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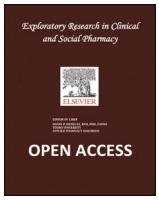

Relevance of the community pharmacy policy environment to pharmacists' performance, as reflected in stakeholders' perspectives on professionalism and standards

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ABSTRACT

Background: A complex array of legislation, regulation, policies and aspirational statements by governments, statutory agencies and pharmacy organisations constitutes the policy environment that influences Australian community pharmacy, including pharmacists' performance.
Objective: The objective was to assess the relevance of the policy environment to Australian community pharmacists' performance by examining stakeholders' perspectives on their professionalism and standards.
Methods: Inductive thematic analysis was undertaken on 38 semi-structured interviews of purposively selected individuals including pharmacists and other key stakeholders, from 4 socio-ecological strata (societal, community, organisational, and individual) that have influence on the person to person interaction that a consumer may have with a pharmacist in a community pharmacy.
Results: As indicators of their performance, pharmacists' professionalism and compliance with standards can no longer be assumed; they must be demonstrated. However, the current dispensing funding model compromises their ability to demonstrate professionalism and policy is lacking in relation to monitoring and rewarding standards. These shortcomings are further compromised by a growth in commercialism in community pharmacy which impacts the delivery of professional services.
Conclusion: The findings of this study have implications for pharmacy as an autonomously regulated profession in Australia. Dispensing funding policy could better support and reward quality in pharmacists' performance, and there is strong support for compulsory monitoring of standards. Compliance with a nation-wide quality framework, and provision of a minimum set of professional services should be an obligatory requirement of all community pharmacies.

1. Introduction

This study was undertaken as part of a larger program of research on the impact of the policy environment on pharmacists' practice in community pharmacy in Australia. This complex environment, which includes governments' legislation and regulation,[1] statutory agencies' guidelines, professional bodies' standards and codes,[2–5] and pharmacy organisations' aspirational statements,[6,7] impacts pharmacists' behaviours, including their performance.

While noting that pharmacists' performance is under-researched, Schafheutle et al. (2011) determined that it is affected by multiple factors including personal and workplace factors.[8] This paper presents a study that explored the relevance of aspects of the policy environment to pharmacists' performance, by examining the perspectives of stakeholders on pharmacists' professionalism as a personal factor, and compliance with standards as a workplace factor.

Professionalism is a dynamic, role-specific construct[9] defined as 'the skill and careful attention that trained people are expected to have'.[10]

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Both Abbott (1991)[11] and Freidson (in Brint 2006)[12] expressed professionalism in terms of the regulation of work practices. Abbott argued that professional behaviour is an alternate to the free market and bureaucratic managerial controls, as a means of organising work.[11] Freidson described 3 attributes of a profession; (i) autonomy; setting and enforcing its own standards of education, (ii) expertise; developing and applying a substantial body of specialist knowledge, and (iii) credentialism; being licensed with exclusive authority to practice within norms set and enforced by its own members.[12–14] Based on these attributes, pharmacy is one of a small number of autonomously regulated professions.[13,14]

Surveys of the Australian public report high levels of trust and respect for members of the profession[15,16] however their professional status has long been questioned in the pharmacy literature.[17,18] Elvey et al. (2013) suggest the diverse clinical, managerial, and business roles of pharmacists have led to role ambiguity, undermining a clear professional identity.[19]

1.1. Pharmacists as professionals

At an individual level the traits of professionalism include knowledge, competence, honesty, integrity, and ethical probity.[20] It has been described as a core competency of pharmacists,[21] and in recent years attention has been given to developing professional identify in undergraduate pharmacists,[22,23] however this, and the historical definition of pharmacy as a profession does not ensure the behaviour of individual pharmacists is professional. Students of medical and other healthcare disciplines are taught that professionalism is 'the cornerstone for safe, effective and ethical health care practice'.[24] Wilkinson et al. (2009)[25] identified five components of professionalism in medical practice, namely (i) adherence to ethical practice principles, (ii) effective interactions with patients and with people who are important to those patients, (iii) effective interactions with people working within the health system, (iv) reliability, and (v) commitment to autonomous maintenance and improvement of competence in oneself, others, and systems. These components serve equally well as measures of pharmacists' professionalism.

1.2. Societal changes regarding the professions and professionalism

Historically, members of autonomously regulated 'traditional professions'[26] such as pharmacy, practised within a 'professional paradigm'. They claimed to act in the interest of their customer-clients, differentiating themselves from other business people whose behaviour was driven by financial self-interest.[27] The increased influence of free-market principles in society has resulted in professional practitioners' commercial interests impacting their behaviour, and the professional paradigm being challenged by the emergence of a financially-focused 'business-paradigm'. This development may be particularly apparent in community pharmacy due to its retail setting and high dependence on product transactions for income.[28]

Furthermore, the term professional, historically reserved for a small number of vocations, is now also applied to individuals such as business and sports people based on their achievements in competitive environments.[29] These developments have weakened the professional paradigm and given rise to 'new professionalism'.[26,30]

1.3. Pharmacists' evolving practices and professionalism

In addition to the aforementioned societal changes, there have been changes in pharmacists' practice that have had a bearing on the perception of them as professionals. When community pharmacy transitioned from dispensing bespoke extemporaneously compounded medicines to stable, standardised, mass-produced medicines,[31] a diminution of pharmacy professionalism was predicted. It was argued the pharmacist would '*find himself* (sic) *prone to becoming more and more just merely the salesman* (sic) *for the big manufacturers*'.[32]

The emergence of mass-produced medicines in Australia coincided with the introduction of the national insurance program, the Pharmaceutical Benefits Scheme (PBS).[33] PBS medicines are normally dispensed in manufacturers' original packs 'off the shelf', and are identical regardless of the pharmacy at which they are dispensed. In ensuring public access to essential medicines, the PBS has become the dominant revenue source for Australian community pharmacies.[34] However, along with a series of Community Pharmacy Agreements,[35] it has constrained pharmacists' professional discretion by standardising and regulating their dispensing procedures and controlling the fees that they can charge for dispensing services.[13]

While the change to dispensing of mass-produced medicines led to constraints on pharmacists' professional autonomy, it led to a change in the nature of their practice from skills-based to knowledge-based.[36] In recent decades, pharmacists have demonstrated this through increased engagement in counselling patients on the appropriate use of medicines, enhancing the perception of them as 'patient-centred professionals'.[37,38] This created the opportunity for pharmacists to play an important role in the Quality Use of Medicines (QUM), which is one of the pillars of the Australian National Medicines Policy.[39]

1.4. Standards in community pharmacy

The term standard relates to the level of quality, the degree of excellence, or how good or bad something is.[40,41] In the context of this analysis, the term encapsulates the codes of practice,[2,3,5] competency statements,[42] practice standards,[4] and codes of ethics[5] by which pharmacists are expected to practice.

The Code of Conduct of the registering authority for pharmacists, the Pharmacy Board of Australia (PBA) incorporates values and behaviours in 11 principle areas including respectful and culturally safe practice, minimising risk, working with patients, and safe, effective and collaborative practice.[2] The PBA also has Guidelines for functions such as compounding, dispensing, advertising, and professional development.[2] Notably, the Code and Guidelines are not used by the PBA in an arbitrary inspection program.

The professional member-based organisation, the Pharmaceutical Society of the Australia (PSA) has published 17 Professional Practice Standards that describe the minimum performance expected of pharmacists in functions such as patient assessment, prescribing, dispensing, compounding and administration of medicines.[4] In spite of the differing nature of the Codes, Guidelines and Standards, focusing either on interpersonal behaviour or on technical functions, both organisations draw a link between compliance and acting professionally.

Compliance with PSA's Professional Practice Standards[4] and Code of Ethics[5] is a requirement of a pharmacy being funded to dispense PBS prescriptions,[43] however this is not systematically monitored. In fact, Mill et al. (2021) reported that pharmacists do not access the two documents in their daily practice.[44] A prior study reported that Australian pharmacists failed to refer to their codes of ethics when experiencing ethical dilemmas in practice[45] and failed to integrate practice standards in work practices. In referring to pharmacists' expanding roles in primary care, Dineen-Griffin et al. (2020) observed there is no legislative framework specifying standards,[46] and Thai et al. (2022) noted the need for applicable policy change.[47] These findings are indicative of the adoption of the standards[48] and by extension, the professionalism of pharmacists in Australia.

The Quality Care Pharmacy Program (QCPP) is an assessment program established in 1997 to support Australian community pharmacies provide consistent care of an approved standard. The QCPP accreditation program incorporates standards relating to business operations, staffing, stock management, and customer service, however compliance is not compulsory.[49] The only circumstance in which standards of practice are used to evaluate performance in Australian community pharmacy is in disciplinary inquiries of the PBA, or state or territory-

based pharmacy authorities, which are normally only instigated following reported transgressions.[50]

In view of changes in the nature of pharmacists' practice, in concepts of professionalism, and the reported limited adoption of promulgated standards, this study was undertaken to examine the relevance of the policy environment to pharmacists' performance in community pharmacy, using the literature-informed lenses of professionalism and standards of practice.

2. Methods

The original research contribution of this study was qualitative in nature, and entailed semi-structured interviews of stakeholders, undertaken within a realist paradigm.[51,52] The study was approved by Monash University Human Research and Ethics Committee (ID: 31875).

2.1. Recruitment

Stratified purposive sampling[53] was used to select individuals from 4 socio-ecological strata of community pharmacy, described in Table 1.[54,55] These four strata describe the concentric environmental layers that surround and have influence on the person to person interaction that a consumer may have with a pharmacist providing patient care.

Presidents of major pharmacy organisations and of non-pharmacy organisations with direct association with pharmacy were approached, as were key opinion leaders in the public domain such as politicians and bureaucrats engaged in pharmacy-policy development, analysis and implementation. Consumers and consumer association representatives active in health advocacy, and with knowledge of pharmacists' practice, were also approached. When necessary, snowball convenience sampling was used in an attempt to achieve equitable representation between the strata.[53] Contact was initially made via email and included an explanatory statement and consent form, with follow up via email or telephone, as appropriate. Of the 49 individuals approached to participate, 7 failed to respond and 4 declined, 2 of whom provided referrals to other suitable individuals.

2.2. Data collection

Interviews of up to one hour in duration were conducted at a day and time of the interviewee's choice, online (Zoom) or face to face, between December 2022 and April 2023. All interviews were conducted by the lead author (JJ), a pharmacist with prolonged engagement in pharmacy ownership, operation, and governance, and who has experience in qualitative research methods, including semi-structured interviews.

Table 1
The socio-ecological strata of community pharmacy.

Strata	Nature	Elements	Members
Macro-strata (outer most layer)	Societal	Public policy, law and regulations at national, state and local levels	Politicians, bureaucrats, regulators, and policy experts
Exo-strata	Community	Standards, guidelines, and codes	Professional, industrial, and commercial organisations Expert commentators
Meso-strata	Organisational	Structures, environment, culture, and commerce	Pharmacy proprietors
Micro-strata (inner most layer)	Individual	Knowledge, attitudes, beliefs, and behaviours	Pharmacists, consumers and consumer organisations

Development of the interview schema was informed by the literature[56] and through preliminary engagement with 10 community pharmacy stakeholders undertaken to identify significant issues in the policy environment of community pharmacy.

Based on the preliminary engagement, a series of open-ended interview questions[57] addressed the nature of professionalism, perceptions of change in professionalism, standards of care, and standards monitoring. Specific follow-up questions are listed in the interview guide, and additional follow-up questions were asked based on the answers to prior questions (Appendix A: Interview guide). Pilot interviews were conducted with experienced pharmacists and the guide modified to ensure comprehension and scope. Confidentiality was maintained throughout, with interviewees identified by a code number in all field notes, interview transcripts and data analysis.

2.3. Data analysis

Professionally transcribed audio recordings of the interviews were checked by the lead author for accuracy against the audio recordings and notes taken during interviews. Following data cleaning, familiarisation was undertaken by rigorous reading of the transcripts. Analyses of the data entailed a combination of summative content analysis using the key concepts of professionalism and standards, and conventional inductive thematic analysis with concepts derived from the content of the interviews.[58] Codes were assigned by the lead author, using the 6-step framework of Pope et al. (2000).[59] The transcripts were closely reread by JJ to identify secondary codes and a coding tree (Appendix B: Coding guide) was created in NVivo (QSR International release 1.3 (535)).[60] The transcripts and coding were reviewed with the research team consisting of 3 pharmacists and an expert in public policy, all of whom are experienced in qualitative analysis. The codes were discussed and defended until consensus was reached that they were coherent, distinct and linked to the research objectives. On further reading of the transcripts, relevant text segments were mapped to the codes, and illustrative quotes identified[59] using NVivo.

2.4. Credibility

Recognising the extensive engagement with community pharmacy by members of the research team, to reduce researcher bias and thereby enhance the validity of the research, input was sought from 10 stakeholders prior to establishing the research focus and questions.[61] The process supported the selection of the research lenses of professionalism and standards.

To establish rigour and trustworthiness of the analysis, an independent researcher (BC), a pharmacist experienced in qualitative research but not engaged in setting the research objectives or the development and conduct of the interviews, was engaged to collaborate as a member of the research team in curating the data and analysing the results. The code selection and mapping by the lead author was checked for clarity and consistency and validated by BC, then reviewed by the remaining three research team members.

The COREQ checklist was adopted as a guide for preparation of a comprehensive report of the study.[62]

3. Results

Thirty-eight interviews were conducted, with an average duration of 46 min (range 26–80 min.). Interviewees included 24 pharmacists(14 females), from 7 of the 8 Australian States and Territories. No repeat interviews were done. The socio-ecological strata of the interviewees are presented in Table 2 and their interview codes, areas of responsibility and expertise are in Appendix C: Interviewee codes to Table 3 Interviewee codes

Table 2
Socio-ecological strata of the interviewees.

Socio-ecological strata of community pharmacy	Sub-strata	Interviewees in each sub-strata	Pharmacists in each sub-strata	Total in each strata
Societal	Politicians	2	–	
	Health bureaucrats	3	2	
	Pharmacy regulators	1	1	
	Health policy experts	3	–	
Total societal				9
Community	Professional, industrial, & commercial pharmacy organisations	9	9	
	Medical, patient, & supplier organisations	3	1	
	Media, business, & banking commentators	3	–	
Total community				15
Organisational	Pharmacy proprietors	4	4 (+3 in other strata)[#]	
Total organisational				7
Individual	Pharmacists working in community, hospital, academic, & consultant practice	7	7	
	Consumers & consumer organisations	3 (+4 in other strata)[^]	-[*^] –	
Total individual				14
Total		38	24	

[#] 3 individuals in other categories were pharmacy proprietor making the total number of pharmacy proprietors interviewed as 7.

[^] 4 individuals in other categories chose to provide responses with a consumer perspective making the total number of consumers interviewed as 7.

4. Professionalism

4.1. Perceptions of professionalism in community pharmacy

"(Professionalism) *is relatively strong but continually at risk from its environment."* (4/Regulator/Phcist).

A number of interviewees adopted a generalised approach and described pharmacists' professionalism using terms such as honesty, integrity, empathy, and trustworthiness. They stated pharmacists' professionalism was linked to their knowledge and willingness to maintain their expert knowledge, and that they were responsive, accountable, accurate and competent. Affiliating with professional associations and abiding by formal codes of ethics, were also identified as characteristics of professional pharmacists.

However, 18 of the interviewees (47 %) said professionalism was not a given or obvious attribute of pharmacists. Twelve of the 24 pharmacists and 6 of the 14 non-pharmacist interviewees stated that a pharmacist's professionalism had to be subjectively demonstrated, for example through *"the level of contribution they make"* (7/Academic Assn/Phcist) in their interactions with patients and colleagues, and that it was apparent when they failed to do so. Factors identified by various interviewees as affecting pharmacists' capacity to demonstrate their professionalism included the sector's policy environment, funding policies, working conditions, workload, and attitudes toward customers.

"Too often pharmacists spend more time being sort of small retail businesses and not enough working as health professionals and utilising their skills and experience. There are many reasons for that, but most of them are systemic and incentives favour that sort of balance." (1/Politician/GP).

When asked specifically about the impact of the current funding policy, pharmacists stated that it "*leads to volume over quality and a great dissatisfaction amongst the workforce" (*4/Regulator/Phcist), which *"has an impact on consumers' perceptions and behaviours"* (7/Academic Assn/Phcist), and *"begs the question, is there a better way to fund provision of medicines in community pharmacy – reward not just the act of doing something, but reward achievement of health outcomes"* (6/PhAssn/Policy Phcist). The funding policy *"may have served the purpose in the past, but … it needs to also evolve to meet this contemporary community pharmacy practice" (*11/PhAssn/Prop Phcist). The opportunity for and nature of interaction between pharmacists and consumers affect perceptions of professionalism. A pharmacist reported "*workload and staff shortages mean that pharmacists realistically don't have the time to spend with consumers"* (28/Phcist), however the corollary for consumers is that pharmacists' professionalism is "*difficult to see from a consumers' point of view because they're usually hidden out the back, … whilst they'll have assistants who don't have the qualification and standards out the front to engage with people like me"* (16/Commentator/Consumer). When interaction does occur, there is ambiguity whether the public are patients or customers, as exemplified by a pharmacy proprietor: *"Doctors see patients, they don't see customers. When they leave a doctor's surgery they are still a patient, when they walk into our pharmacy we need to engage* [them as] *patients."* (38/PhAssn/Prop Phcist).

Interviewees associated professionalism with increased attention to privacy, the installation of consulting rooms, and the introduction of roles that expand the scope of pharmacists' practice. Many respondents stated that community pharmacy's response to the COVID19 pandemic, particularly their administration of vaccines, was widely admired by the public, and linked it with growing professionalism.

4.2. Business models and professionalism

Both consumer and pharmacist interviewees decried the consequence of pharmacies adopting price and volume business models. Respondents claimed such business models, which are enabled by the PBS funding model, fostered the perception of pharmacists as retailers rather than health professionals.

"Big bulk discount pharmacies, they're not conducive environments for interacting with patients. It's all about volume, doing things leaner and quicker and with students, not necessarily with pharmacists." (19/Prop/Accred Phcist) *"They seem to be like a supermarket for drugs so you've lost that feeling of being professional and really caring."* (20/Consumer).

The workload, business model, and physical layout may constrain personal interaction in some pharmacies, however a distinction was made by one interviewee between professionalism of individual pharmacists and their environments.

"People's perception of (discount pharmacy) *is not of professionalism but of commercialism. That doesn't mean to say that the pharmacists that are working there are not professional, but the public's perception of professionalism is critical"* (12/Policy Phcist).

It was emphasised that the characteristics of professional pharmacists are consistent across all settings, with a pharmacy regulator stating *"I think professionalism in hospital pharmacy is at a higher level because it doesn't have those same commercial retail pressures"* (4/Regulator/Phcist).

4.3. Individual pharmacists and professionalism

At a personal level, the low remuneration received by employed pharmacists compared with other health care professionals, and poor recognition by employers were cited a number of times as undermining professionalism. Some interviewees suggested poor reward and inter-

personal relations contributed to a shortage of pharmacists which, along with the funding-model-driven high workloads, adversely affected individual pharmacists' capacity to appear professional.

Concern regarding pharmacists being compelled to compromise their professionalism or operate beyond their preparedness in terms of risk and remuneration in order to support the pharmacy owner's commercial venture, was expressed by both non-pharmacist and pharmacist interviewees.

"I think that [business maximisation] *actually has a really big impact on the satisfaction of the pharmacist who has a lot of skills that aren't being appropriately utilised in a retail space because of the volume of turnover and less time for spending with patients"* (22/Assn/GP).

*"The professionalism of the employee is not always valued by the employer. If the employee wants to follow their professionalism and refuse a service, that can obviously go contrary to the wishes of the owner. There's such a power imbalance … it's hard for the employee to maintain their professionalism and stay in the good books." (*5/PhAssn/Phcist).

5. Standards

5.1. Application of standards

The level of understanding, application and evidence of compliance with standards was repeatedly reported to be inconsistent across the profession. There were perceived to be pockets of excellence, but wide and random variation in the application of standards, in part due to most pharmacies being individual enterprises.

"The application of standards really is left to the person responsible for the clinical governance of that small business and so it can be variable" (22/Assn/GP).

The PSA, rather than the PBA, was the body most frequently identified by interviewees as being responsible for setting standards for community pharmacy, and the existence of standards from numerous agencies, along with workloads and financial pressures in the retail environment, were identified as affecting compliance.

"I think the complexity of multiple standards across multiple different spaces, understanding what they are, means that at times I don't think all the standards are being met … and that's not through wilful disregard" (31/Phcist).

There was criticism of the nature of some current standards, with interviewees suggesting standards would ideally be developed in collaboration with consumers and other key stakeholders, and encapsulate aspects of patient care, professional services, business operations, customer service, and cultural safety, by which community pharmacy could be held accountable.

".. a lot of them [standards] *don't actually demonstrate professionalism, and they can be a hinderance to actual proper professional practicing, because of the administrative side of what they are trying to achieve"* (30/Prop/Accred Phcist).

Meeting standards has a commercial cost and one proprietor perceived *"a lack of willingness within the industry to look at standards because there may be inadequate commercial imperative … if you're not financially motivated, then you're not going to embrace the standards, especially if they're not mandatory"* (19/Prop/Accred Phcist). Another pharmacist suggested that people will do the minimum possible; *"It needs to have a bigger stick and more teeth to make it work properly"* (10/PhAssn/Accred Phcist).

Providing health care in a retail environment was cited as being relevant to the standards that patients have the right to expect, particularly when compared with more traditional clinical environments such as general medical practices. Participants were of the view that the absence of privacy, selling products of questionable therapeutic benefit, and business models built around the speed of dispensing, undermine the perception of compliance with standards. Work place demands were identified by a number of interviewees as having a negative impact on standards. *"There can be situations where there's just too many balls in the air at one time and something slips. It could be a matter of time and place, you know it might be a one-off lapse"* (36/PhAssn/Policy Phcist).

5.2. Evidence of compliance with standards

Rather than assessment of standards being a reactive disciplinary process by regulatory authorities, many interviewees saw the need for on-going evidence of compliance, as a means of providing confidence to the government, funders and the public as to the quality of services delivered in community pharmacy. *"For pharmacy to meet the demands of society, we do need to not just have standards as a guide, we need to have standards that people are comfortable and confident are being followed"* (31/Phcist). Assessment of standards was also thought to have a potential impact on the incidence of medication related harm and linking pharmacists' standards to the Quality Use of Medicine aspect of the National Medicines Policy was proposed.

The voluntary Quality Care Pharmacy Program (QCPP) was the only example provided of standards assessment however it was seen as a basic program with a focus on premises and human resources to the exclusion of professional practice and patient care. While being QCCP accredited enabled access to some funded professional programs, it was criticised for being undertaken remotely and not being used to benchmark required standards. An interviewee with an intimate knowledge of QCPP assessment stated *"there are flaws and gaps … I don't think it's as rigorous as it could be"* and *"if assessors were on site they would be a lot more in tune and be aware of potential issues"* (28/Phcist). Another cited that it is "*not necessarily an overtly independent process"* (34/Phcist/Consumer) and a third said *"I don't think it's appropriate, I think the principle of having a quality framework is needed, but I think it needs to be relevant and I think it's being used in the incorrect manner at the moment"* (21/Prop Phcist). Expressions such as 'tick and flick' were used on a number of occasions in reference to preparing for QCCP assessment, and its impact on practice was questioned. "*I've locumed* (sic) *in pharmacies that are QCPP accredited and they have absolutely atrocious standards of professional care"* (30/Prop/Accred Phcist).

5.3. Compulsory monitoring of standards

The interviewees were asked specifically whether the monitoring of standards should be compulsory. Two stated they thought it was already monitored to some extent, while 34 of the 38 interviewees (89 %) were supportive of monitoring, making statements such as *"it's a real failure they are not monitored"* (7/Academic Assn Phcist), "*the* (Pharmacy) *Board should use their teeth more"* (17/Policy), *"the public should demand it"* (25/Commentator), and it should be undertaken *"by an independent and unbiased assessor"* (33/Consumer).

Consumers were adamant standards monitoring should be mandatory, with one stating "*We don't believe in self-regulation or voluntary standards, we don't believe they work in the consumers' interests"* (14/Consumer). The absence of monitoring was equated with a lack of accountability for fees received by pharmacists for dispensing, with another consumer stating "*The preference would be self-regulating if you could trust them to do it. An external body unfortunately may be the only way of doing it."* (16/Commentator/Consumer).

Adapting and adopting accreditation processes that currently exist in other health care sectors such as general medical practice and hospitals, was proposed. An interviewee from a pharmacy association saw value in a health-system-wide approach, proposing one organisation conduct monitoring across all health professions to ensure consistency (36/PhAssn/Policy Phcist).

6. Discussion

Globally, community pharmacy, like other private sector health care services, has a duality of interests in and long-standing tension between the provision of health care and maintaining a viable business.[28,63] It is

apparent from the results that the growing dominance of the 'business paradigm' over the 'professional paradigm' in some community pharmacies in Australia, as assessed by their professionalism and standards, has led the duality of interests to develop into a business-professional role dichotomy.[28,64] A similar tension was described by Keller et al. (2021) as a 'dissonance' between pharmacists' desired and embodied identities, and a barrier to practice change.[65]

Professionalism in Australian community pharmacy is ostensibly high but cannot be assumed, and pharmacists need to demonstrate professionalism through personal interaction and by meeting standards. The findings indicated community pharmacy's commercial environment, including the dispensing funding model, and subsequent work practices and workloads, compromise some pharmacists' professional behaviour. Treating people as 'customers' rather than patients adversely affected the perception of pharmacists' professionalism, and the warning of pharmacists becoming '*merely the salesman for the big manufacturers*'[32] appeared a reality in some pharmacies. This illustrated a compromise by pharmacists of two of the components of professionalism identified by Wilkinson et al. (2009), namely adherence to ethical principles, and effective interactions with patients.[25]

The standards that do exist in Australia are not systematically monitored, there are limited financial imperatives to implement them, and the commercial environment in some pharmacies limits their application. The only prospective assessment process, the Quality Care Pharmacy Program was reported to be inadequate in both scope and application. Compulsory external monitoring of standards was strongly supported by stakeholders from within and outside the profession.

6.1. The policy environment of community pharmacy

Acting professionally and meeting standards in community pharmacy are not ends in themselves, rather they are expressions of the quality of pharmacists' performance. Furthermore, as members of an autonomous 'traditional profession', pharmacists have both the ethical responsibility and a social authority to apply their expertise for the betterment of public health.[66] Consequently, an issue for the profession, governments and the wider community revealed by this study is the potential influence of the growing business-professional role dichotomy on the provision of health care.

This dichotomy was perceived by some stakeholders to have led to an organisational culture in some pharmacies, particularly discount pharmacies, that impacts pharmacists' professionalism, including the provision of professional services.[67] In the interest of public health, we argue government policy should require the provision of a minimum set of professional services in all pharmacies. This was recommended the National Competition Policy Review of Pharmacy[68] and precedent exists in the Essential Services of the Community Pharmacy Contractual Framework in England.[69]

As it is apparent from our results that the current level of professionalism and compliance with standards in community pharmacy may compromise patient care, two further aspects of government policy warrant consideration; the obligation of pharmacists to meet standards, and funding that may induce or impede their implementation of standards. Examples from the literature that could be considered include a multi-faceted, nation-wide, quality framework for community pharmacy,[70] paying pharmacies for achievement of quality standards,[71] and aligning remuneration for professional services with patient needs[72] and outcomes.[73]

The purpose of a quality framework would be to make clear what is expected of pharmacists in relation to systems, professional practice, ethical behaviour, and interaction and communication with patients and with people working within the health system. As in the UK Pharmacy Quality Scheme, it should foster a shift from volume to quality.[74] A focal point of a quality framework would be the Quality Use of Medicines, including medication safety. The Medication Safety Standard of the Australian Commission on Safety and Quality in Healthcare[75] which is applied in hospitals, addresses clinical governance, quality improvement systems, medication management processes, and clinical processes such as medication reconciliation. Community pharmacy guidelines that exist in these and comparable areas should be incorporated into the quality framework.

Externally conducted quality audits could form part of the pharmacy quality framework and the Practice Incentive Program in general medical practice in Australia[71] which includes payment for compliance, provides a precedent. Alternatively, random monitoring could be undertaken and when there is evidence of standards not being met, result in financial or other penalties being placed on pharmacies. In either model, proprietors of community pharmacies should be responsible for compliance.

6.2. Funding policy and quality

In line with the global trend to value-based care,[76] a further means of encouraging quality in community pharmacy would be for the funding policy for dispensing and others aspects of patient care to incorporate quality principles and for payment to potentially be adjusted in relation to patient needs and health outcomes.[72]

It would be in the public interest for national, state, and territory governments to collaboratively develop funding, workforce, and scope of service policies, plus quality standards that enable pharmacists to spend adequate time with patients to counsel them on safe and appropriate medication use. However, as is apparent from the interviews, setting policies to foster enhanced health care does not ensure compliance or improved outcomes. Adjusting remuneration based on patient outcome measures has been used in performance-based pharmacy payments in the United States[73] as a means of influencing pharmacists' behaviour in support of quality. Adoption of this policy could be considered if outcome measures with high correlation and specificity for the services provided by pharmacists can be identified. In the absence of such measures, the existing payment model for pharmacists could be changed to incentivise the provision of service for patients of greatest complexity.

6.3. Policy and individual practitioners

Interpersonal issues between employer-proprietor pharmacists and employed pharmacists were identified by interviewees as negatively impacting professionalism. What were described on occasions as reflecting master-servant relationships rather than intra-professional relationships, undermine the professional independence of staff pharmacists. One policy aimed at supporting quality outcomes, would be for owners and managers of community pharmacies to be restricted from interfering with employed pharmacists' autonomy to adhere to their code of ethics. In addition, a policy that shares payment for dispensing between a pharmacist who delivers the professional service, and the pharmacy businesses in which they work, may help address the low remuneration of pharmacists, improve retention and engagement, and contribute to quality.[72]

6.4. Strengths and weakness of the research

A strength of this research is the large number of interviews conducted with stakeholders from multiple socio-ecological strata and substrata of community pharmacy, providing diverse opinions, and the enabling alignment of professionalism and standards with policy. However, as the large cohort of interviewees was spread across multiple sub-strata it was not feasible to undertake sub-group analysis, other than between pharmacists and non-pharmacists. The inclusion of 33 quotes drawn from 23 of the interviews provides a strong evidentiary base for the interpretations and recommendations presented in the discussion.

To address any pre-conceptions of the researcher undertaking the interviews and other pharmacist-members of the research team,

thorough review and discussion processes were adopted to minimise bias and enhance trustworthiness, however the findings are interpretive and caution should be adopted in wider applicability. The single country nature of the study may be perceived as a weakness, although the authors believe the findings may be relevant in any setting where pharmacists practice in a commercial environment, as trends in practice and professionalism are trans-national.

6.5. Future research

As funding was frequently identified as affecting pharmacists' performance, further research is warranted into the nature and options for funding that rewards behaviour aligned with quality outcomes. To support such a value-based remuneration structure, research is also necessary to identify and validate patient outcomes with high specificity and correlation with pharmacists' activities.

7. Conclusion

This study explored performative aspects of pharmacists' behaviour including professionalism and adherence to standards, and the findings have implications for the classification of pharmacy as an autonomously regulated profession in Australia. The government funding policy for PBS dispensing rewards speed and volume, which can compromise pharmacists spending time counselling patients, and was therefore seen to be detrimental to perceptions of professionalism. The inconsistent application of standards undermines trust in the profession. Both changes to the existing funding policy, and the introduction of an externally monitored quality framework could be used to foster compliance and improve performance. Policies aimed at addressing the impact of the growing business paradigm in community pharmacy should flag clearly the communities' expectations in relation to professionalism, standards, and the provision of professional services, provide incentives to comply with the standards, support compulsory independent monitoring, and reward achievement.

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Institutional review board statement / ethics approval

The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of Monash University (protocol code 31875 7 March 2022).

CRediT authorship contribution statement

John K. Jackson: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Carl M. Kirkpatrick:** Writing – review & editing, Writing – original draft, Supervision, Formal analysis, Conceptualization. **Shane L. Scahill:** Writing – review & editing, Validation, Formal analysis, Conceptualization. **Michael Mintrom:** Writing – review & editing, Methodology, Formal analysis, Conceptualization. **Betty B. Chaar:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation.

Declaration of competing interest

JJ is a director two community pharmacy enterprises that receive funding for dispensing prescriptions, negotiated under the Community Pharmacy Agreement. He holds no pecuniary interest in either enterprise.

C.M.K., S.S., M.M., and B.C. report that they have no competing interests or financial relationships that may have direct or indirect interest in this subject matter.

Appendix A. Interviewee codes

Code	Sex	Strata	Sub-strata	Pharmacist	Expertise
1/Politician/GP	M	Societal	Politician	No	Medical practitioner
2/Politician	M	Societal	Politician	No	Health policy
3/Phcist	F	Interpersonal	Other phcist	Hospital	Standards
4/Regulator/Phcist	M	Societal	Regulator	Regulatory	State Phcy Authority
5/PhAssn/Phcist	M	Community	Phcy asscn	Community	Industrial association
6/PhAssn/Policy Phcist	M	Community	Phcy asscn	Hospital	Policy officer
7/Academic Assn/Phcist	M	Community	Other org	Academia	Assn. representative
8/Phcist	M	Interpersonal	Other phcist	Regulatory	Legislation expert
9/Prop Phcist	M	Organisational	Proprietor	Proprietor	
10/PhAssn/Accred Phcist	M	Community	Phcy asscn	Consultant	Association CEO
11/PhAssn/Prop Phcist	F	Community	Phcy asscn	Proprietor	Proprietor
12/Policy Phcist	M	Societal	Bureaucrat	Policy	Federal bureaucrat
13/Bureaucrat/Phcist	F	Societal	Bureaucrat	Regulatory	State bureaucrat
14/Consumer	F	Interpersonal	Consumer	No	Consumer Association
15/PhAssn/Student Phcist	M	Community	Phcy asscn	Community	Student
16/Commentator/Consumer	M	Community	Commentator	No	Financial advisor
17/Policy	M	Societal	Policy expert	No	Political advisor
18/Policy	M	Societal	Policy expert	No	Health economist
19/Prop/Accred Phcist	M	Organisational	Proprietor	Proprietor	Accredited pharmacist
20/Consumer	F	Interpersonal	Consumer	No	Consumer
21/Prop Phcist	F	Organisational	Proprietor	Hospital	
22/Assn/GP	F	Community	Other org	No	Medial practitioner
23/Phcist	F	Interpersonal	Phcist comm	Community	Friendly society phcy
24/Policy	M	Societal	Policy expert	No	Regulator, economist
25/Commentator	M	Community	Commentator	No	Journalist
26/Bureaucrat/Consumer	F	Societal	Bureaucrat	No	Federal bureaucrat
27/Accred Phcist	F	Interpersonal	Other phcist	Consultant	Gen Med Practice
28/Phcist	M	Interpersonal	Phcist comm	Community	Industrial affairs
29/Assn	M	Community	Other org	No	Supply chain
30/Prop/Accred Phcist	M	Organisational	Proprietor	Proprietor	Rural

(*continued on next page*)

(*continued*)

Code	Sex	Strata	Sub-strata	Pharmacist	Expertise
31/Phcist	F	Interpersonal	Other phcist	Academia	Indigenous
32/Commentator	F	Community	Commentator	No	Bank
33/Consumer	F	Interpersonal	Consumer	No	Consumer Assn.
34/Phcist/Consumer	M	Interpersonal	Consumer	Policy	Indigenous
35/Phcist	F	Interpersonal	Phcist comm	Community	
36/PhAssn/Policy Phcist	M	Community	Phcy asscn	Community	Policy
37/PhAssn/Prop Phcist	M	Community	Org	Community	Proprietor
38/PhAssn/Prop Phcist	M	Community	Org	Community	Proprietor

Appendix B. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.rcsop.2024.100499.

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