the disease-state, and the state. For example, tobacco cessation protocols may

include both nicotine replacement therapy, which is a group of over-the-counter medicines, and other prescription-only medicines used for tobacco cessation.

(4) Reading/writing access to patients' records
Access to patients' records may or may not be a requirement for participation in a protocol but may help in increasing the efficiency of care delivery to a patient. For example, between 6 July 2022 and 11 May 2023, pharmacists could prescribe COVID-19 oral antivirals nationwide via temporary authority granted by the federal government and a protocol developed by a federal agency. To prescribe the COVID-19 oral antiviral, the pharmacist first had to review the patients renal and hepatic function, and their medicines list. While access to a patient's records was not an explicit requirement to participate in the programme, the ability to access the patients' records could increase how efficiently the pharmacist could prescribe the COVID-19 oral antiviral.

This example can translate to other state protocols that may include requirements to review past medical history, medicines lists, and lab results which may be efficiently reviewed through accessing a patients' records.

(5) Patient signs paperwork
It is not common for a patient to be required to sign paperwork or a protocol. In some instances, patients may be asked to sign or read language asking them to consent to treatment in the protocol. This consent may be a requirement within a protocol as directed by the state government or a private policy adopted by the pharmacy.

(6) Billing
There is currently no ability to directly cover pharmacists' services under the United States national health insurance plan for older adult patients (Medicare). Over the past 10 years, there has been an expansion of coverage of pharmacists' patient care services in state administered health insurance plans for patients under a level of the poverty line (Medicaid — 31 states) and in privatised health insurance plans (13 states). In these programmes, pharmacists' services are commonly being covered similarly to how other healthcare professionals' (physicians, nurse practitioners, physician assistants, etc) services are being covered. The coverage for pharmacists' services is distinct from the coverage for the medicine and the dispensing of the medicine.

(7) Pharmacist prescribing authority
Pharmacists' prescriptive authority is often tied to authority designated by state government agencies. This is often through umbrella prescriptions that can be used to dispense a medicine for any patient within specific inclusion and exclusion criteria or through a protocol that includes specific parameters for the prescribing of a medicine. In rare instances, pharmacists may be granted independent prescriptive authority by their state government. In these instances, pharmacists have authority to prescribe medicines for specified indications that is comparable to that of physicians.

[Section B] Regulatory and remuneration frameworks for CAS

3. **Professional standards and/or regulatory requirements for pharmacists or pharmacies to provide CAS in the country/territory.**	
a. Practice guidelines and quality assurance	Practice guidelines vary between state and protocol. In general, pharmacists are expected to adhere to the most recently accepted guidelines of their practice. However, in rare instances pharmacists may be required to practise informed by certain political decisions, which may or may not align with generally accepted guidelines of their practice.

b. Education and qualification(s)	For pharmacists to participate in protocols, they are required to have an active registered pharmacist licence by their state government. Since 2006, to achieve this pharmacists have been required to complete a doctor of pharmacy degree programme at an accredited university and subsequently pass a national clinical exam and state law exam. Beyond licensure requirements, many protocols require additional educational requirements of pharmacists, such as completing training programmes for a specified period on a topic relevant to the protocol.
c. Requirements for CAS provision	There are rarely additional requirements beyond education for pharmacists to provide care comparable to a CAS. In very rare instances, there may restrictions on pharmacists' ability to bill for their services if they do not meet specific requirements (having a licence beyond a registered pharmacist, receiving a referral from a prescribing practitioner, only providing a specified number of services per year, only providing services within a specific geographical area within a state, etc).

4. Financial reimbursement and/or billing policy in place for pharmacists who provide CAS services to eligible patients.

See section *"6. Billing"* in the standard workflow section above.

[Section C] Details of the implementation process

5. Most important factor(s) or key priority area(s) that the country/territory considered for the implementation of a CAS or an equivalent scheme.

There is not currently a nationwide scheme in place in the United States because pharmacists' scope of practice is dictated by state-level governments. At the state level, there are various factors that are considered throughout the policymaking process and the implementation process. Public health outcomes are a focus throughout the policymaking and implementation process to understand gaps in public health that pharmacists could fill through the completion of the scheme.

Throughout the policymaking process, the economic factors of the scheme are consistently focused on. This is an important consideration for policymakers as they are evaluating government budgetary impacts of the scheme. Additionally, throughout the policymaking process, support from relevant stakeholders is necessary. This support may include organised medicine associations, individual physicians, patients and patient advocacy organisations.

Throughout the implementation process, pharmacists' education and workflow are key areas of focus. This is to ensure pharmacists have appropriate training to provide the services and have the resources to incorporate the services into their current workflow. Additionally, patient education is important through the implementation process. This is to show patients that they can receive these services from their pharmacist and to market to the community of this new health care offering.

6. Timeline of the process towards achieving and/or expanding the CAS authority of pharmacists.

Date	Event(s)
Non-applicable	CAS authority is determined by state governments and is variable between states and between protocols within states.

7. Main challenges and/or limitations during the implementation process of the CAS in the country/territory.

The main challenges related to the implementation of CAS in the US include coverage of pharmacists' services under government-funded or privatised health insurance plans. Under the counties national health insurance plan for older adults (Medicare), there is not currently ability for pharmacists to directly bill for their services. However, there has been an expansion of coverage in Medicaid (31 states) and commercial insurance (13 states) in the states. Additionally, pharmacists face opposition from organised medicine and challenges related to pharmacists implementing programmes (cost of IT, billing software, electronic health records, building consultation room, etc).

8. Existence of a pilot programme or a post-implementation assessment to measure the impact of CAS implementation.

☐ Yes ☒ No

[Section D] Mobilisation and ongoing engagement

9. Engaging stakeholders:

a. With/from other healthcare professional groups	State pharmacy associations frequently interact with state medical associations when planning to introduce legislation to expand pharmacists' scope of practice. Often these discussions result in negotiations and compromises that eventually inform the legislative process. In rare instances, state pharmacy associations and state medical associations will partner together on legislation that expands the scope of practice of pharmacists.
b. With/from policymakers	Pharmacy stakeholders frequently engage with policymakers when expanding opportunities for pharmacists to provide care via protocols. Pharmacy stakeholders frequently leverage community advocates from geographical areas that policymakers represent to increase the relevance of the issues they are advocating. Additionally, pharmacy stakeholders frequently utilise scientific literature to exemplify the evidence supporting the policy that is being advocated.
c. With/from the public	Pharmacy stakeholders frequently leverage patients to support efforts to increase access to pharmacist provided care. Additionally, pharmacy stakeholders frequently partner with patient advocacy organisations to further elevate the importance of the policy that is being advocated to specific patient populations.
d. With/from pharmacists	Pharmacists are frequently engaged throughout the process of implementing protocols that increase access to pharmacist provided patient care. Throughout the policy process, pharmacists are engaged to advocate to their elected officials. Following the policy process, pharmacists are engaged through educational offerings and implementation resources to support their rollout of programmes.

10. Additional comments: what general tips and advice would you give to other member organisations who are considering the implementation of CAS?

If possible, we would recommend against policies related to scope of practice and reimbursement being limited to a state or locality. While the ability to dictate these policies at the state government level allows for a greater level of innovation, this is offset by a significant amount of negative and unintended consequences. Negative consequences include extreme variability in what a pharmacist is authorised to do from one state to another, variability in whether a pharmacist is authorised to bill for their services from one state to another, and instead of one policy change needing to be made there are more than 50 policy changes that need to be made. Unintended consequences include, but are not limited to, challenges with national pharmacy

businesses rolling out programmes due to the variability between state in what a pharmacist can do and their ability to bill for services as well as differing patient access to these services.

5 Insight board discussion

To explore the role of pharmacists globally in the effective management of common ailments, specifically within the framework of common ailment schemes (CAS), FIP convened an insight board small group discussion meeting on 26 July 2023. Among the goals were to collate international best practices and gain qualitative insights from the individuals and organisations involved in CAS, and to convey crucial advocacy messages to interested member organisations, pursuing avenues for optimising pharmacists' involvement in CAS.

5.1 Methods

5.1.1 Recruitment of participants

Participants were selected from a group that represented the member organisations of various eligible countries or territories. These were identified through a survey conducted earlier in the project, as detailed in Chapter 3. The eligibility criteria included any FIP member organisation that reported having implemented CAS or equivalent programmes in their respective countries or territories.

From June to July 2023, invitation letters were emailed along with a comprehensive briefing document. This document provided detailed information about the insight board discussion and the conditions for participation. If the invited representatives were unable to participate but still wished to contribute, they were encouraged to extend the invitation to their colleagues within their organisation who might be interested.

5.1.2 Data collection and analysis

In anticipation of the insight board meeting, a thorough discussion guide was developed to ensure the seamless facilitation of the session and the strategic collection of insights. The discussion guide underwent validation to confirm question validity and ensure a coherent discussion flow. During the discussion, the following questions were asked:

- What are the best outcomes expected from implementing CAS?
- What are the potential barriers or limitations of CAS implementation?
- What advocacy messages would you suggest for other member organisations interested in implementing CAS?

Prior to the insight board, all participants were appropriately informed about the recording of the discussion, with the understanding that the collected data would be used to formulate this report. Furthermore, explicit verbal consent was obtained from each participant for the inclusion of their names and roles in the final report.

The insight board discussion was conducted exclusively through the online platform Zoom, overseen by a moderator and supported by two note-takers. The moderator's role was to ensure the discussion remained centred on the designated topic, while the note-takers recorded field notes and offered technical assistance to participants encountering any issues.

After the meeting, participants were encouraged to provide further comments if they wished to contribute additional viewpoints. Following the session, the recording and transcript from the insight board were retrieved, and participant responses were analysed and interpreted. A total of 10 participants from nine different countries attended the virtual meeting. The names and affiliations of the participants who engaged in the discussion are presented below in Table 5.

Table 5. Participant names, roles and representing member organisations and countries.

Country/Territory	Name	Role	FIP member organisation
Australia	Sarah Dineen-Griffin	Moderator/Vice President of the FIP Community	

Country/Territory	Name	Role	FIP member organisation
		Pharmacy Section Executive Committee	
Canada	Kelsey Skromeda	Policy and research manager	Canadian Pharmacists Association
England, UK	Bharat Nathwani	Policy officer	Pharmacists' Defence Association
Ireland	Susan O'Donnell	Professional services pharmacist	Irish Pharmacy Union
New Zealand	Billy Allen	Pharmacy team manager	Te Whatu Ora – Health New Zealand / Ministry of Health (on behalf of Pharmaceutical Society of New Zealand)
Portugal	Maria João Mendes	Area manager at Centre of Medicines Information and Pharmaceutical Interventions	National Association of Pharmacies
Scotland, UK	Maurice Hickey	Head of policy	Pharmacists' Defence Association
South Africa	Sham Moodley	Vice chair, board of directors	Independent Community Pharmacy Association
Spain	Álvaro Salcedo Gómez	Pharmacy care services technician	General Pharmaceutical Council of Spain
Switzerland	Martine Ruggli	President	PharmaSuisse
USA	Michael Murphy	Advisor for state government affairs	American Pharmacists Association

5.2 Results

5.2.1 Question 1: Best outcomes from CAS implementation

The positive feedback from the major stakeholder groups such as patients, pharmacists and doctors was shared by insight board participants. The most frequently mentioned outcomes included:

- Enhanced access to health care;
- Leveraging pharmacist expertise; and
- Reduced pressure on general practitioners and other care settings.

5.2.1.1 Enhanced patient access to health care

Enhanced patient access to health care emerged as one of the most commendable outcomes of CAS. The representative from Canada noted that primary health care access experienced significant enhancement, particularly in contrast to the long wait times for consultations with other healthcare services. Adding to this perspective, the participant from New Zealand expressed that patients held a strong affinity for CAS, while pharmacists were instrumental in identifying previously unmet healthcare requirements, especially within low socioeconomic communities. Further underscoring the point, the participant from the United States emphasised the advantageous proximity of CAS pharmacies, leading to a marked improvement in patient accessibility, as follows:

> *"I'll use Alaska as an example, where some patients must travel three to four hours to get to the doctor's or the physician's office. But there's a local pharmacist right there, and they could go and they could get access to COVID-19 oral antivirals if they tested positive for COVID." — Michael Murphy, American Pharmacists Association, USA*

5.2.1.2 Leveraging pharmacist expertise

The recurring theme of leveraging pharmacist skillsets and broadening the scope of practice was evident in participants' comments. The participant from New Zealand said "pharmacists love it [CAS], because it's starting to use their skills and be paid for", highlighting that pharmacists embraced CAS due to its utilisation of their skills and the corresponding compensation for their services. Reflecting this view further, the

participant from the United States summarised the favourable effects on both patients and pharmacists as follows:

> *". . . combination of remuneration, but also the prescriptive authority, is where we see a lot of pharmacists wanting to participate and also patients are excited to receive these services from their community."*
> *— Michael Murphy, American Pharmacists Association, USA*

5.2.1.3 Reduced pressure on general practitioners and higher care settings

Participants also expressed favourable views on the alleviation of pressure on general practitioners and hospital emergency departments. The England representative underscored how CAS pharmacists were proactively contributing to the "political imperative of reducing general practitioners' workload" and adeptly "managing [public] expectations" thus far. Expanding on this notion, the representative from Portugal explained the rationale behind adopting CAS, citing the high number of patients in Portugal who visit emergency departments for non-urgent conditions. Furthermore, the Portuguese participant pointed out the positive impact of CAS in effectively reducing the burden on emergency departments.

> *". . . upskilling pharmacists to respond to common ailments as a means of managing basically the considerable workload pressures on GPs and also on emergency departments and freeing them [doctors] for tasks where the intervention is really needed." — Maria João Mendes, National Association of Pharmacies, Portugal*

5.2.2 Question 2: Barriers or limitations in CAS implementation

Insight board participants outlined an array of constraints and challenges faced by the three key stakeholder groups — patients, pharmacy owners and general practitioners. Notable themes that emerged from the discussions included:

- Discrepancies in operations and bureaucratic limitations, leading to diminished motivation;
- Professional boundaries with general practitioners; and
- Public perception and household economic implications

5.2.2.1 Discrepancies in operations and bureaucratic limitations

The representative from the United States highlighted that while a remuneration pathway exists through a state-funded programme, inconsistencies in CAS initiatives across states have led to confusion and limited engagement among pharmacy owners. Additionally, the participant noted substantial initial costs incurred by pharmacy owners for CAS implementation, including the establishment of private consultation spaces and IT infrastructure.

The Spanish representative emphasised that the most challenging aspect involved enhancing the perception and motivation of pharmacy owners, particularly since participating pharmacists received no reimbursement for delivering CAS services. Furthermore, the Spanish participant revealed the limitation of restricted access to patients' medical records for CAS pharmacists, compounding the existing challenges.

In South Africa, operational hurdles were encountered by pharmacists. The South African participant noted that despite the pharmacy council's mandate for registered pharmacists to provide CAS, bureaucratic barriers impeded proactive CAS initiation.

> *"The major barrier is that pharmacists themselves and the issue of them embracing [CAS], this concept of a service provision together with a basket of medicines, it's continued to be treated as an OTC and a patient demand rather than a pharmacy initiative . . . we might want to focus on and concentrate on this on some of the difficulties in administering the service." — Dr Sham Moodley, Independent Community Pharmacy Association, South Africa*

These limitations included the requirement to qualify as an "authorised prescriber" and the obligation to maintain electronic records. The complexity of CAS frameworks was also evident in the United Kingdom, as noted by the English and Scottish participants.

5.2.2.2 Professional boundaries with general practitioners

An aspect of conflicts concerning the division of remunerative roles between pharmacists and general practitioners emerged as a secondary theme within the discussion. Describing this dynamic, representatives from Scotland and Switzerland elaborated on the persistent opposition generated by the general practitioner group, encapsulated in the following manner:

> *"GPs did not want their income stream to be interrupted [by pharmacists] . . . after all, there was no impact on GP remuneration at all."— Maurice Hickey, Pharmacists Defence Association, Scotland, UK*

> *"In Switzerland, it is still very difficult [to integrate CAS] because we have dispensing doctors and so they see the pharmacies as a competition. So, it's very difficult to work with physicians together". — Martine Ruggli, PharmaSuisse, Switzerland*

The New Zealand participant commented that the GPs in New Zealand were "relatively supportive" of CAS as the range of the eligible conditions was narrow and limited for low-risk conditions, unlike some of the most extended scopes of CAS which might cover chronic or complicated conditions (e.g., hormonal contraception or opioid dependence).

5.2.2.3 Public perception and household economic implications

Some participants highlighted the economic implications for patients, particularly the out-of-pocket costs associated with CAS. The participant from New Zealand explained how this directly affected individuals within low socioeconomic groups, subsequently triggering responses from higher-income groups and taxpayers.

> *"Patients did not want to pay [for CAS] . . . taxpayers already pay for doctors, and they do not like to pay for low socioeconomic group." — Billy Allen, Te Whatu Ora, New Zealand*

A sentiment of disapproval towards the CAS payment structure among the Scottish public mirrored that seen elsewhere. The Scottish participant remarked that patients displayed a certain aversion to the generic medicines offered by CAS pharmacists. The rationale for this sentiment was grounded in the belief that utilising CAS instead of a GP did not hold substantial merit. This viewpoint was reflected in the Scottish participant's quotation, "Prescription charges and health benefits override the cost of [CAS] services."

Nonetheless, the prevailing public perception of CAS appeared to be optimistic in both the UK and New Zealand. As conveyed by participants from these countries, the pharmacy sector effectively offered expedited health services to patients, exemplified by phrases like "access to health care is faster [compared with GPs]". Moreover, the combination of effective communication and service delivery appeared to have not only met but also "satisfied the public's expectations", fostering a sense of contentment among the service recipients.

5.2.3 Question 3: Future considerations for sustaining/implementing CAS

When prompted to offer a key take-home message for FIP member organisations considering CAS implementation in their respective countries, participants highlighted two primary aspects:

- Early engagement of stakeholder groups; and
- Enhancement of patient access to CAS pharmacies.

5.2.3.1 Early engagement of stakeholder groups

The primary focus of the discussion centred around patients, who hold a paramount role in the context. The representative from England emphasised that patients tend to value having authority over their own health decisions. Echoing this sentiment, the representative from Ireland highlighted the crucial role of involving consumer groups. This viewpoint found resonance in the representative from New Zealand, who further endorsed the notion of empowering patients for effective CAS implementation. The New Zealand

representative shared insights into their successful CAS implementation, underlining the extensive engagement of the public. Notably, this involvement encompassed diverse segments like schoolchildren, along with the provision of educational resources on official government platforms.

In the engagement spectrum, participants extended beyond patients to encompass pharmacy students and newly registered pharmacists. The representative from Scotland emphasised the pivotal nature of undergraduate CAS training, a reflection of CAS's establishment as the national practice standard across the UK. There was an expectation from the community pharmacy sector that newly registered pharmacists should receive CAS training right from the outset of their education, as encapsulated by the participant from England.

> *"So, I think it's managing [patients'] expectations, making sure the training is in place and making sure the funding model is properly structured." — Bharat Nathwani, Pharmacists' Defence Association, England, UK*

5.2.3.2 Enhancement of patient access to CAS pharmacies.

Enhanced accessibility to CAS pharmacies emerged as a recurring and prominent theme throughout the discussions. The representative from England emphasised the significance of having pharmacies conveniently located, a vital aspect during the CAS implementation in the UK. Meanwhile, the New Zealand representative highlighted the efficacy of offering a contact list of CAS pharmacies, which effectively guided patients to the nearest available options. Adding to the accessibility theme, the Canadian representative expanded on the concept of proximity. This participant noted the rising popularity of pharmacist-led clinics within pharmacy premises among the public in Canada, further underscoring the importance of having CAS services within easy reach for patients. Building on this notion of accessibility, a quote from the Scottish participant illustrates the universal availability of CAS services:

> *"So, anybody who lives at one end of the country can walk in a pharmacy at the other end of the country, can access the [CAS] service and get the best advice." — Maurice Hickey, Pharmacists' Defence Association, Scotland, UK*

Developing on the theme of improved access, participants discussed the use of telehealth in providing CAS in remote settings. The discussion revealed that telehealth was being used in some states in Canada and the US, especially in rural communities, with reimbursement rates increased during the COVID-19 pandemic. According to the representative from England, telehealth was used during the pandemic, but with the expanded scope and ongoing evaluations, face-to-face consultations were now preferred.

6 Conclusion

6.1 Summary of participant demographics

This report collated survey feedback from 25 member organisations (MOs) spanning 24 countries. This was followed by nine MO case studies (eight countries) and input from 10 MO participants (nine countries) in the insight board discussion. It is noteworthy to highlight the overlapping participation of several countries across the data collection stages. Canada, England, Ireland, New Zealand, Scotland, South Africa, Spain, Switzerland, and the USA engaged in all three data collection stages. The European region dominated the data contribution across all three stages, providing 17 of the 25 survey responses, five of the nine case studies, and six of the 10 insight board participants. The Americas region had the next highest responses, contributing three survey responses, two case studies, and two participants for the insight board discussion. Overall regional contributions to this report by the WHO classification are as described in Table 6:

Table 6. Number of FIP member organisations contributing to this report by the WHO classification

WHO classification of regions	Number of FIP member organisations participated*	Countries
European region	17	Belgium, Bulgaria, Denmark, Finland, France, Germany, Ireland, The Netherlands, Norway, the Republic of North Macedonia, Romania, Portugal, Slovenia, Spain, Switzerland, and the United Kingdom (England and Scotland);
Americas region	3	Canada, Uruguay, and the United States
Western Pacific region	2	Australia and New Zealand
African region	2	Nigeria and South Africa
Eastern Mediterranean region	1	Israel
South-East Asian region	Nil	Nil

**Repeat contributions from the same country during different data collection phases were excluded from the overall counts.*

6.2 Summary of key findings

This report revealed a diverse range of ailments addressed by common ailment schemes (CAS), ranging from common ailments such as headaches to specialised treatments like COVID-19 antivirals. Most medicines dispensed were either fully or partially funded through a CAS payment system, with public funding being the primary source of pharmacist remuneration in half of the cases. Two-thirds of CAS nations mandated extra training for pharmacists, which often entailed understanding a specific list of eligible medicines.

Both clinically and economically, CAS has demonstrated significant benefits. According to the current literature, patients reported enhanced quality of life, symptom relief and triaging to GPs, largely due to pharmacists' prompt interventions. Economically, CAS offered a more affordable alternative to traditional GP or emergency visits, generating significant national savings. It also reduced GP workload, allowing more

focused care on complicated cases and strengthening collaborations between GPs and pharmacists. Key benefits highlighted by the respondents included quicker health care access and recognition of pharmacists' expertise, leading to reduced GP and emergency department pressures.

There was a proposal to simplify the CAS system. Participants' responses suggested operational refinements, such as simplified training requirements and improved medical record access. Many pharmacists saw the enhanced prerequisites as barriers, and when considering remuneration significant resistance was observed, especially from doctors and nurses.

6.3 Limitations of the report

Several limitations were identified. Primarily, most respondents were from the European region, with limited participation from the African, Americas and Western Pacific regions. Specifically, the Eastern Mediterranean region contributed minimally (one out of 27 surveys), while the South-East Asian region had no representation, so the uneven distribution of response might lead to a bias towards European insights, compromising the generalisability of the report across regions and the world.

Additionally, there was a greater UK representation, with two participants (from Scotland and England) representing a single nation, which may skew European data. Nonetheless, the survey was sent to all FIP member organisations across all six WHO regions, with participation encouraged from all countries. Subsequently, the aim of the survey along with the case studies and insight board discussion was to collect best practices and examples of innovation. A possible interpretation of the uneven distribution of responses across the world's regions is that common ailment schemes may not yet be available, or not be a priority for FIP member organisations from those regions that are underrepresented in this report.

Furthermore, the responses provided in the survey are subjective interpretations of the respondents, not necessarily representative of every pharmacy group in each country, comprising a select few FIP-registered entities from each country or territory — it might not encapsulate the broader perspectives of other pharmacy groups or stakeholders from the represented nations. Essentially, further engagement is crucial across nations, regions and the world.

6.4 Recommendations and future implications

First, it was emphasised that future implementation of CAS should be accompanied by a wider ranging strategy, such as raising public confidence, early engagement of stakeholders and relevant advisory groups, and establishing a robust evaluation framework, backed by evidence from cost-evaluation studies. Gathering evidence on potential cost savings from CAS is imperative before presenting it to taxpayers or governments. Strengthening collaboration between pharmacists and general practitioners is crucial, particularly in devising referral procedures. This finding was also mirrored in the previous literature.[42–44]

Secondly, clearly defining common ailments and designing systematic protocols, including a cost-effective medicines formulary, were regarded to be foundational steps. To ensure consistency and equal access across pharmacies, a standardised service procedure was deemed essential. It was recommended that broader, consistent policies over localised ones prevent discrepancies in pharmacists' roles and billing rights and remuneration, and ultimately patient access. This should be complemented by adequate training and a registration platform for pharmacists.

In summary, this report explored the roles and responsibilities of pharmacists worldwide within the context of common ailment schemes. Drawing from current literature, alongside insights from member organisations via surveys, case studies and discussions, the report revealed significant diversity in eligible disease states and standards of CAS practice across the globe. While challenges persist, especially in stakeholder engagement and remuneration disagreements among pharmacists, physicians and patients, the overarching positive health and economic outcomes remain significant in promoting and advancing CAS.

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8 Appendix 1 — Survey questionnaire

1. Are pharmacists in your country delivering interventions in some of the areas pointed out above under the framework of a structured CAS?
    - Yes, in the entire country
    - Yes, but only in some parts of the country
    - No ***[END SURVEY]***

2. Which ailments or clinical areas are covered by the CAS?

    A. Infectious Diseases:
        i. Head lice
        ii. Vaginal candidiasis/thrush
        iii. Threadworm
        iv. Conjunctivitis
        v. Upper respiratory tract infection
        vi. Scabies
        vii. Chickenpox
        viii. Uncomplicated urinary tract infection

    B. Gastrointestinal Disorders:
        i. Diarrhoea
        ii. Constipation
        iii. Indigestion
        iv. Gripe/colic/wind

    C. Respiratory Conditions:
        i. Sore throat
        ii. Cough
        iii. Hay fever
        iv. Nasal congestion
        v. Asthma

    D. Pain and Inflammation:
        i. Headache
        ii. Earache
        iii. Toothache
        iv. Pain
        v. Minor burn
        vi. Musculoskeletal disorders
        vii. Soft tissue injury

    E. Dermatological Conditions:
        i. Bites and stings
        ii. Athlete's foot
        iii. Mouth ulcers
        iv. Nappy rash
        v. Haemorrhoids
        vi. Cold sores
        vii. Warts/verrucae
        viii. Fungal infection
        ix. Eczema/allergy
        x. Acne
        xi. Dermatitis
        xii. Psoriasis
        xiii. Oral thrush
        xiv. Allergic conjunctivitis
        xv. Dry eyes
        xvi. Ear wax

    F. Others:
        i. Teething
        ii. Emergency hormonal contraception
        iii. Travel sickness
        iv. Post-vaccination pyrexia

v. Laceration

3. How are pharmacists remunerated for CAS interventions?
    - They are reimbursed by public health systems /third-party payers
    - They are reimbursed by private health insurance companies /third-party payers
    - They receive no remuneration for CAS interventions
    - Paid out of pocket by patients
    - Other. Please provide details:

4. Are medicines dispensed under the CAS reimbursed by third-party payers?
    - Yes, for all medicines covered the CAS
    - Yes, for some medicines
    - No

5. Are there specific professional regulations, standards or requirements in place for these services?
    - Yes
    - No
    - Yes, but it varies depending on which part of the country

6. Are pharmacists providing interventions under a CAS required to undergo additional education or training?
    - Yes
    - No
    - Yes, but only for specific areas under the CAS.

7. Is there a list of pharmacist-only non-prescription medicines in your country/territory that requires a pharmacist to do a clinical assessment and decide on the dispensing of the medicine?
    - Yes
    - No
    - No, but there is a list of pharmacy-only non-prescription medicines for which any pharmacy team member can dispense the medicine.

8. If yes, is there a specific dispensing fee for pharmacist-only medicines? *[Question only shown if 'yes' in Q7.]*

    - Yes
    - No

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