



Beyond Placement: Power, Legitimacy, and Equity in Integrating Practice Pharmacists into Primary Healthcare

Comment on “Developing Integrated Extended Pharmacist Roles and Services for Equitable Access and Outcomes in Primary Healthcare: A Realist Evaluation”

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Abstract

Officer and colleagues show that integrating practice pharmacists into primary healthcare (PHC) involves more than adding a new professional to the team. It represents a health-system change shaped by policy, funding, workplace culture, professional relationships, infrastructure, and patient trust. Building on their realist evaluation, this commentary argues that extended pharmacist roles also redistribute authority, resources, and responsibilities within PHC. Sustainable integration therefore depends on institutional legitimacy, built through a clear policy mandate, secure employment, defined roles, access to shared information, acceptance within healthcare teams, and public understanding of the role. The arrangements through which this legitimacy is built also have important equity consequences, as funding, copayments, deployment, and local capacity shape where services are available, who can access them, and whether they can be sustained. The commentary therefore draws out implications for how extended pharmacist roles should be financed, governed, adapted, and evaluated to support equitable and sustainable integration into PHC.

Keywords: Primary Healthcare, Practice Pharmacists, Health Equity, Workforce Governance, Realist Evaluation, New Zealand

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Citation: Buthelezi U. Beyond placement: power, legitimacy, and equity in integrating practice pharmacists into primary healthcare: Comment on “Developing integrated extended pharmacist roles and services for equitable access and outcomes in primary healthcare: a realist evaluation.” *Int J Health Policy Manag.* 2026;15:10224. doi:10.34172/ijhpm.10224

Article History:

Received: 31 July 2026

Accepted: 5 October 2026

ePublished: 26 October 2026

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Introduction

Officer and colleagues move the discussion beyond whether practice pharmacists can contribute to primary healthcare (PHC) to the more important question of what helps their roles become integrated, sustained, and equitable.¹ Their realist evaluation shows that professional expertise alone is not enough. Outcomes depend on policy leadership, funding, employment arrangements, organisational infrastructure, relationships within the team, role fit, and patient understanding. This is important because workforce expansion is often presented as a technical response to shortages, even though it also changes relationships, authority, and accountability within the health system.

This commentary argues that integration should not be understood simply as placing a practice pharmacist inside general practice. Although co-location may support communication and trust, meaningful integration also depends on how influence is exercised and how the role is recognised within the wider health system. The policy challenge is not only how to introduce practice pharmacists, but how to ensure that the role has the authority, resources, and legitimacy needed for meaningful integration.

Integration Is More Than Placement

The programme theories developed by Officer et al identify several conditions that make practice pharmacist roles more likely to be accepted and used. These include visible clinical contribution, sufficient time within practice, access to patient information, supportive colleagues, appropriate infrastructure, and a role that fits the practice and community.¹ Wider evidence points to the same conditions, particularly trust, role clarity, orientation, professional support, strong working relationships, and sustained funding.^{2,3} Institutional legitimacy is related to these conditions but is broader than any one of them. In this commentary, it refers to the extent to which the practice-pharmacist role is recognised as appropriate and supported within prevailing policy, organisational, and professional arrangements. It therefore builds on, but is not reducible to, role clarity, professional acceptance, or participation within the care team.

To examine how these conditions come together in practice, this commentary considers integration across five connected dimensions: spatial, functional, relational, institutional, and normative. This analytical synthesis is tailored to practice-pharmacist integration and draws in part on the Rainbow

Model of Integrated Care, particularly its functional and normative dimensions.⁴ Spatial integration concerns the practice pharmacist's presence within practice; functional integration involves shared records, referral pathways, communication routines, and coordinated workflows; relational integration depends on trust, recognition of competence, and confidence that recommendations will be considered and acted upon; and institutional integration requires a policy-recognised mandate, appropriate authority, secure employment, training pathways, and accountability for results. In the Rainbow Model, normative integration concerns the shared mission, values, and culture that connect professionals, organisations, and levels of care.⁴ Applied here, it involves a shared understanding among policy-makers, practices, professionals, and communities of practice pharmacists' roles, purpose, and contribution to equitable PHC. A practice pharmacist may therefore be physically present yet remain poorly integrated if excluded from clinical decisions, referrals are inconsistent, professional authority is constrained, or patients do not understand the role.

This distinction also changes what health systems should measure. Counting pharmacist posts, practices reached, or consultations delivered is not enough. Integration should also be assessed through referral use, responses to pharmacist recommendations, participation in team decisions, access to shared information, continuity of follow-up, patient understanding, and whether the role continues after pilot funding ends. Integration is therefore an achieved relationship between a worker and a health system, rather than something automatically created by a job title or physical location.

Skill-Mix Reform Redistributes Power

Extended roles change professional boundaries. They affect who makes prescribing and medicines-related decisions, whose expertise is recognised, who can access and update clinical records, who receives referrals, and who carries responsibility when care is delayed or fragmented. Power in this sense is not reducible to prescribing authority; it also operates through access to information, influence over decisions, recognition of expertise, and control over referral and care processes. Research on interprofessional teams shows that these boundaries are shaped through leadership, trust, professional autonomy, and organisational arrangements.^{5,6} Therefore, how these boundaries are negotiated ultimately shapes whether the pharmacist role becomes a legitimate and integrated part of the care team or remains peripheral despite formal expansion.

In addition, the 'burning platform' created by workforce shortages and increasingly complex patient needs may build support for expanding pharmacist roles.¹ However, changes introduced mainly in response to a crisis can produce narrow roles designed primarily to reduce doctors' workloads. Reducing workload is valuable, but the key question is whether the role also allows pharmacists to use their distinct expertise to improve patient care. Its value should also be considered in relation to the productivity of the wider care pathway, since differences in pay, productivity, and practice patterns influence the workforce and cost implications of

skill-mix change.⁷ Evidence from Francetic et al suggests that the effects of skill-mix change vary across settings and arrangements, including in prescribing, costs, and patient experience.⁸

Role expansion therefore requires clear agreement on how professions will work together, what authority each role carries, and who is accountable for different parts of care. Scopes of practice should not create rigid silos, but teams need shared expectations about decision-making, referrals, clinical escalation, and follow-up. Without these arrangements, pharmacists may be held responsible for outcomes without having the authority, information, or organisational support needed to influence them.

Funding Is a Governance Instrument

One of the lead article's most important findings is that funding operated across different levels of the system and could function as both context and mechanism.¹ External funding encouraged practices to take up pharmacist services, while direct investment by a practice could strengthen local commitment. However, money alone did not overcome poor role fit, limited space, weak understanding, or lack of ownership. Realist thinking helps clarify this finding by separating the resource that is introduced from how people interpret and respond to it in a particular setting.⁹ The effects of funding therefore depend not only on how much is available, but also on the employment, governance, and service arrangements it creates. It influences who employs the pharmacist, who sets priorities, whether local teams can adapt the service, whether posts are secure or temporary, and whether patients must pay for services.

These arrangements further shape how pharmacists can fully become embedded within individual practices and how services are distributed across the wider primary care system. For example, a pharmacist employed externally and working across several practices may support population-level goals, but may have less time to build visibility, trust, and continuity within each practice. In contrast, local employment may strengthen adaptation and ownership. However, where such employment depends on individual practices' financial capacity, it may also create a situation where better-resourced practices are more able to establish or sustain these roles, with implications for geographic and socioeconomic equity.

These trade-offs show that funding pharmacist services is not a neutral administrative choice; it is a tool of governance. The central policy principle is that financing should align authority, accountability, sustainability, and access, rather than simply pay for an additional worker. Alignment across these elements can support practice pharmacists' integration into PHC and strengthen the institutional legitimacy of their role, but it does not guarantee integration on its own.

Equity Must Be Built Into the Implementation Pathway

Officer et al include equitable access and outcomes in the desired endpoint of their programme theory, while acknowledging that their evaluation primarily examined role development, acceptance, and use rather than longer-term clinical or equity outcomes.¹ Building on this limitation,

and drawing on wider equity-focused implementation literature, this commentary argues that equity should be considered throughout implementation rather than only as an endpoint.^{10,11} Service design, organisational settings, implementation processes, and the circumstances of intended users can interact to create or reduce disparities.

Viewed through this implementation lens, equity in design concerns who decides where practice pharmacists are located and which services they provide. Equity in implementation concerns whether rural, Indigenous, low-income, and clinically complex populations receive access according to need. Equity in experience concerns whether patients understand the role, trust the practice pharmacist, and experience care as culturally safe. Equity in outcomes concerns whether improvements in medicines safety, adherence, condition control, avoidable hospital use, and patient-reported outcomes are shared fairly across population groups.

In Aotearoa New Zealand, wider cultural-safety literature suggests that equitable integration requires more than directing mainstream services towards Māori patients. Cultural safety scholarship emphasises that organisations and health systems must examine power, institutional arrangements, and accountability, while placing the judgement of safety with patients and communities rather than relying only on professional intention.¹² A Te Tiriti-consistent approach to integration would therefore involve Māori participation in governance and priority-setting, support for Māori-led models, patient-defined measures of cultural safety, and transparent reporting of access and outcomes. Evidence from Māori primary care similarly shows that high-need providers cannot reasonably be expected to achieve equal outcomes when they operate with fewer resources and limited system support.¹³

Furthermore, addressing copayments is particularly important. Financial barriers to PHC and prescription access in Aotearoa New Zealand remain strongly linked to ethnicity and socioeconomic position.¹⁴ Therefore, a service cannot be considered equity-oriented simply because it targets high-need patients if those patients are least able to pay for it. These financial barriers suggest that public funding, rural and outreach supplements, protection from patient fees, and adjustment for multimorbidity and deprivation should be considered as part of service design rather than as external financing issues.

Patients Should Not Carry the Burden of Understanding New Roles

Officer et al found that the seven patients interviewed had already accessed practice-pharmacist services and often developed trust after receiving care, despite limited prior understanding of the role.¹ Their experiences are therefore informative about care among service users, but cannot establish how well the wider population understands, reaches, or takes up these services. Patients may still be left to work out which professional they need, whether the practice pharmacist replaces or supports a doctor, whether information will be shared, what the consultation may cost, and who remains responsible for follow-up.

Research on patients' experiences of new PHC roles describes this additional effort as patient "work."¹⁵ Public communication should therefore be considered part of implementation rather than optional marketing. Patients need clear explanations of practice pharmacists' competence and authority, their relationships with other clinicians, referral processes, costs, and continuity arrangements. Patient representatives can also help assess whether service language and pathways are understandable before implementation. Understanding the experiences of those who use the service is important, but equitable access also requires attention to those who remain unaware of the service, cannot reach it, do not trust it, or cannot afford it.

International Transfer Requires Whole-Workforce Planning

The programme theories developed in Aotearoa New Zealand may have relevance beyond that setting; however, their transfer should focus on the underlying mechanisms rather than assume equivalence or copy the service model. Evidence from low- and middle-income countries often concerns community pharmacists, whose employment arrangements, access to clinical records, referral relationships, prescribing authority, and organisational accountability may differ from those of practice pharmacists integrated into general-practice teams.¹⁶ Such evidence is therefore informative about the broader challenges of formal recognition, collaboration, and professional development, but cannot be transferred directly. Trust, legitimacy, role clarity, access to information, and sustainable funding may be relevant across settings, while the policies and organisational arrangements needed to create them may differ.

Expansion should therefore be considered within needs-based whole-workforce planning rather than pharmacy workforce planning alone. Starting from population health needs and the model of care required to meet them, planning should consider how tasks are distributed across professional groups, including the productivity and workforce implications of role shifting and substitution.⁷ Moving pharmacists into general practice may strengthen one part of the system while worsening shortages in community, hospital, or rural pharmacy. Workforce planning should therefore consider these flows alongside training and prescribing pathways, career development, and the services from which practice pharmacists are drawn. The broader lesson is that new and extended practice-pharmacist roles depend on health systems that recognise, support, and connect them to the wider pathway of care.

Key Considerations for Equitable and Accountable Integration

Table synthesises Officer and colleagues' findings together with the policy and implementation implications developed in this commentary into four areas relevant to practice-pharmacist integration.

Conclusion

Extended pharmacist roles will not become fully integrated or equitable simply because pharmacists are clinically capable, physically located within PHC teams, or accepted by patients

Table. Policy and Implementation Considerations for Equitable Practice-Pharmacist Integration

Area	Proposed System Arrangements	Suggested Monitoring	Main Level(s) Responsible
Institutional legitimacy and financing	Establish the role through an endorsed policy or service strategy, with appropriate authority, recurrent financing, secure employment, shared records, and suitable infrastructure.	Continuity of posts; authorised activities; access to records; referrals and follow-up.	National/regional policy and funders; PHC organisations and practices.
Community participation and cultural safety	Involve priority communities in service design and governance; support culturally safe and understandable service pathways.	Community participation; awareness; patient experience; reasons for non-use.	PHC organisations and practices, working with communities.
Equitable access and outcomes	Align service location, referral pathways, and patient costs with population need.	Access, experience, continuity, and outcomes across population groups.	Funders, PHC organisations, and practices.
Workforce stewardship	Link role expansion to needs-based whole-workforce planning, training, and viable career pathways.	Workforce movement; vacancies; workload; service availability; rural retention.	National/regional workforce planners, funders, and professional bodies.

Abbreviation: PHC, primary healthcare.

who use their services. However, integration can be produced when policy and financing provide a clear mandate and secure employment; organisational infrastructure enables shared information and coordinated care; professional authority and team relationships legitimise the pharmacist's contribution; and community participation, public understanding, and equity-focused accountability ensure that services are accessible, culturally safe, and responsive. The next stage of pharmacist workforce reform should therefore move beyond counting posts and documenting acceptance. It should examine who receives these services, who remains excluded, how professional and patient relationships are changing, and whether expanded roles reduce rather than reproduce inequalities in PHC.

Disclosure of artificial intelligence (AI) use

Not applicable.

Ethical issues

Not applicable.

Conflicts of interest

Author declares that he has no conflicts of interest.

References

- Officer TN, McDonald J, Smiler K, et al. Developing Integrated Extended Pharmacist Roles and Services for Equitable Access and Outcomes in Primary Healthcare: A Realist Evaluation. *Int J Health Policy Manag.* 2025;14(1):1-16. doi:10.34172/ijhpm.9127
- Owen-Boukra E, Cai Z, Duddy C, et al. Collaborative and integrated working between general practice and community pharmacies: A realist review of what works, for whom, and in which contexts. *J Health Serv Res Policy.* 2025;30(2):136-148. doi:10.1177/13558196241290923
- Jorgenson D, Laubscher T, Lyons B, Palmer R. Integrating pharmacists into primary care teams: barriers and facilitators. *Int J Pharm Pract.* 2014;22(4):292-299. doi:10.1111/ijpp.12080
- Valentijn PP, Boesveld IC, van der Klauw DM, et al. Towards a taxonomy for integrated care: a mixed-methods study. *Int J Integr Care.* 2015;15(1). doi:10.5334/ijic.1513
- MacNaughton K, Chreim S, Bourgeault IL. Role construction and boundaries in interprofessional primary health care teams: a qualitative study. *BMC Health Serv Res.* 2013;13(1):486. doi:10.1186/1472-6963-13-486
- King O, Nancarrow SA, Borthwick AM, Grace S. Contested professional role boundaries in health care: a systematic review of the literature. *J Foot Ankle Res.* 2015;8(1):2. doi:10.1186/s13047-015-0061-1
- Birch S, Gibson J, McBride A, Munros team. Opportunities for, and implications of, skill mix changes in health care pathways: Pay, productivity and practice variations in a needs-based planning framework. *Soc Sci Med.* 2020;250:112863. doi:10.1016/j.socscimed.2020.112863
- Francetic I, Gibson J, Spooner S, Checkland K, Sutton M. Skill-mix change and outcomes in primary care: Longitudinal analysis of general practices in England 2015–2019. *Soc Sci Med.* 2022;308:115224. doi:10.1016/j.socscimed.2022.115224
- Dalkin SM, Greenhalgh J, Jones D, Cunningham B, Lhussier M. What's in a mechanism? Development of a key concept in realist evaluation. *Implement Sci.* 2015;10(1):49. doi:10.1186/s13012-015-0237-x
- Gustafson P, Lambert M, Bartholomew K, et al. Adapting an equity-focused implementation process framework with a focus on ethnic health inequities in the Aotearoa New Zealand context. *Int J Equity Health.* 2024;23(1):15. doi:10.1186/s12939-023-02087-y
- Woodward EN, Matthieu MM, Uchendu US, Rogal S, Kirchner JE. The health equity implementation framework: proposal and preliminary study of hepatitis C virus treatment. *Implement Sci.* 2019;14(1):26. doi:10.1186/s13012-019-0861-y
- Curtis E, Jones R, Tipene-Leach D, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health.* 2019;18(1):174. doi:10.1186/s12939-019-1082-3
- Sheridan N, Jansen RM, Harwood M, et al. Hauora Māori – Māori health: a right to equal outcomes in primary care. *Int J Equity Health.* 2024;23(1):42. doi:10.1186/s12939-023-02071-6
- Jeffreys M, Ellison-Loschmann L, Irurzun-Lopez M, Cumming J, McKenzie F, on behalf of the Primary Health Care Programme Grant Team. Financial barriers to primary health care in Aotearoa New Zealand. *Fam Pract.* 2024;41(6):995-1001. doi:10.1093/fampra/cmada096
- Dalgarno E, McDermott I, Goff M, et al. The patient experience of skill mix changes in primary care: an in-depth study of patient 'work' when accessing primary care. *J Public Health (Oxf).* 2023;45(Suppl 1):i54-i62. doi:10.1093/pubmed/fdad203
- Hedima EW, Okoro RN. Primary health care roles of community pharmacists in low- and middle-income countries: a mixed methods systematic review. *BMC Health Serv Res.* 2025;25(1):1269. doi:10.1186/s12913-025-13387-0