

Rural pharmacist and consumer perspectives of expanded pharmacy services to address inequity in accessing health services

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Abstract

Objectives: Australians living in rural and remote communities have inadequate access to health services, contributing to poorer health outcomes compared to their metropolitan counterparts. This study investigated consumers' and pharmacists' perspectives of expanded pharmacy services in rural and remote communities in Australia. It aims to identify the role of the pharmacist in addressing the inequity of access to healthcare through the provision of expanded services in rural and remote practice.

Methods: A concurrent parallel mixed-methods study was undertaken in rural Western Queensland, Australia to include a survey of 167 consumers and in-depth interviews with 10 pharmacists. Quantitative data analysis employed descriptive statistics and chi-square tests, while qualitative data were analysed thematically against the constructs of the Diffusion of Innovations Theory.

Key findings: Consumers indicated that they would like to access weight management services (53%), whereas pharmacists thought it was important to offer respiratory clinics and services. Both pharmacists and consumers would like to see diabetes checks (30% and 56%, respectively) and vision, hearing, and ear checks (40% and 53%, respectively) implemented as services in community pharmacies. Most consumers (97%) believe pharmacists have the skills and knowledge to deliver expanded services and in doing so, they would improve the overall health of the community. Pharmacists reported staffing availability, workload and time constraints, cost, and jeopardizing inter-professional relationships as barriers to implementing expanded services.

Conclusions: Consumers were supportive of pharmacists working to their full scope of practice to provide expanded services, whereas pharmacists, while open to the idea, highlighted that there were barriers to overcome.

Keywords: Delivery of Care; Health Promotion; Professional Practice

Introduction

Australians living in rural and remote communities constantly face significant challenges in accessing healthcare [1]. Evidence suggests that the limited availability of healthcare professionals in geographically isolated areas contributes to poorer health outcomes, with Australians living in rural and remote areas experiencing higher rates of disease, hospitalization, and mortality compared to their metropolitan counterparts [1]. Importantly the rate of potentially preventable hospitalizations (conditions where hospitalization could have potentially been prevented through the provision of appropriate individualized preventative health interventions and early disease management, usually delivered in primary care and community-based settings) is two to three times higher for those living in remote and very remote areas [1]. Internationally in countries with equivalent economies and health systems such as Canada, the UK, Ireland, the USA, and New Zealand, shortages of health professionals have been addressed by expanding the scope

of practice of pharmacists to provide services including administration of injectable medicines (including vaccines), therapeutic substitution and adaptation, medication continuation, prescribing, and laboratory testing [2, 3]. There is this potential for pharmacists practicing in rural and remote Australia to expand their scope of practice with the aim of bridging existing healthcare gaps between rural and remote and metropolitan regions by providing equitable and accessible healthcare [2].

Chronic diseases including ischaemic heart disease, type 2 diabetes, and various cancers are of particular concern as they are more poorly managed in rural and remote areas and occur at higher rates than in metropolitan areas [1, 4–7]. Serious complications from chronic diseases [8] are increasingly prevalent in these areas due to consumers experiencing various demographic, socioeconomic, and environmental factors producing barriers to accessing treatment in a timely manner [4]. As a result, easily treated conditions such as lifestyle-related chronic diseases [4], and simple infections such as otitis media [9], are left to progress to more severe diseases

[4], increasing mortality rates and resulting in overall poorer health outcomes [3].

To improve these health outcomes in rural and remote communities, convenient access to high-quality health care needs to be addressed. Pharmacists are considered to be more accessible than other health professionals [2, 3], and as primary healthcare providers, they are often the first point of contact for consumers requiring medical attention [3]. Two-thirds of Australians living outside metropolitan areas live within 2.5 km of a community pharmacy, making pharmacists, highly trusted health professionals that are conveniently placed to provide such healthcare [10]. Expanded services offered by community pharmacists, successfully internationally [2, 11], include prescribing of drug treatments for common chronic health conditions including hypertension, cardiovascular disease, Parkinson's disease, epilepsy, mental health, and respiratory conditions [3] as well as performing screening and treatment services for urinary tract infections, back pain, and eczema [3, 11].

Previous studies have identified the value of expanded scope of practice by rural and remote pharmacists [2, 12], and have also demonstrated the importance of collaboration between pharmacists practicing to their full scope and other health professionals [12]. The LISTEN UP study [9] conducted in remote Queensland successfully demonstrated that pharmacists could provide accessible and immediate ear care upon presentation of ear complaints in a community pharmacy. This included conducting ear examinations and assessments using otoscopy for visual inspection and tympanometry, which has traditionally been conducted by other health professionals [9]. This service, which included a direct referral pathway to a medical practitioner for treatment was met with success, with most participants reporting high levels of satisfaction with the service [9]. The provision of such a service on a large scale would assist in preventing unnecessary referrals to emergency departments, resulting in improved accessibility to ear care in geographically isolated areas. Other expanded pharmacist services that have previously been identified as having value in rural and remote settings include vaccinations, diabetes checks, and wound care [2, 3, 12]. Data from these studies suggest that the implementation of expanded services will reduce preventable hospitalizations as well as improve health outcomes in rural and remote areas [3, 11, 12].

While current literature has established the benefit of an expanded scope of practice for pharmacists, there has been a lack of research examining both consumer and pharmacist perspectives on expanding these services. Investigating both perspectives is important both to the development of an expanded service as well as determining the barriers to the provision of these services in rural and remote community pharmacies. This study thus aims to build on existing literature by investigating consumers' and pharmacists' perspectives of expanded pharmacy services in rural and remote communities in Australia to identify the role of the pharmacist in addressing the inequity of access to healthcare through the provision of expanded services in rural and remote practice.

Methods

Study design and setting

The study was conducted using a convergent parallel mixed-method design. The research team comprised of regional pharmacists and educators with experience in primary care

pharmacy services. A quantitative survey and qualitative in-depth interviews exploring consumers' and pharmacists' perspectives of expanded services were undertaken concurrently. Data were collected during January and February of 2023 in community pharmacies. Based on the Modified Monash Model (MM) categories which measure remoteness (where 7 is very remote and 1 is a major city) the following rural and remote towns of Australia were included in the study: Alpha (MM7), Barcaldine (MM7), Winton (MM7) and Mount Isa (MM6) with populations varying from 453 in Alpha to 13 136 people aged over 18 years in Mount Isa [13]. Participants were recruited using convenience sampling with participants over the age of 18 years having an appropriate understanding and application of the English language were included.

Quantitative—survey

A survey tool was designed to be administered to consumers (people conveniently attending the community pharmacy for product or service).

Quantitative data were collected via a survey which consisted of two sections.

- Part 1: Health needs in the community, services currently offered, and extra services required.
- Part 2: Questions to determine perceptions relating to the delivery of extra services by pharmacists.

In Part 1 questions were designed to determine the health needs of the community. Consumers were also asked to identify from a list of 12, any expanded services their local pharmacy currently provides, with the option of entering options not listed. Tick box-style questions were also used to determine what expanded services the consumer would like the pharmacist to provide as well as their willingness to pay for those services. In Part 2, four-point Likert scale response options (strongly agree, agree, disagree, and strongly disagree) were used to determine consumer opinions on the ability of pharmacists to provide these additional services. The final part of the survey collected demographic information such as gender, age, and postcode.

Face and content validity of the survey was ensured via a thorough review of the literature and evaluation of the survey by an expert panel consisting of pharmacy academics and community pharmacists. The survey questions were assessed by the panel for comprehension, clarity, readability, coherence, and logical flow. A pilot test was conducted with five participants who were not part of the study population but had similar characteristics. Participants were asked to complete the survey and provide feedback on the clarity, length, and overall design. The feedback indicated that the survey was clear and appropriately targeted, with only minor adjustments needed to improve wording and flow. The results from the pilot study were not included in the final dataset.

The survey responses were entered into Microsoft Excel® and variables were coded appropriately, and descriptive analysis was undertaken. Once the data had been collated in Microsoft Excel® the data was also imported into SPSS® for inferential statistical testing. A chi-square analysis was conducted in order to detect significant associations between categorical variables. Where associations were detected, *post-hoc* testing was carried out using adjusted residuals where required. Statistical significance was defined as $\alpha \leq 0.05$.

Theoretical framework

Everett Roger's Diffusion of Innovations Theory was used to inform the design of the interview schedule and analyse the resulting qualitative data to explore how expanded services could be implemented in rural and remote communities [14].

Qualitative—interview

In-depth semi-structured interviews were conducted with six open-ended questions exploring the pharmacists' perspectives of expanded services to understand current expanded services provided, consumer demand for these services, and barriers and enablers to the implementation of these and future services.

Registered pharmacists and Intern pharmacists (those undertaking a one-year training and supervision program prior to registration) were invited to participate in the interview. All community pharmacists working in the towns where the research was conducted were invited via email and followed up with a phone call. An information sheet was provided and written/verbal consent was obtained to schedule and conduct the interview. Interviews were audio/video recorded, transcribed then coded manually using a hybrid approach and thematically mapped, to the five constructs of the Diffusion of Innovations Theory: relative advantage, compatibility, complexity, trialability, and observability [14]. A three-cycle coding process was undertaken with three researchers contributing to cycles two and three to ensure transparency, validity, and rigor. This collaborative coding process combined with the member checking process included in the face to face interviews improved the trustworthiness of the data and allowed the researchers to explore reflexivity and limit personal bias. Saturation was achieved when replication of data was evident and no new themes emerged in two consecutive interviews.

Data integration

The data were triangulated to compare pharmacist and consumer perspectives [15]. To converge the data, questions that were similar from both consumer surveys and pharmacist interviews highlighted similarities and differences in their responses to inform both the demand for these expanded services and the feasibility of their delivery. The interpretation of this data is reported as a discussion of convergence, divergence, and complementarity.

Results

A total of 167 surveys from rural consumers were included in the study, representing a response rate of 75%. This included 120 responses from Mount Isa (MM 6) and a combined 47 responses from Alpha, Barcaldine, and Winton (MM 7). Most respondents were 41–62 years (44%), with the average age being 49 years. Semi-structured interviews were also conducted with 10 pharmacists currently practicing in these rural and remote communities. On average, pharmacists had 8.5 years of experience as pharmacists and 6.4 years of practicing in rural and remote communities (see Table 1). Interviews varied in duration from 22 to 45 min with an average of 27 min. Data from interviews had reached saturation at seven interviews, however, the additional three pharmacists were interviewed and data were collected to ensure no additional themes emerged.

Table 1. Pharmacist and consumer demographic characteristics.

Participant group	Characteristics	n (%)
Consumers N = 167		
Age group	18–40	57 (34)
	41–62	73 (44)
	63–85	37 (22)
Gender	Women	107 (35)
	Men	58 (64)
	Other	2 (1)
Location	Mount Isa	120 (72)
	Barcaldine	26 (16)
	Winton	12 (7)
	Alpha	9 (5)
Pharmacists N = 10		
Years practising as a pharmacist	<1–5	5 (50)
	6–15	4 (40)
	>15	1 (10)
Years practising in a rural pharmacy	<1–5	7 (70)
	6–15	3 (30)
	>15	0 (0)

Health needs

Consumers provided with a list of possible health needs were asked to identify the health needs they believed were prevalent in their communities. When combined, the four towns recorded mental health as being the most prevalent need. The highest-ranked health need reported by consumers in Winton was cancer (75%), while Alpha consumers reported blood pressure and cholesterol (78%) (Fig. 1). Mount Isa consumers (79%) and 77% of consumers in Barcaldine reported mental health most common health need (Fig. 1). Lung disease, poverty, homelessness, and infections were among the lowest-ranked health needs identified by 50% or less of consumers across all of the towns (Fig. 1).

Expanded services

Consumers were provided with a list of possible expanded services and were asked to identify which services they would like to access within their community pharmacy. Barcaldine and Winton reported a lower need for expanded services with consumers identifying an average of five services. Alpha which had the smallest population and Mount Isa which had the largest population among our surveyed towns, were shown to have the highest proportion of respondents identifying the need for services (Fig. 2). The top-ranked expanded service identified by all consumers was vaccinations for all age groups.

Health needs versus expanded services

The expanded services that consumers reported they would like to access in their community pharmacies, did not reflect the reported health needs (Table 2). Although mental health was the most prevalent health need identified across the towns, only 41% of consumers identified mental health testing as an expanded service they would like to access. Alcohol and drug testing was another prevalent health need

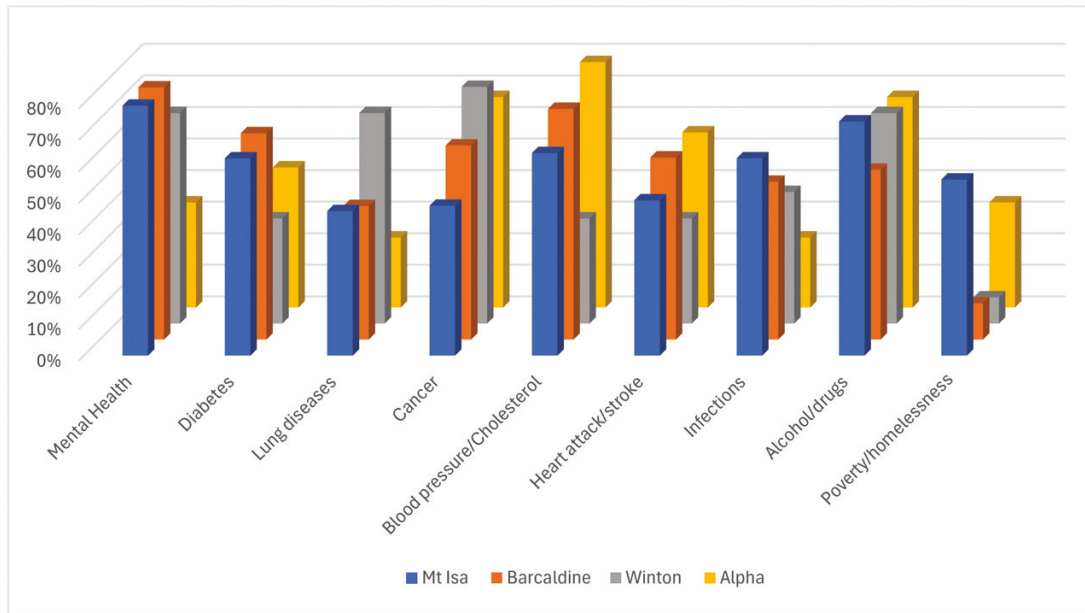


Figure 1. Health needs as perceived by consumers across Mount Isa, Barcaldine, Winton, and Alpha.

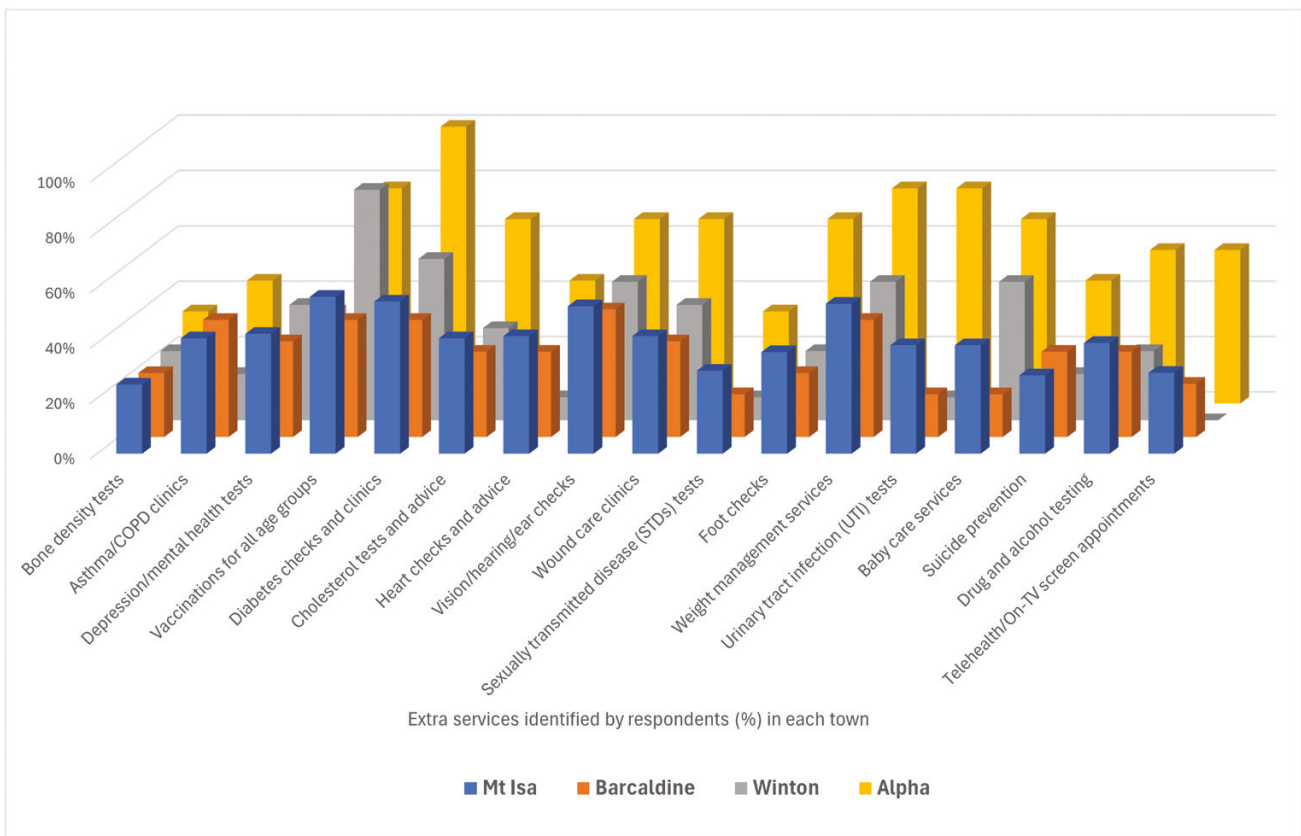


Figure 2. Expanded services consumers would like to see implemented.

however, it was among the lowest reported expanded services identified by consumers across all towns (Table 2).

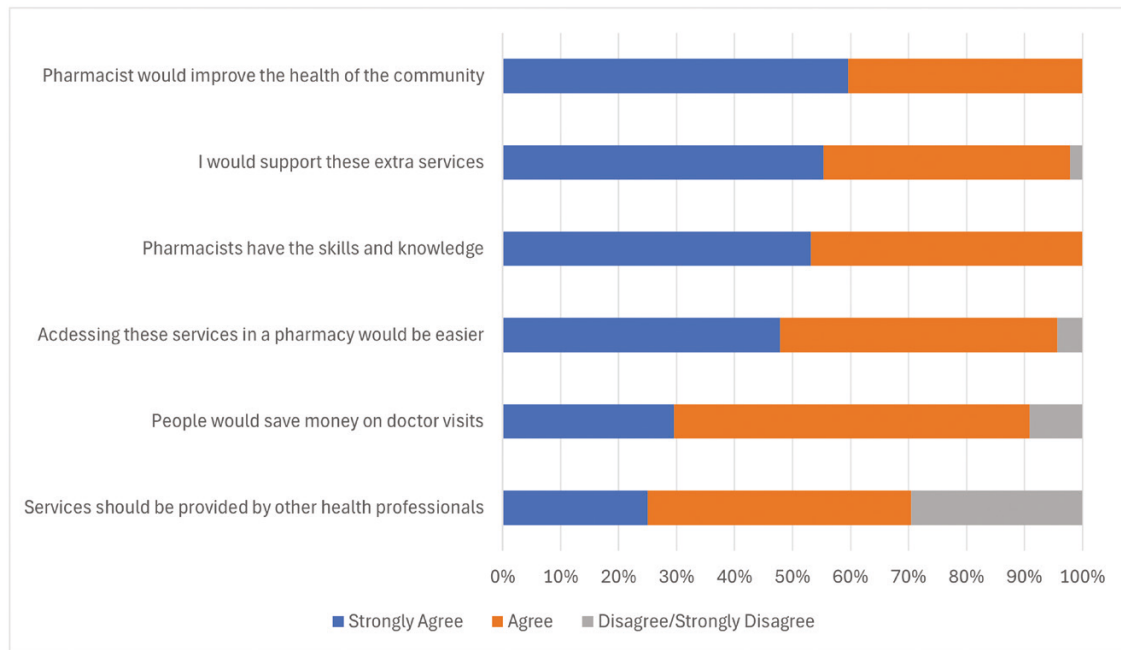
Consumer support for expanded services

Using Likert-scale responses, consumers were asked to indicate their level of agreement with statements in relation to pharmacists and the provision of expanded services (Fig. 3).

Findings showed that most consumers (97%) believe pharmacists have the skills and knowledge to deliver expanded services (Fig. 3) and that such services improve the health of the community. However, the results also showed that two-thirds of all consumers believed these services should be provided by other healthcare professionals (Fig. 3). Consumers in Mount Isa (93%) and 91% from Barcaldine, Winton, and Alpha also agreed that they would save money

Table 2. Identified health needs for all towns versus the identified expanded service by consumers.

Service	Reported as a health need (%)	Reported as a wanted expanded service (%)	% Difference
Mental health tests	75	41	34
Diabetes	60	56	4
Lung diseases	45	40	5
Heart attack/stroke	50	38	12
Alcohol/drug testing	70	38	33

**Figure 3.** Likert-scale consumer responses to pharmacists and the provision of expanded services.

by accessing these services from a pharmacy (Fig. 3). In relation to payment for services, it was found that 33% of all consumers reported that pharmacy services should be provided free of charge, whereas 66% of consumers would be willing to pay for these expanded services.

Chi-square tests were carried out to identify possible associations between categorical demographic variables and identify a need for expanded services. Participant age was significantly associated with a need for suicide services (χ^2 (1, $N = 167$) = 8.9, $P < .05$) and sexually transmitted disease (STD) testing (χ^2 (1, $N = 167$) = 14.2, $P < .001$). *Post-hoc* analysis revealed that younger consumers (18–40 years) in particular, were significantly associated with each of these services ($P = .02$, $P = .001$ respectively). Age was also found to be associated with a need for depression services (χ^2 (1, $N = 167$) = 7.8, $P = .020$), with *post-hoc* analysis revealing older consumers (63–85 years) being associated with this service ($P = .03$). Gender was significantly associated with a need for urinary tract infectoin (UTI) services, with women ($n = 107$) more likely to report this need (χ^2 (1, $N = 167$) = 15.9, $P < .001$).

Qualitative—pharmacist interviews

Semi-structured interviews revealed that each pharmacy offered an average of six additional health services and most of the pharmacists (Table 1 demographics) agreed that

they'd like to provide more services. From the interviews, six themes were identified, five mapped to the constructs of Roger's Diffusion of Innovations Theory [15], and an additional theme, 'training' emerged (Table 3; Supplementary Material).

Integrating pharmacist versus consumer health needs and services

Both consumers and the pharmacists agreed that blood pressure (hypertension) and cholesterol were common health needs within the communities. However, consumers also identified mental health and alcohol and drugs as prevalent health needs (Fig. 1), whereas pharmacists identified diabetes and respiratory conditions such as asthma. Pharmacists would like to introduce diabetes checks and clinics to provide education and HbA1c testing as well as respiratory and lung services into their community pharmacies, which is consistent with what they reported to be the health needs of the community. Pharmacists and consumers agree that they would like to see vision, hearing, and ear checks introduced into the pharmacy, which is aligned with a previous consumer study [11], where vision and eye checks were rated as important. Both pharmacists and consumers also had a low demand for UTI testing and prescribing, which is a service that pharmacies with trained pharmacists can already offer in Australia.

Table 3. Qualitative data mapped to constructs of Roger's diffusion of innovations theory [15].

Theme	Description	Quote
Relative advantage	Pharmacists highlighted the advantages of practicing to their full scope, and how offering expanded services would be advantageous for consumers and improve their health outcomes and management of their disease states. This particularly relates to medication safety, where low health literacy is prevalent.	<i>'If we [pharmacists] are able to expand our scope, I think that will be very helpful in the community.'</i> [P2—Pharmacist] <i>'If it's not really expressed to them, the importance of their medications or general lifestyle advice, they just get missed. Literally, people will die from [lack of medical advice]. In rural areas, there is a high risk of that.'</i> [P1—Pharmacist]
Compatibility	Belief that expanded scope was compatible with the views, values, and needs of the community and with their practice, especially alleviating additional stress on the health-care system. Although isolation limits viability and is associated with increased workload and responsibilities, as well as a lack of accessible resources and the need to form close-knit professional relationships with other health professionals in the community.	<i>'It comes down to time constraints because it is only me, and I only have so much time. And as I said, I do really have a good professional working relationship with the doctors here at the medical practice. I just feel it would really impact them if I were to offer those services.'</i> [P6—Pharmacist] <i>'When you're in a consultation with someone, you want that whole time to be undisturbed, but if you're the sole pharmacist, sometimes you don't get that luxury.'</i> [P7—Pharmacist]
Complexity	There are four distinct barriers identified that prevent the effective implementation of expanded scope: staffing, including the availability of staff and staff retention, workload and time constraints, costs and the potential for jeopardizing inter- professional relationships, particularly with the local doctors.	<i>'Because of the shortage of pharmacists out there, we've had to drop professional services a lot... Retention of pharmacists is probably the biggest barrier.'</i> [P1—Pharmacist] <i>'It can easily be perceived as money being taken out the pockets of other healthcare services...it's going to be the pharmacists on the ground and in the small communities who have to deal with the problems that crop up.'</i> [P3—Pharmacist]
Trialability	There was connection made to the challenges of pharmacists practicing to their full scope of practice as it has not been trialed in Australia. The importance of frequency was raised, related to the need to provide a particular service more frequently to become competent and for the service to be financially viable.	<i>'A lot of these amazing plans never get off the ground because no one knows how to make it operational.'</i> [P4—Pharmacist] <i>'It's hard to roll out a service like that unless you're seeing it all the time.'</i> [P1—Pharmacist]
Observability	Unanimously, pharmacists agreed that implementation practice would be difficult, particularly when the public are not aware of the services that they currently offer. However, once the service is off the ground and readily being used, a substantial impact on improving health outcomes was expected/observed.	<i>"People don't actually know that our services are actually available in the community pharmacy."</i> [P8—Pharmacist] <i>"The MA, Medical Council, doctors didn't want us [vaccinating], but you can see how successful it was."</i> [P2—Pharmacist]
Training	A recurring theme was the fact that although there are training platforms available, there was a consensus that in-person training is more effective in preparing pharmacists for the delivery of additional services. However, this form of training is not readily available to rural and remote pharmacists, which is proving to be a significant barrier.	<i>"It's not realistically or humanly possible for us to attend [face to face training]. The best we can generally manage is online resources. We are missing the human element out here."</i> [P3—Pharmacist]

Discussion

Perspectives of both the community as well as the pharmacists that serve them are important in determining what expanded services should be implemented in rural and remote pharmacy practice. The perspectives of health professionals and consumers on the expanded scope of practice have been researched separately [9, 11, 12], however, their combined opinions have not been reported. Pharmacists and consumers agree on service provision to treat chronic conditions, such as blood pressure and cholesterol. Both groups also agree on community pharmacy as a site for health checks such as vision and hearing. However, while pharmacists highlighted the need for diabetic services, consumers were also focused on mental health and substance abuse as needs in their rural communities. This study revealed a positive community perception of pharmacists' ability to deliver these expanded services and while pharmacists agreed and were supportive of expanding their services, they consistently identified barriers such as lack of staff and sustainability of service provision.

The strength of this study is that it considers both pharmacists' and consumers' perspectives, which has allowed

for the integration of data from these key stakeholders. Limitations of the study include the small sample sizes used to obtain quantitative data, and the use of convenience sampling, which could have resulted in sampling bias. Findings may therefore be generalized to represent the Central West and Northwest areas of Queensland but do not represent the entire rural and remote population in Australia or Internationally.

The most frequently cited health needs by consumers included mental health, substance abuse, blood pressure, and cholesterol, with these findings consistent in terms of health needs and their incidence in rural and remote Australia [16–19]. Mental health is rated as the most prevalent health need by consumers in this study, aligned with studies that have shown an increased prevalence of alcohol consumption and illicit substance use [18], and suicide rates that continually increase with remoteness [16, 17]. Other recent data have shown that deaths attributable to cardiovascular disease are 50% higher in remote areas when compared with capital cities [19]. Consumers in this study recognized hypertension and hypercholesterolemia as prevalent health needs, which

are known risk factors for the development of cardiovascular disease [4, 6].

An interesting finding for support of expanded services indicated that although two-thirds of consumers believed expanded services should be provided by other health professionals, almost all consumers (98%) stated that they would be supportive of expanded services in community pharmacies. These findings may indicate that consumers feel it more appropriate to consult a pharmacist about specific health needs such as vaccinations or diabetes, instead of other health needs such as mental health or substance abuse. A possible reason for this is the perceived lack of privacy in the pharmacy environment; several studies have suggested that consumers may be tentative about speaking to a pharmacist about sensitive issues, where there is potential for consultations being overheard, or for other breaches of privacy [20–22]. Despite being ranked lower in prevalence than other health needs by consumers, diabetes is indeed a significant health issue for Australians living in rural and remote areas. Recent data revealed that hospitalization rates for diabetes-related complications were almost three times higher in remote areas, while death rates from diabetes were twice as high in remote areas from 2019 to 2020 [23].

Pharmacists reported diabetes, high blood pressure, and high cholesterol as the most prevalent health needs in their communities, with respiratory conditions and infectious diseases also cited. The services that pharmacists most frequently expressed interest in implementing aligned with the health needs that they perceived as being the most prevalent. These services included diabetes clinics, respiratory services, and vision, hearing, and ear checks. A study by Taylor *et al.* exclusively examining pharmacists' perspectives on expanded scope yielded similar results, with those pharmacists citing similar health needs including cardiovascular disease, diabetes, and acute infections as being the most prevalent, while also expressing an interest in introducing new diabetes services [24].

Pharmacists in our study agreed that providing expanded services would have a positive impact on the health of their community, however, they also felt that significant barriers exist, which include staffing and funding to deliver these services. Some sole pharmacist pharmacies were challenged in the provision of extra services while maintaining their usual services. Concerns about cost-effectiveness and funding required to pay for service-related expenses were raised. The quality of training was another issue identified. Most pharmacists felt that face-to-face training would increase confidence in the delivery of services, however, face-to-face training sessions are almost always held in major cities and are thus often inaccessible. These barriers have been identified in other rural pilot studies and need to be considered when developing expanded services for rural practice [25].

Several pharmacists were also concerned about the implications for their practice in terms of their professional relationships with other healthcare providers in the community, fearing that introducing new services would damage those relationships. Substantial resistance from doctors in the media [25] has likely contributed to this perception, with one study finding that doctors more frequently expressed their opposition to expanded practice by pharmacists than other health professionals [12]. The barriers identified in this study are consistent with those found in the literature; understaffing, poor funding, lack of training, and potential harm to inter-professional relationships have all been reported in various studies [12, 24, 26]. Further incentives to attract

pharmacists to the rural and remote settings to alleviate the maldistribution of pharmacists in Australia, accompanied by funding for these services to ensure their sustainability is recommended. Future increased observability of the success of expanded services would also increase public recognition of pharmacists as primary healthcare providers capable of improving health outcomes in rural and remote communities.

Conclusion

The study aimed to investigate the perceptions of consumers and pharmacists living in rural Western Queensland towns on expanded pharmacy services. Consumers believed that pharmacists have the skills and knowledge to deliver services such as vaccinations for all age groups, diabetes checks, clinics, and weight management advice. Pharmacists were mostly in agreement that expanding their scope of practice would improve health outcomes of rural and remote communities, however they were more conservative about the implementation and sustainability of these additional services. Both pharmacists and consumers agreed that diabetes is a major health concern and that pharmacists providing diabetes checks and clinics would be supported and improve the health of the community. Future research exploring in-depth consumer perceptions across diverse rural and remote geographic locations will allow findings to be generalizable to inform the implementation of expanded services for all rural and remote communities in Australia.

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Supplementary data

Supplementary data is available at *International journal of Pharmacy Practice* online.

Author contributions

Selina Taylor: Conceptualization, Methodology, Investigation, Data Curation, Writing—original draft preparation, Project Administration. Jai-ann Eastaughffe: Investigation, Data Curation, Writing—original draft preparation. Rosemarie Dixon: Investigation, Data Curation, Writing—original draft preparation. Izabella Kent: Investigation, Data Curation, Writing—original draft preparation. Chloe Kappel: Investigation, Data Curation, Writing—Original draft preparation. Martina Mylrea: Methodology, Supervision, Writing—review and Editing. Beverley Glass: Conceptualization, Methodology, Validation, Supervision, Writing—review and Editing. All authors had complete access to the study data to support the publication.

Conflict of interest statement: None declared.

Ethics approval

Ethics approval for the study was obtained from James Cook University's Human Research Ethics Committee (Approval Number: H8969, Date: 22 December 2022).

Informed consent

Informed consent from participants was obtained for written surveys and verbally (interviews).

Data accessibility

The authors continue to have complete access to the study data, including survey results and interview audio recordings/transcriptions.

Data availability

Data available on request. The data underlying this article will be shared on reasonable request to the corresponding author.

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