

## Pharmacist-led care for minor illnesses in India: an urgent need for a regulatory framework

Sir,

Minor illnesses such as common colds, uncomplicated skin conditions, and mild gastrointestinal disturbances represent a significant share of primary care visits in India, despite being self-limiting and suitable for protocol-based management at the community level. The growing burden of these conditions places avoidable pressure on overstrained primary health facilities. In this context, community pharmacists, the most accessible healthcare professionals in India, could be empowered to deliver safe, protocol-driven management of minor illnesses. While informal pharmacist consultations are widespread, the absence of a formal framework, regulatory clarity, and standardized training continues to impede safe and accountable practice. While existing literature in India has largely focused on pharmacists' roles in dispensing and chronic disease management, structured pharmacist-led models for minor illness care remain largely unexplored.

Globally, countries such as the United Kingdom, Canada, and Australia have demonstrated the value of pharmacist-led care through reduced physician workload, improved patient satisfaction, and measurable cost savings.<sup>1</sup> In India, emerging evidence also shows strong public willingness to consult pharmacists for minor ailments, with satisfaction levels exceeding 90%.<sup>2,3</sup> Furthermore, pharmacist-led interventions in chronic disease management have yielded improved clinical outcomes and reduced healthcare costs.<sup>4</sup> However, evidence alone cannot transform practice; it requires a deliberate national policy framework.

It is imperative to translate this underutilized potential into structured and accountable services. We argue that a regulatory framework for pharmacist-led minor illness care is urgently needed and outline strategic pillars for implementation.

First, regulatory reform must take precedence. Amendments to the Pharmacy Act and the Drugs and Cosmetics Act are required to explicitly define the scope of pharmacists in assessing and managing a nationally approved list of minor illnesses.

To safeguard public trust, this expansion should be strictly bounded by evidence-based protocols and red-flag criteria for referral. Here, the Standard Treatment Workflows (STWs) developed by the Indian Council of Medical Research (ICMR) should be adapted specifically for pharmacist use. Translating these protocols into simple, actionable algorithms at the point of care will ensure uniformity, safety, and accountability.

Second, integration with digital health platforms is essential. The Ayushman Bharat Digital Mission (ABDM) offers a ready-made infrastructure for documentation, prescription monitoring, and patient record linkage. Embedding pharmacist encounters into these systems will not only strengthen continuity of care but also generate valuable data for quality assurance and evaluation.

Third, education and certification mechanisms must support expanded roles. Undergraduate curricula should integrate training in patient assessment, red-flag identification, and communication. For practicing pharmacists, a Minor Ailment Certification Program under the Pharmacy Council of India, complemented by continuing professional development (CPD), would ensure competency and public confidence. A conceptual competency framework for pharmacists in primary health care has already been proposed in India, and this can serve as a foundation for designing training and certification modules.<sup>5</sup>

Finally, public awareness campaigns will be crucial. Campaigns should highlight the role of pharmacists in managing minor ailments, clarify the boundaries of their services, and reassure the public about safety and accountability. Partnerships with frontline workers such as ASHAs and ANMs could reinforce awareness and create strong referral linkages.

Pharmacist-led care is not intended to displace physicians but to complement existing healthcare structures. By managing minor, self-limiting illnesses, pharmacists can relieve physicians to focus on more complex cases, thereby improving efficiency and access. Given that a large proportion of outpatient visits in India are due to minor, self-limiting conditions, even partial task-shifting to pharmacists could substantially reduce healthcare system burden. In a country where both accessibility and affordability remain persistent challenges, failing to harness pharmacists' potential represents a missed opportunity.

In conclusion, a national framework for pharmacist-led care of minor illnesses is urgently needed in India. By combining regulatory reform, digital integration, competency-based certification, professional incentives, and public engagement, India can systematically operationalize this underutilized resource. Such reforms will not only decongest primary care facilities but also move India closer to its goal of equitable and efficient healthcare delivery.

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