Pharmacist-led common ailments schemes

A global intelligence report

EXECUTIVE SUMMARY

2024

fip International Pharmaceutical Federation

Colophon

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Foreword

In today's dynamic healthcare landscape, the International Pharmaceutical Federation (FIP) stands at the forefront of supporting both excellence and accessibility in primary healthcare. 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 health care 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 in depth 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)

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 primary health practitioners, 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.

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.

FIP published a global report on "Pharmacist-led common ailment schemes" to provide a holistic understanding of the role of pharmacists in CAS, amalgamating best practices and advancing patient care internationally. Additionally, this report aimed to convey crucial advocacy messages to interested member organisations, pursuing avenues for optimising pharmacists' involvement in patient care.

A comprehensive search of the existing literature laid the groundwork for this report. Simultaneously, collating data from 24 countries (n=25 Member Organisations (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.

Key findings

- The clinical areas that CAS covered across countries included infectious diseases, gastrointestinal disorders, respiratory conditions, dermatological conditions, pain and inflammation.
- The cross-sectional view of CAS across various countries showcased a diversity of professional standards, legislative frameworks and remuneration mechanisms. 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 mandatory additional training existed in two-thirds of the nations with CAS. A notable difference also exists in collaborative arrangements with GPs (general practitioners).
- Lack of access to patient medical information, absence of dispensing separation, time constraints, a lack of collaborative relationships with GPs, low public awareness, bureaucracy, inadequate remuneration and support from other healthcare professionals are some barriers to CAS implementation.
- Clinically, CAS enhanced patient quality of life and convenience of access to care and reduced general practitioner (GP) workloads. Economically, it presented cost-effective alternatives.
- Operational challenges persisted, particularly in inconsistencies in service requirements and stakeholder engagement.

Clinical areas covered by the common ailment schemes in each country

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
Toothache	Nigeria, Scotland, South Africa, Spain, USA
Non-specific pain	Canada, New Zealand, Nigeria, Scotland, South Africa, Spain, Switzerland, USA

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

Recommendations

Successful CAS implementation can be seen to require a multi-factorial strategy, with valuable 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. 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.

Pharmacy professional organisations are encouraged to:

- Consider a multi-disciplinary approach focusing on citizens' health needs, for the development of a CAS proposal. Stakeholder groups, from the government to consumer groups, should be engaged from an early stage.
- Consult pharmacist professional organisations on the design process for any CAS.
- Establish that common ailments pharmacists are qualified to treat, develop algorithms that adhere to scientific protocols, and select cost-effective medicines.
- Gather evidence-based data on possible savings for the health systems and present these data to healthcare payers and the government.
- Establish a procedure to provide the service in a proper and standardised manner for all pharmacies, thus giving equal access to all pharmacies.
- Associate future implementation of CAS with 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.
- Capitalise on major external factors (the current health system pressures and the significant role of pharmacists during COVID-19) to encourage pharmacists' increasing role in primary care, patient needs, and their trust in pharmacists. These are essential for continued support and funding for pharmacy.
- Consider broader, consistent policies over localised ones to prevent discrepancies in pharmacists' roles, billing rights and remuneration, and ultimately patient access.

Key advocacy messages for stakeholders

- Implementing CAS could optimise the role of pharmacists, leading to improved patient care and enhanced overall healthcare delivery.
- The negative consequences of underutilising pharmacists' skills and expertise could lead to suboptimal utilisation of public health budgets and patient outcomes.
- Enhancing the accessibility of pharmacies offering these services, for example, through convenient location and innovative activities such as providing a contact list of CAS pharmacies that effectively guides patients to the nearest available choices, will generate awareness for these services.
- Patients value having authority over their own health decisions. Therefore, involving consumer groups is crucial in empowering patients for effective CAS implementation.
- The nature of undergraduate CAS training is pivotal and can reflect CAS's establishment as the national practice standard.

Conclusion

This report revealed a diverse range of ailments addressed by common ailment schemes (CAS), ranging from 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 nations with CAS 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. Many pharmacists saw the enhanced prerequisites as barriers, and when considering remuneration significant resistance was observed, especially from doctors and nurses. However, simplifying the CAS system through operational refinements, such as simplified training requirements and improved medical record access would support the key benefits of quicker healthcare access and recognition of pharmacists' expertise, leading to reduced GP and emergency department pressures, which were highlighted by the respondents. It is essential to demonstrate these clinical and economic benefits to support the implementation of CAS and advocate for improved practices with various stakeholders.

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