MDForLives

THE GLOBAL PULSE OF HEALTHCARE · PHARMACY PRACTICE INSIGHT REPORT

Pharmacist Patient Care: What Still Limits a Bigger Clinical Role?

Responses from pharmacists across six countries on how direct patient care is expanding beyond dispensing, where workload and information gaps constrain intervention, how collaboration functions in practice, and what changes could unlock a larger clinical role.

Role → Workflow → Constraints → Expansion

159	6	77.4%	8978519
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate	Survey ID

WHY THIS REPORT

Pharmacists are taking on more clinical responsibility, but the work still competes with the structure of traditional pharmacy practice.

A medication problem can surface at the pharmacy counter long before the next medical appointment. A patient may be confused about two medicines that appear to do the same thing, report an adverse effect, struggle with adherence, need a vaccination, ask about a chronic condition, or present with a problem that may require escalation.

For pharmacists, recognizing the problem is only the first step. Acting on it depends on time, access to patient information, scope of practice, reimbursement, training, technology, and the quality of collaboration with physicians and other healthcare professionals. These conditions decide whether the pharmacist can resolve the issue directly, coordinate a change, or refer the patient elsewhere.

This report examines that operating reality. It looks at how rapidly the direct-care role is expanding, which services pharmacists already provide, how much working time clinical care occupies, what shapes intervention decisions, what blocks greater responsibility, how well information and collaboration support the role, and which changes pharmacists believe would make the biggest difference next.

CLINICAL CONTEXT

The profession is moving toward broader pharmaceutical care, but role expansion needs system support.

WHO/Europe described the pharmacist role in 2024 as evolving beyond the traditional supply and dispensing of medicines toward pharmaceutical care, chronic disease support, and acute services such as vaccination. FIP's 2025 Global Situation Report on Pharmacy likewise highlights workforce capacity, evolving pharmacy services, digital health transformation, and professional resilience as linked priorities for the profession.

Those external trends help frame the MDForLives findings without replacing them. The survey does not ask whether expanded pharmacy practice is desirable in theory. It asks what pharmacists themselves are already doing, what limits them, and which operating conditions would make direct patient care more workable.

Collaboration is another part of that context. In the United States, CDC guidance notes that scope-of-practice laws and collaborative practice agreements can enable pharmacists to contribute to chronic disease management, care transitions, and medication therapy management. The legal mechanisms differ across countries, but the underlying implementation question is broader: when pharmacists are expected to provide clinical care, are authority, information, workflow, and accountability aligned?

> **Methodology:** MDForLives All Markets report for SGID 8978519, Pharmacist Insight Survey_Sep. The source contains 159 total survey records and a 77.4% completion rate across the USA, UK, Canada, Italy, France, and Germany. Closed-question bases vary by item from 125 to 129 as respondents progressed through the survey. Multi-select questions allowed up to three selections where stated. The open-response lens reflects 20 visible substantive comments. Hidden operational, store-text, end-word, and honeypot fields were excluded.

EXECUTIVE SUMMARY

Six signals that define the current gap between pharmacist capability and clinical capacity.

INSIGHT 01

78.6% - Workload and staffing are the dominant constraint

Limited consultation time, staffing pressure, and workload are selected more often than scope, information, technology, or collaboration as barriers to taking on greater clinical responsibility.

INSIGHT 02

79.8% - Medication review is already mainstream

Medication review, optimization, and adherence counseling are the most commonly reported services beyond traditional dispensing, showing that direct clinical work is already embedded in many settings.

INSIGHT 03

82.7% - Patient need leads the intervene-or-refer decision

Clinical severity and immediate patient need are the leading influence, but scope, information access, time, confidence, and referral pathways still shape what the pharmacist can do next.

INSIGHT 04

35.7% - Most have information access, but not full access

The largest group can access most information needed, while only 27.8% report full access and another 27.8% describe partial or fragmented access.

INSIGHT 05

36.8% - Collaboration is more often general than highly integrated

Only 20.8% describe regular shared-care communication as highly integrated. The most common answer is generally collaborative, suggesting cooperation without full workflow integration.

INSIGHT 06

68.0% - Pharmacists ask for both scope and protected capacity

Broader scope and reimbursement tie with protected consultation time, staffing, and lower administrative burden as the most selected changes for strengthening direct patient care.

01

ROLE EXPANSION

The direct-care role is expanding faster than a traditional dispensing model can easily absorb

45.7% say the role of pharmacists in direct patient care has expanded significantly over the past three years.

CONTEXT

Pharmacy practice is increasingly judged not only by whether the correct medicine is supplied, but by what happens around the medicine: whether therapy is appropriate, safe, understood, affordable, adhered to, and monitored. That creates a broader clinical role while the prescription-dispensing function remains essential.

WHAT THE DATA SHOWS

45.7% say the direct-care role has expanded significantly and 38.0% say it has expanded moderately. 14.7% say it has remained largely unchanged, while 1.6% say it has become more limited.

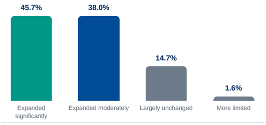
THE INSIGHT

The direction of travel is clear even though the pace differs by setting. Most respondents describe some degree of expansion, which means clinical care is no longer a peripheral activity for many pharmacists. Yet expanding responsibility changes the workload: clinical assessment and counseling take time that cannot be created simply by adding another expectation to an unchanged dispensing process.

WHY IT MATTERS

WHO/Europe has described a similar move toward pharmaceutical care, chronic disease support, and vaccination. The survey adds the operational side of that transition: broader roles need workflows that recognize clinical tasks as planned work rather than optional work completed when dispensing slows down.

How the pharmacist role in direct patient care has changed



02

SERVICES BEYOND DISPENSING

Medication review leads a broad portfolio of patient-facing pharmacy services

79.8% provide medication review, optimization, or adherence counseling beyond traditional dispensing.

CONTEXT

Direct patient care in pharmacy is not one service. Depending on setting and jurisdiction, the pharmacist may review therapy, counsel on adherence, vaccinate, screen, test, support chronic conditions, manage minor ailments, or deliver prevention and medication-safety services.

WHAT THE DATA SHOWS

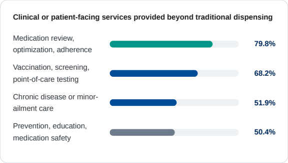
79.8% report medication review, optimization, or adherence counseling. 68.2% provide vaccination, screening, or point-of-care testing. 51.9% report chronic disease management or minor-ailment care, and 50.4% report preventive care, patient education, or medication safety services. Respondents could select up to three services.

THE INSIGHT

Medication optimization remains the clearest shared clinical function, but the distribution also shows a broader public-health and primary-care footprint. The pharmacist is increasingly positioned at the intersection of medicines, prevention, access, and early clinical triage.

WHY IT MATTERS

A wider service mix creates more handoffs, documentation, follow-up, and coordination. If these services are expected to grow, staffing models, technology, reimbursement, and physical consultation space need to be designed around a portfolio of patient-care tasks rather than a single service line.


Clinical or patient-facing services provided beyond traditional dispensing

03

CLINICAL TIME

Direct patient care takes a substantial share of the working day for some pharmacists, but not for all

34.4% spend more than half of their working time on direct clinical or patient-care activities beyond dispensing.

CONTEXT

Role expansion becomes operationally meaningful when it changes how the working day is allocated. A pharmacist who spends most of the day on direct care requires a different staffing and workflow model from one who delivers clinical services intermittently around dispensing.

WHAT THE DATA SHOWS

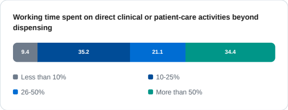
34.4% report that more than half of their working time is spent on direct clinical or patient-care activity beyond dispensing. 21.1% place the share at 26-50%, 35.2% at 10-25%, and 9.4% at less than 10%.

THE INSIGHT

The distribution shows two realities at once. Clinical care is a major part of the job for a sizeable group, but many pharmacists still deliver it within a more limited time window. That variation helps explain why the same expanded scope can feel routine in one setting and difficult to operationalize in another.

WHY IT MATTERS

Protected clinical time cannot be defined only by professional title. It has to match the service model, patient volume, staffing mix, and expected follow-up. A pharmacy that wants more patient-care activity needs to decide which work will be redistributed, automated, scheduled differently, or reimbursed differently to create that capacity.


Working time spent on direct clinical or patient-care activities beyond dispensing

04

INTERVENE OR REFER

Patient need drives the clinical decision, but the system defines the range of possible action

82.7% say clinical severity and the patient's immediate needs influence whether they intervene directly or refer.

CONTEXT

Pharmacists often encounter problems in an in-between space: important enough to require action, but not always severe enough to need emergency or physician-led care. The safest next step depends on the problem and on what the pharmacist can reliably assess, treat, monitor, or escalate.

WHAT THE DATA SHOWS

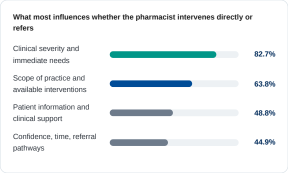
82.7% select clinical severity and immediate patient need as an influence on intervention versus referral. 63.8% select scope of practice and available interventions, 48.8% select access to patient information and clinical support, and 44.9% select clinical confidence, time, and established referral pathways.

THE INSIGHT

Clinical urgency leads the decision, but it does not make the decision alone. Scope, information, confidence, time, and referral infrastructure determine whether the pharmacist can close the loop personally or must transfer responsibility to someone else.

WHY IT MATTERS

Expanding pharmacist patient care without clarifying escalation pathways can create ambiguity. The goal is not maximal autonomy in every situation. It is a reliable boundary between what the pharmacist manages directly, what is managed collaboratively, and what requires referral, supported by information and communication that make the handoff safe.



What most influences whether the pharmacist intervenes directly or refers

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05

WORKLOAD AND CAPACITY

The largest barrier is the time and staffing needed to turn clinical capability into routine care

78.6% select workload, staffing, or limited consultation time as a main factor limiting greater clinical responsibility.

CONTEXT

Clinical work creates a different rhythm from high-volume dispensing. A medication review or chronic-care consultation may require a private conversation, review of records, documentation, follow-up, or contact with another professional. Those tasks are difficult to compress when staffing is already tight.

WHAT THE DATA SHOWS

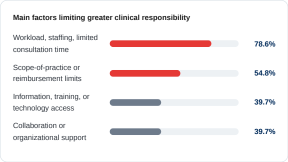
78.6% select workload, staffing, or limited consultation time. 54.8% select scope-of-practice or reimbursement limitations. Limited access to patient information, training, or technology and limited collaboration or organizational support are each selected by 39.7%.

THE INSIGHT

The barrier hierarchy puts capacity before permission. Scope and reimbursement matter, but the highest response is about whether the pharmacist has enough time and staff support to do the clinical work properly. That suggests role expansion can fail even where legal authority already exists.

WHY IT MATTERS

FIP's 2025 global pharmacy work highlights workforce capacity and professional resilience alongside evolving service scope. The survey makes that connection concrete: if clinical work is added without redesigning staffing and workload, the pharmacist may be asked to carry two full operating models at once.



Main factors limiting greater clinical responsibility

06

PATIENT INFORMATION

Many pharmacists can access some clinical information, but full access is not the norm

Only 27.8% report full access to the clinical information they need for effective patient care.

CONTEXT

A pharmacist can recognize a potential medication issue yet still need context before acting. Recent diagnoses, laboratory values, allergy history, specialist notes, current medicine changes, treatment goals, and prior adverse reactions can all affect the safety of a recommendation.

WHAT THE DATA SHOWS

27.8% report full access to relevant clinical information. The largest group, 35.7%, report access to most information needed. Another 27.8% describe partial or fragmented access, and 8.7% report very limited or no meaningful access.

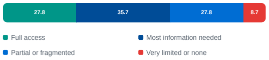
THE INSIGHT

The information problem is not simply access versus no access. A large middle group has enough information to work with, but not necessarily a complete picture. That can create extra calls, repeated history-taking, reliance on patient recall, or a more conservative decision when uncertainty remains.

WHY IT MATTERS

Better record access is also one of the survey's requested enablers. As pharmacy services move further into medication optimization, chronic disease care, screening, and monitoring, interoperable information becomes clinical infrastructure rather than an administrative convenience.

Access to patient information needed for effective clinical care



07

COLLABORATION

Collaboration is common, but highly integrated shared care remains less common

36.8% describe collaboration as generally collaborative, while 20.8% describe highly integrated shared-care communication.

CONTEXT

Pharmacist patient care often crosses professional boundaries. A therapy may need confirmation from a prescriber, a monitoring result may need follow-up, a patient may need referral, or a pharmacist recommendation may need to be visible to the wider care team.

WHAT THE DATA SHOWS

36.8% describe collaboration as generally collaborative. 28.8% say collaboration occurs only for selected patients or situations, 20.8% report highly integrated care with regular shared-care communication, and 13.6% describe collaboration as limited or mostly transactional.

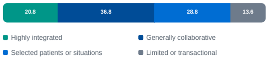
THE INSIGHT

Most respondents are not working in isolation, but collaboration does not always mean integration. The difference matters. A pharmacist may have a good professional relationship with local clinicians yet still lack shared records, defined response times, agreed protocols, or a routine channel for closing the loop after a recommendation.

WHY IT MATTERS

CDC guidance in the United States provides one example of formalizing team-based care through collaborative practice agreements. Other countries use different mechanisms. The common design principle is clarity: who can do what, what information is shared, when escalation is required, and how the care team knows the issue was resolved.

How pharmacists describe collaboration with other healthcare professionals



08

NEXT SERVICE FRONTIER

Pharmacists see the strongest growth potential in medication optimization and chronic disease management

35.2% select medication optimization and chronic disease management as the pharmacist-led service with the greatest expansion potential.

CONTEXT

The profession has several plausible directions for growth: deeper medication management, more prevention and vaccination, more minor-ailment and point-of-care care, or more digital and collaborative models. The survey forces a single choice, revealing where respondents see the strongest near-term potential.

WHAT THE DATA SHOWS

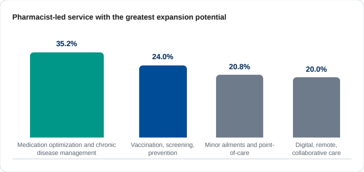
35.2% choose medication optimization and chronic disease management. 24.0% select vaccination, screening, and preventive health services. 20.8% choose minor-ailment management and point-of-care care, while 20.0% select digital, remote, or collaborative pharmacist-led care.

THE INSIGHT

The leading answer stays close to pharmacists' core medicines expertise but moves it deeper into longitudinal care. Respondents appear to see the biggest opportunity not in leaving medicines behind, but in using medication expertise more actively across chronic treatment decisions, monitoring, adherence, and optimization.

WHY IT MATTERS

This direction increases the importance of longitudinal information, reliable follow-up, and collaboration. Chronic disease management is not a one-off service. It requires continuity, documentation, and clarity about when the pharmacist can adjust care directly and when another clinician needs to be involved.


Pharmacist-led service with the greatest expansion potential

09

ENABLERS FOR DIRECT CARE

The profession is asking for role expansion and workload redesign at the same time

68.0% select broader scope and reimbursement, and 68.0% select protected consultation time, staffing, and reduced administrative workload.

CONTEXT

The survey's final closed question moves from describing barriers to asking what would actually strengthen direct patient care. The options cover information, scope and payment, protected time and staffing, and training and collaboration.

WHAT THE DATA SHOWS

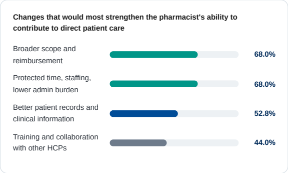
Broader scope of practice and reimbursement for clinical services is selected by 68.0%. The same 68.0% select protected consultation time, staffing, and reduced administrative workload. 52.8% select greater access to patient records and clinical information, and 44.0% select stronger clinical training and collaboration with other healthcare professionals.

THE INSIGHT

No single lever is enough. Authority without time can create an unfunded workload. Time without information can limit safe decisions. Information without collaborative pathways can leave recommendations disconnected from the rest of care. The pattern suggests that pharmacist patient care is an operating-model question, not simply a scope-of-practice question.

WHY IT MATTERS

Implementation needs to bundle the enablers. Health systems, employers, payers, professional bodies, and regulators may control different pieces, but the pharmacist experiences them as one workflow. The strongest model is the one in which scope, staffing, records, reimbursement, training, and team communication reinforce each other.


Changes that would most strengthen the pharmacist's ability to contribute to direct patient care

OPEN RESPONSE LENS

In pharmacists' own words, the missing pieces are records, time, authority, reimbursement, and recognition.

The open-ended question asked what one change would most meaningfully transform the pharmacist's contribution to patient care. Twenty substantive responses were visible in the source report, including comments in English, German, French, and Italian. They were reviewed qualitatively after excluding hidden operational and quality-control text.

The comments should not be converted into prevalence percentages without formal coding. Qualitatively, however, they reinforce the closed-question pattern and add a more human description of where current practice feels constrained.

Clinical information that follows the patient

Several comments ask for access to clinical notes, medication history, electronic records, lab data, or a universal information format so decisions do not depend only on the patient's memory.

Protected time and staffing

Respondents call for more staff, fewer competing metrics, and more time for consultations or medication management rather than trying to fit clinical care around existing workload.

Greater scope and autonomy

Some pharmacists want more authority to order tests, assess problems, manage medicines, or make defined treatment decisions within their competence and local regulatory framework.

Payment for clinical services

Reimbursement, incentives, and provider recognition recur as ways to make clinical pharmacy services financially sustainable instead of relying on unpaid additional effort.

Recognition as a care professional

Several responses describe a gap between what pharmacists can contribute and how patients or the wider system still perceive the role, especially the idea that pharmacy is only about filling prescriptions.

Collaboration and capability

Comments also call for stronger collaboration with physicians, clinical counseling in complex polypharmacy, training, and clearer pathways that let pharmacists use their medicines expertise more fully.

> **What the qualitative feedback adds:** The closed questions identify the barriers. The open comments show how those barriers feel in practice: waiting for information, lacking time to consult, being unable to act on a problem, or providing clinical value that the workflow and payment model do not fully recognize.

PEOPLE ALSO ASK · TOPIC FAQ

Frequently asked questions about pharmacist patient care.

What clinical services can pharmacists provide beyond dispensing?

Depending on local laws and practice settings, pharmacists may provide medication reviews, adherence support, vaccinations, screening or point-of-care testing, chronic disease support, preventive care, minor-ailment services, and other medication-related clinical services.

What is medication therapy management?

Medication therapy management is a structured pharmacist-led service that reviews a patient's medicines, identifies medication-related problems, supports adherence, and helps optimize the safety and effectiveness of treatment in coordination with the wider care team.

Can pharmacists help manage chronic diseases?

Yes. In many health systems pharmacists contribute to chronic disease care through medication optimization, monitoring, education, adherence support, and collaborative care. The exact services they can provide depend on jurisdiction, scope of practice, and local clinical arrangements.

What is a pharmacist collaborative practice agreement?

A collaborative practice agreement is a formal arrangement that can authorize pharmacists to provide defined patient-care functions in partnership with prescribers. The activities allowed vary by jurisdiction and may include medication adjustment, monitoring, or ordering certain tests under agreed protocols.

Why do pharmacists need access to patient health records?

Relevant clinical information can help pharmacists assess medication safety, duplication, interactions, treatment goals, laboratory results, and follow-up needs. Limited or fragmented access can make clinical decisions more dependent on incomplete information or patient recall.

How can workload affect pharmacist patient care?

Clinical services require time for assessment, documentation, patient counseling, coordination, and follow-up. When dispensing volume, staffing gaps, administrative work, and interruptions compete for the same time, pharmacists may have less capacity for direct patient-care activities.

PHARMACY PRACTICE LENS

What this means at four points in the pharmacist patient-care pathway.

The survey findings suggest that role expansion works best when the clinical task, information needed, decision authority, and handoff to the wider care team are designed together.

1. Identification at the point of contact

Design priority: Make it easy to move from a medication concern or patient question into a protected assessment process without losing the patient to queue pressure or competing dispensing tasks.

2. Medication assessment and action

Design priority: Give pharmacists the relevant record, laboratory, medication, and referral information needed to decide what can be managed directly and what needs escalation.

3. Shared chronic-care management

Design priority: Define who is responsible for monitoring, medication changes, follow-up, and communication so collaboration moves from goodwill to a repeatable shared-care workflow.

4. Sustainable service delivery

Design priority: Match scope expansion with staffing, consultation time, documentation systems, training, and reimbursement so clinical services can be delivered consistently rather than opportunistically.

CLOSING PERSPECTIVE

The next step for pharmacist patient care is not simply a wider scope. It is a better operating model for using that scope.

The survey shows that pharmacists are already delivering a meaningful range of clinical and patient-facing services. The role has expanded for most respondents, medication review and adherence work are widespread, and many pharmacists devote a substantial portion of the working day to care beyond dispensing.

The tension is that expanded clinical expectations still sit inside systems that may not provide enough time, staffing, information, reimbursement, or integrated collaboration. That tension appears repeatedly across the data. Clinical severity determines whether a patient needs action, but scope and information influence what action is possible. Workload is the most selected barrier, but reimbursement and authority remain major constraints. Collaboration is usually present, but highly integrated shared care is not yet the dominant experience. Future growth is expected most in medication optimization and chronic disease management, which will make continuity, record access, and team communication even more important.

The open responses make the same story more concrete. Pharmacists ask for access to clinical notes and laboratory data, time for consultation, greater autonomy, reimbursement for services, better staffing, stronger physician collaboration, and recognition as care professionals. These are not separate complaints. They are parts of one implementation problem: how to turn medicines expertise into a consistent patient-care service without making the pharmacist choose between clinical responsibility and an already full operational workload.

The most useful next steps therefore sit across workflow, technology, policy, education, and payment. Employers can protect clinical time and redesign staffing. Health systems can improve record access and referral pathways. Professional bodies and regulators can clarify scope and accountability. Payers can recognize clinical services. Education and continuing development can support new responsibilities. None of these levers works alone, but together they can make the clinical role more reliable, visible, and sustainable.

1 · Protect clinical time

Schedule and staff patient-care activity so assessment, counseling, documentation, and follow-up are treated as core work.

2 · Build usable record access

Give pharmacists the medication, diagnosis, laboratory, allergy, and care-plan information required for safe clinical decisions.

3 · Align scope with reimbursement

Where clinical responsibilities expand, payment and service recognition need to support the work rather than depend on unpaid extra effort.

4 · Clarify collaborative pathways

Define what pharmacists manage directly, what is shared, how referrals work, and how the care team closes the communication loop.

5 · Invest in team capacity and training

Use technicians, workflow redesign, continuing development, and appropriate technology to create space for higher-value clinical work.

6 · Measure the clinical contribution

Track interventions, follow-up, outcomes, and service demand so staffing and policy decisions reflect the patient-care work pharmacists actually perform.

Help future pharmacy insights reflect what happens beyond the prescription.

Join MDForLives to share professional perspectives on medication management, workflow, patient information, collaboration, and the evolving clinical role of pharmacists.

Join the Panel

REFERENCES AND DATA SOURCE

Sources used for this report

1. **MDForLives internal survey report.** All Markets Report for SGID 8978519, Project: Engagement Campaign | Pharmacist Insight Survey_Sep. 159 total survey records, 77.4% completion rate, across the USA, UK, Canada, Italy, France, and Germany. Closed-question bases vary by item from 125 to 129. Open-response analysis uses the 20 visible substantive comments.
2. **World Health Organization Regional Office for Europe.** "Advancing the role of pharmacists to meet changing patient and health system needs." 20 September 2024. WHO/Europe.
3. **International Pharmaceutical Federation.** *Global Situation Report on Pharmacy 2025: Workforce, Practice and Policy.* The Hague: FIP; 2025. FIP report.
4. **Centers for Disease Control and Prevention.** "Public Health Strategies for Pharmacists to Improve Health for People With Chronic Disease." Updated 8 September 2026. Used as a US-specific example of scope-of-practice and collaborative-care mechanisms. CDC.
5. **World Health Organization.** *Medication without harm: Policy brief.* 7 March 2024. Used as global medication-safety context. WHO policy brief.

The Global Pulse of Healthcare

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