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Research Article

Leadership and Ethics in Philippine Community Pharmacy: Toward a Sustainable Compensation and Service Model

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ABSTRACT

This study examines pharmacist compensation in Philippine community pharmacies as a professional, economic, ethical, regulatory, and health-system issue. A structured case and policy analysis was conducted using evidence from Google Scholar, PubMed, Scopus, and Philippine E-Journals, emphasizing 2015–2026 literature and relevant Philippine laws and professional standards. The analysis examined the structural causes of compensation difficulties, ethical leadership considerations, economic and financial implications, regulatory requirements, and the feasibility of the proposed 1:3 digital-supervision model. Findings indicate that compensation cannot be evaluated solely as a labor cost because pharmacists provide professional judgment, medication safety, supervision, and accountability. The hypothetical financial analysis shows that pharmacy capacity varies and that an inability to afford appropriate compensation does not establish pharmacist overpayment. Telepharmacy may improve service access, but evidence does not support a universal 1:3 staffing ratio. A differentiated model combining risk-appropriate onsite staffing, regulated shared supervision, and separate financing for professional services is recommended to balance fair compensation, patient safety, pharmacy viability, and medicine affordability.

Keywords*: Community Pharmacy, Pharmacist Compensation, Pharmacy Sustainability, Professional Services Financing, Telepharmacy*

Introduction

Pharmacists contribute to medication safety, patient care, and pharmacovigilance through their professional responsibilities (Carandang et al., 2024). Their role has also expanded beyond dispensing to include collaboration with other healthcare professionals in prescription management and the care of patients with chronic conditions (Mariano & Faller, 2026). In community pharmacy, these responsibilities are carried out within a business setting where pharmacists must balance professional obligations with patients' ability to pay and the financial capacity of the establishment. Community pharmacies also serve as accessible points of care, particularly where

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other healthcare services are limited, and pharmacists contribute to the appropriate use of medicines (Cristuta & Cesar, 2024). This places community pharmacists in a position where professional accountability and business sustainability must be considered together.

Republic Act No. 10918, or the Philippine Pharmacy Act of 2016, recognizes the professional responsibilities associated with pharmaceutical practice. These include pharmaceutical care, drug information, medication counseling, and health promotion. The legislation also establishes requirements for pharmacist supervision across different categories of pharmaceutical establishments. These responsibilities carry professional and legal accountability. They should therefore be reflected in how pharmacists are employed, compensated, and supported.

Pharmacists can contribute to reducing avoidable healthcare costs through the identification and prevention of medication-related problems (Dalton & Byrne, 2017). This professional responsibility is reflected in Republic Act No. 10918, which establishes supervision requirements for pharmaceutical establishments. Under Section 31, Category A establishments require the direct and immediate control and supervision of a registered and licensed pharmacist, while Category B establishments are subject to pharmacist supervision and oversight under the applicable provisions, including arrangements involving telepharmacy services (Republic Act No. 10918, 2016).

These professional requirements, must be considered alongside the financial conditions under which community pharmacies operate. Pharmacist compensation is often financed from the same revenue margins used to cover inventory, rent, utilities, personnel, regulatory compliance, taxes, and other operating expenses. Increasing compensation may place additional pressure on pharmacies with limited financial capacity. Keeping compensation low, on the other hand, places an unfair burden on pharmacists and may undermine the sustainability of professional services. The central issue is therefore whether the existing pharmacy business model can adequately support both fair pharmacist compensation and safe pharmaceutical care. The challenge is particularly relevant in the Philippines, where community pharmacies serve as accessible points of healthcare while operating under varying financial and workforce conditions.

Philippine studies have identified workforce and operational concerns that are relevant to the sustainability of community pharmacy practice. Salo et al. (2025) reported gaps between workforce supply and demand, together with geographic disparities in pharmacist distribution. Ngo et al. (2025) described operational challenges and adjustments in Philippine community pharmacies. These findings suggest that pharmacist compensation should not be examined in isolation. It must also be considered in relation to workforce availability, the capacity of pharmacy establishments, and the delivery of accessible pharmaceutical services.

This case analysis addresses two central questions:

1. How can the Philippines improve pharmacist compensation without making medicines less affordable, forcing viable pharmacies out of business, or weakening the quality, accessibility, and accountability of pharmaceutical care?
2. If a pharmacy cannot afford to provide appropriate compensation to the pharmacist required for its safe operation, should the pharmacist be considered overpaid, or does the situation indicate a problem with the pharmacy's business model?

To address these questions, the analysis examines the structural factors affecting pharmacist compensation, considers their ethical and economic implications, evaluates the feasibility and risks of shared digital supervision, and develops a proposed leadership and financing model for sustainable community pharmacy practice. In this study, the 1:3 model refers to a hypothetical shared-supervision arrangement in which one pharmacist provides professional oversight to as many as three eligible pharmacy establishments through appropriate digital systems. It is examined as a proposed operational model, not as an established staffing ratio under Republic Act No. 10918. Any implementation would require regulatory authoriza-

tion and compliance with applicable supervision, licensing, workload, and patient-safety requirements.

Theoretical Framework and Analytical Propositions

This analysis draws on four complementary perspectives: Human Capital Theory, the Theory of the Firm, value-based healthcare, and the pharmaceutical-care framework. Together, these perspectives provide a basis for examining pharmacist compensation, pharmacy financial capacity, and the professional value of pharmaceutical services.

Human Capital Theory

Becker (1964) explains that education, training, and specialized knowledge contribute to an individual's productive capacity and economic value. In community pharmacy, this perspective is relevant because a licensed pharmacist brings professional education, clinical judgment, regulatory knowledge, and continuing professional development to the establishment. These competencies carry responsibilities that extend beyond dispensing medicines. In the Philippine retail pharmacy setting, where compensation is often financed from the same margins used to cover inventory and other operating expenses, the pharmacist's professional contribution can be overlooked when staffing is treated mainly as a business cost. Human Capital Theory supports evaluating compensation in relation to the pharmacist's qualifications, responsibilities, and contribution to safe pharmaceutical care.

Theory of the Firm

Jensen and Meckling (1976) provide a framework for understanding how ownership, organizational decisions, incentives, and resource allocation influence business operations. In community pharmacy, these decisions include staffing, operating expenses, inventory management, and the allocation of revenue to professional services. Although owners must maintain financial viability, pharmacist supervision and professional accountability cannot simply be treated as optional expenses when required for safe and lawful operation. A pharmacy that struggles to finance these responsibilities may be facing limitations in its revenue structure, operating model, or resource allocation. This helps distinguish the financial difficulties of an establishment from the professional value of the pharmacist.

Value-Based Healthcare Perspective

Porter and Teisberg (2006) describe healthcare value in terms of health outcomes relative to the resources used to achieve them. In community pharmacy, this provides a basis for assessing the contribution of pharmacists beyond the number of prescriptions dispensed or medicines sold. Their work includes medication assessment, patient counseling, identification of medication-related problems, and support for appropriate medicine use. These activities require professional time and resources but may also contribute to better medication management and patient care. Pharmacist compensation should be considered alongside the value of the services delivered, rather than evaluated solely as an operating expense.

Pharmaceutical-Care Perspective

Hepler and Strand (1990) describe pharmaceutical care as the pharmacist's responsibility to address patients' medication-related needs and achieve intended therapeutic outcomes. This places patient care, rather than the sale of medicines alone, at the center of pharmacy practice. Phimarn et al. (2023) examined the economic evaluation of pharmacy services and highlighted the importance of assessing their costs and outcomes when developing specialized services. For community pharmacy, these support recognizing professional activities such as medication assessment, counseling, and the identification of medication-related problems as distinct services. Their contribution must be assessed through appropriate clinical and economic measures, rather than assumed solely from the pharmacist's presence in the establishment.

These perspectives produce five analytical propositions:

P1: Fair pharmacist compensation is a component of sustainable pharmaceutical care.

P2: A pharmacy's inability to afford appropriate compensation does not, by itself, establish that the pharmacist is overpaid.

P3: Dependence on medicine margins creates tension among pharmacist compensation, pharmacy profitability, and medicine affordability.

P4: Separately financing professional pharmacy services may reduce dependence on medicine margins.

P5: Shared or remote pharmacist models must be evaluated according to patient safety, accountability, workload, technology reliability, support-personnel competence, auditability, equity, and regulatory compliance—not cost reduction alone.

Methodology

Research Design

This study used a structured case and policy analysis informed by a case-study methodology. The case was defined as the sustainability of pharmacist compensation and professional supervision within Philippine community pharmacy, focusing on the interaction among pharmacist compensation, pharmacy viability, medicine affordability, patient safety, and regulatory accountability.

The analytical design was guided by Yin's (2018) case-study methodology, particularly the definition of the case, the use of theoretical propositions, the examination of multiple sources of evidence, systematic analysis, and consideration of competing explanations.

Literature and Evidence Search

Evidence was identified through Google Scholar, PubMed, Scopus, and the Philippine E-Journals database, with the primary contemporary literature and evidence base covering publications from 2015 to 2026. Older references were retained only when they served as foundational theoretical, methodological, conceptual, ethical, or pharmaceutical-care sources. These include Becker (1964) for Human Capital Theory, Jensen and Meckling (1976) for Theory of the Firm, Hepler and Strand (1990) for pharmaceutical care, and Porter and Teisberg (2006) for value-based healthcare. Their inclusion was intentional and does not represent a replacement of the contemporary 2015–2026 evidence base.

Search concepts included combinations of pharmacist compensation, pharmacist salary, remuneration, community pharmacy economics, pharmacy margins, pharmaceutical care, pharmacist professional services, medicine affordability, medicine pricing, pharmacy staffing, telepharmacy, remote pharmacist supervision, and healthcare financing.

Eligibility and Evidence Selection

The primary evidence base included 2015–2026 peer-reviewed studies and systematic reviews, Philippine laws and administrative regulations, professional standards, health-economic literature, and relevant evidence concerning the pharmacist workforce, community pharmacy practice, pharmaceutical care, and telepharmacy. Particular attention was given to contemporary Philippine evidence on pharmacy workforce and community-pharmacy practice and to recent systematic reviews addressing telepharmacy service models, clinical outcomes, patient outcomes, and implementation considerations. Anecdotal salary reports, social-media discussions, informal online claims, and isolated individual experiences were excluded as evidence of national compensation patterns.

Analytical Procedure

Evidence was organized into five analytical domains:

1. Diagnosis of the compensation problem
2. Ethical leadership analysis
3. Economic and financial analysis
4. Regulatory analysis
5. Stress test of the 1:3 digital supervision model

For the hypothetical financial scenarios, gross profit and operating expenses were used to calculate the amount remaining before pharmacist compensation. Net profit was not calculated because the scenarios do not specify all other possible expenses, taxes, financing costs, or owner withdrawals. Regulatory analysis distinguished between statutory requirements, current administrative implementation, and

proposed policy reform. The proposed 1:3 digital-supervision model was subjected to a structured stress test covering patient safety, pharmacist workload, professional accountability, clinical quality, technology reliability, support-personnel competence, documentation and auditability, equity, and ethical implications. The findings were integrated with the theoretical propositions to formulate the recommended leadership model.

Construction of the Hypothetical Financial Scenarios

The financial scenarios for Pharmacies A, B, and C were developed by the author as illustrative economic simulations. They were not derived from actual pharmacy financial statements, field surveys, interviews, or primary accounting records. The figures were constructed to represent different hypothetical levels of gross profit and operating expenses, allowing examination of the financial capacity of individual establishments to meet pharmacist compensation requirements.

For each scenario, the amount remaining before pharmacist compensation was calculated by subtracting operating expenses from gross profit. A hypothetical monthly pharmacist compensation package of ₱30,000–₱35,000 was subsequently applied to determine the resulting financial position. The scenarios were used exclusively for comparative financial illustration. They do not represent national industry averages, actual pharmacy profitability, prevailing salary benchmarks, or empirical estimates of the Philippine community pharmacy sector.

The analysis distinguishes the hypothetical financial simulations from the literature-based and regulatory evidence used in the study. No statistical inference or population-level generalization was drawn from the simulated figures.

Results and Case Analysis

Diagnosis of the Compensation Problem

The compensation problem is multifactorial, involving workforce supply and distribution, geographic access, pharmacy margins, ownership structure, staffing requirements, professional mobility, migration, alternative employment, and dependence on product-based revenue. Salo et al. (2025) found that the Philippine pharmacy workforce faces supply-demand and geographic distribution concerns. These findings indicate that pharmacist availability cannot be separated from the broader economics of professional employment.

At the practice level, Ngo et al. (2025) documented operational challenges and adaptive changes affecting Philippine community pharmacy practice. This supports viewing community pharmacy as a healthcare setting operating under both commercial and professional pressures. The central structural issue is that professional services may be financed indirectly through medicine margins. This creates competition between pharmacist compensation and other operating costs. Yet the pharmacist contributes clinical judgment, prescription assessment, dispensing responsibility, counseling, supervision, medication safety, regulatory accountability, and risk management. The problem is therefore partly a healthcare-financing and business-model problem, not simply a labor-cost problem.

Ethical Leadership Analysis

The issue involves justice, beneficence, non-maleficence, autonomy, and professional duty. Justice requires fair treatment of pharmacists and patients. Beneficence requires sufficient professional capacity to support safe medication use, while non-maleficence requires the prevention of avoidable medication-related harm and unsafe working conditions. Autonomy requires respect for patients' rights and access to appropriate professional information. The Philippine Code of Ethics places patient and community health at the center of pharmacy practice and emphasizes professional competence, responsibility, and safe and effective medicine use (Professional Regulatory Board of Pharmacy, 2021).

Maintaining low pharmacist compensation solely to preserve medicine affordability is ethically problematic because it transfers part of the system's cost to the professional. Conversely, financing compensation exclusively through higher medicine prices transfers the burden to patients. Ethical leadership within community pharmacy is essential for

upholding superior patient care standards and operational efficiency (Bayram et al., 2025). Ethical leadership therefore requires a financing structure that recognizes professional pharmacy services while protecting affordability.

Economic and Financial Analysis

The following figures are hypothetical case figures, not national industry averages.

Pharmacy	Gross Profit	Operating Expenses*	Remaining Before Pharmacist Compensation
A	₱133,000	₱95,000	₱38,000
B	₱100,500	₱68,000	₱32,500
C	₱66,500	₱47,000	₱19,500

*Operating expenses before pharmacist compensation.

At a hypothetical monthly pharmacist compensation package of ₱30,000–₱35,000, Pharmacy A would retain approximately ₱3,000–₱8,000 after compensation. Pharmacy B would retain ₱2,500 at the lower compensation level but incur a ₱2,500 shortfall at the upper level. Pharmacy C would incur a shortfall of approximately ₱10,500–₱15,500. These calculations illustrate differences in hypothetical business capacity; they do not establish that pharmacists are overpaid, nor do they represent actual net profit or national salary benchmarks.

Under the hypothetical traditional model, three pharmacists would cost approximately ₱90,000–₱105,000 per month. A shared model could instead employ one senior pharmacist at approximately ₱55,000–₱70,000 per month, supported by trained pharmacy personnel, quality systems, secure technology, audit mechanisms, and professional liability safeguards. The potential economic advantage of shared supervision does not establish that the model is automatically safe, clinically appropriate, or legally permissible.

Regulatory Analysis

Adams (2020) highlights the potential of regulatory boards to address regulatory burdens even without legislative intervention. Republic Act No. 10918 establishes different pharmacist supervision requirements according to the classification of pharmaceutical establishments. Under Section 31, Category A establishments require the direct and immediate control and supervision of a duly registered and licensed pharmacist per establishment. Category B establishments require pharmacist supervision and oversight under applicable provisions of law. The latter category includes institutions providing telepharmacy services.

Section 31 also provides that a pharmacist working in a Category A establishment may be allowed to simultaneously work or render pharmacy services in Category B establishments. The maximum number of hours for such arrangements must be determined through guidelines established by the Board in coordination with the FDA and other relevant agencies and institutions. This recognizes the possibility of shared professional services, but it should not be interpreted as automatic authorization for a universal pharmacist-to-pharmacy ratio of 1:3 (Republic Act No. 10918, 2016).

FDA Administrative Order No. 2024-0015 provides the rules, requirements, and procedures for licensing covered health-product establishments. Its application to pharmaceutical outlets must be considered alongside the professional supervision requirements under RA 10918. Establishment licensing and pharmacist supervision address related but distinct regulatory responsibilities. Compliance with licensing requirements does not remove the obligation to maintain the appropriate level of pharmacist supervision.

The regulatory implications for digital supervision are therefore substantial. A Category B telepharmacy arrangement must remain within the applicable licensing and professional practice requirements. Digital communication cannot be used to circumvent the direct and immediate supervision requirements applicable to Category A establishments. Nor should the economic advantages of shared staffing take precedence over the pharmacist's

professional responsibility for safe pharmaceutical practice.

The FDA, in coordination with the Professional Regulatory Board of Pharmacy and other relevant authorities, should clarify the operational requirements for any proposed shared-supervision arrangement. These should address establishment eligibility, pharmacist workload, maximum service hours, real-time accessibility, documentation, professional accountability, and conditions requiring immediate intervention or suspension of dispensing.

The proposed 1:3 arrangement should consequently be treated as a policy hypothesis requiring regulatory assessment, not as an existing universal entitlement. Before implementation, a controlled pilot should establish whether the arrangement can maintain adequate supervision and patient safety under actual operating conditions. Independent safety audits, documented pharmacist interventions, incident reporting, and periodic regulatory evaluation should form part of the proposed safeguards. No financial justification should exempt an establishment from applicable licensing, professional supervision, or patient-safety requirements.

These safeguards must examine pharmacist workload, supervision availability, medication-related incidents, documentation, response times, and compliance with applicable professional and licensing requirements. The proposed audits are policy safeguards recommended by this study; they should not be interpreted as requirements expressly established by FDA Administrative Order No. 2024-0015. Financial limitations or operational convenience must never be used to justify dispensing under conditions that fail to meet the applicable standards of professional supervision and patient safety.

Stress Test of the 1:3 Digital-Supervision Model

Contemporary evidence supports telepharmacy as a potential mechanism for extending pharmacist-led services through telephone, video, and other digital modalities. Snoswell et al. (2025) reviewed 103 studies of synchronous telepharmacy for adult outpatients and identified counseling, medication histories, and ongoing clinical support among the services delivered.

Chong et al. (2025), in a systematic review of reviews, identified telehealth as an expanding component of pharmacy practice and emphasized the need for appropriate implementation and evaluation. Gehrke et al. (2026) reviewed remote patient-monitoring telepharmacy models and identified reported positive patient and service outcomes while noting the need for further investigation. These findings demonstrate the feasibility of telepharmacy as a service-delivery mechanism, but they do not validate a universal 1:3 pharmacist-to-pharmacy ratio. The reviewed interventions differ in patient populations, clinical complexity, technology, service design, and pharmacist workload. Therefore, 1:3 should be treated as a risk-based operational hypothesis rather than a fixed safe ratio.

The model becomes unsafe when prescription volume exceeds pharmacist capacity, patient complexity increases, high-risk medicines require intensive review, support personnel lack competence, communication fails, or the pharmacist cannot intervene in real time. Required safeguards include secure audiovisual communication, electronic prescriptions and medication records, documented pharmacist authorization, barcode verification, clinical alerts, intervention logs, identity and timestamp trails, escalation protocols, workload limits, and a stop-dispense procedure when connectivity, staffing, or clinical conditions prevent safe supervision. Technology should extend professional capacity; it should not substitute for professional accountability.

Redesigning the Pharmacy Business Model

A sustainable model should diversify financing beyond medicine margins.

1. **Separately Identifiable Professional-Service Fees**

The patient or payer finances the professional component of care. The pharmacist provides identifiable services such as medication assessment, counseling, medication-related problem identification, and medication-use support.

Who pays: patient or third-party payer.

Who benefits: patient, pharmacist, and pharmacy.

Risk: poorly designed fees may reduce affordability.

2. Reimbursable Medication-Management Services

Government, insurers, or other payers reimburse defined clinical pharmacy services.

Who pays: government, insurers, or other health-system payers.

Who benefits: patients and the health system.

Risk: reimbursement requires defined eligibility, documentation, quality measures, and payment mechanisms.

3. Government Support for Underserved Areas

Government provides targeted incentives or subsidies for pharmacies serving geographically isolated or economically disadvantaged populations.

Who pays: government.

Who benefits: underserved communities and pharmacies operating in high-need areas.

Risk: poorly designed subsidies may be temporary, inefficient, or inadequately targeted.

4. Shared Clinical Infrastructure

Where legally authorized and clinically appropriate, affiliated pharmacies may share senior clinical supervision, technology, quality systems, and audit infrastructure.

Who pays: participating pharmacies or an affiliated network.

Who benefits: pharmacies through reduced duplication and patients through improved access.

Risk: cost efficiency may become unsafe if pharmacist workload exceeds the capacity for meaningful supervision.

The financing question should therefore shift from "How can pharmacist compensation be squeezed into the medicine margin?" to "How should the professional service required for safe pharmaceutical care be financed?"

Discussion

The analysis places pharmacist compensation within a wider pharmacy-system problem. Professional qualifications and responsibilities have economic value, but community pharmacies must finance these obligations from resources that also support daily operations. The difficulty becomes more apparent when professional services are treated as an indirect expense of medicine sales rather than as identifiable healthcare services.

Human Capital Theory provides a useful explanation for recognizing the value of pharmacists' education, licensure, specialized knowledge, and professional judgment (Becker, 1964). These qualifications are particularly relevant in community pharmacy, where decisions concerning prescriptions, dispensing, counseling, and medication safety carry consequences for patients. The Theory of the Firm helps explain why pharmacy owners must allocate limited resources among staffing, inventory, regulatory compliance, and other operating requirements (Jensen & Meckling, 1976). The two perspectives reveal a tension: the pharmacist represents specialized professional capacity, while the pharmacy must maintain sufficient financial resources to sustain that capacity.

The hypothetical financial scenarios illustrate this tension. Pharmacy A has ₱38,000 remaining before pharmacist compensation, compared with ₱32,500 for Pharmacy B and ₱19,500 for Pharmacy C. Applying the assumed monthly compensation range of ₱30,000–₱35,000 produces substantially different financial outcomes. These figures do not establish prevailing salary rates or national profitability. Their purpose is narrower: to show why the same compensation obligation may be financially manageable for one establishment but difficult for another. A pharmacy's inability to meet the cost does not, on its own, establish that professional compensation is excessive.

The more fundamental question concerns how the professional component of pharmaceutical care is financed. If pharmacists are expected to perform medication assessment, counseling, supervision, and other clinical responsibilities, relying exclusively on medicine margins may place competing demands on the

same revenue source. The value-based healthcare perspective offers another basis for evaluating pharmacy services: professional contributions should be considered in relation to medication safety and patient outcomes, not merely their immediate cost to the establishment (Porter & Teisberg, 2006). Pharmaceutical care places responsibility for medication-related outcomes at the center of pharmacy practice (Hepler & Strand, 1990).

The evidence on telepharmacy introduces a possible operational response, but it requires caution. Snoswell et al. (2025) reviewed synchronous telepharmacy models for adult outpatients, identifying services such as counseling, medication histories, and continuing clinical support. Chong et al. (2025) examined telehealth interventions in pharmacy practice, while Gehrke et al. (2026) reviewed remote patient-monitoring telepharmacy services. These studies support the potential of digital delivery to extend pharmacist-led services. They do not establish that one pharmacist can safely supervise three pharmacies under all operating conditions.

The Philippine regulatory framework reinforces this distinction. Republic Act No. 10918 differentiates Category A establishments, which require the direct and immediate control and supervision of a registered and licensed pharmacist for each establishment, from Category B establishments, which are subject to pharmacist supervision and oversight under the applicable provisions. Institutions providing telepharmacy services are included under Category B. Section 31 also allows a pharmacist working in a Category A establishment to simultaneously work or render pharmacy services in Category B establishments, subject to applicable guidelines on maximum working hours. This provision does not establish a universal 1:3 pharmacist-to-pharmacy ratio or remove the supervision requirements applicable to either category.

FDA Administrative Order No. 2024-0015 prescribes the licensing requirements and procedures for covered health-product establishments, including pharmaceutical outlets. Its regulatory function must be distinguished from the professional supervision requirements established under Republic Act No. 10918. An FDA license to operate does not, by itself, authorize a particular shared or remote pharmacist-supervision arrangement. Any proposed model must satisfy both the applicable establishment-licensing requirements and the professional supervision requirements governing the pharmacy category. The implementation of shared digital supervision requires regulatory coordination between the FDA and the Professional Regulatory Board of Pharmacy to clarify operational conditions, pharmacist responsibilities, and patient-safety safeguards.

For this reason, a differentiated supervision model is more defensible than a universal numerical ratio. Establishments with high prescription volumes, complex patients, or medicines requiring closer professional attention should maintain appropriate onsite pharmacist coverage. Shared or remote supervision may be considered only in settings where it is legally authorized, operationally feasible, and supported by adequate safeguards. These include reliable communication systems, documented pharmacist authorization, competent support personnel, workload limits, escalation procedures, secure records, and auditable professional interventions. When the pharmacist cannot provide meaningful supervision because of excessive workload, connectivity failure, or clinical risk, dispensing should be suspended until safe conditions are restored.

The policy implications extend beyond supervision. Separate financing for identifiable professional services may reduce the pressure to recover all pharmacist-related costs through medicine margins. Reimbursable medication-management services, targeted government support for underserved areas, and shared clinical infrastructure offer possible mechanisms. Each requires appropriate payment arrangements, eligibility criteria, service definitions, and accountability measures. Their feasibility should be tested rather than assumed.

The leadership decision is not to reduce professional requirements in response to financial pressure. It is to develop financing and staffing arrangements that recognize differences in pharmacy capacity while protecting patients. A sustainable community pharmacy system should be financially realistic, but

financial efficiency cannot justify inadequate professional supervision.

Leadership Decision and Policy Model

Selected Model: Differentiated Pharmacy Supervision

The recommended national model is a differentiated system:

1. Dedicated onsite pharmacists for higher-risk, high-volume, complex, or clinically demanding settings.
2. Shared or remote pharmacist supervision only for defined lower-risk or underserved settings, subject to regulatory authorization and demonstrated safety.
3. Risk-based pharmacist-to-pharmacy ratios, rather than a universal 1:3 rule.
4. Separate financing mechanisms for professional pharmacy services.
5. Mandatory technology, documentation, auditability, liability, and emergency safeguards.

The model recognizes that pharmacy settings differ in prescription volume, medicine risk, patient complexity, operating hours, support-personnel competence, and connectivity. Staffing should therefore be determined by clinical and operational risk rather than an arbitrary numerical ratio. Non-negotiable safeguards include competent support personnel, real-time pharmacist access, defined workload thresholds, clinical escalation criteria, cybersecurity, audit trails, professional liability, regulatory oversight, and immediate suspension of dispensing when safe supervision cannot be maintained. The model should fail and revert to a more conservative staffing arrangement when patient risk, workload, technology failure, or professional capacity exceeds predefined thresholds.

First 100 Days Implementation

Proposed First 100 Days Implementation Roadmap

Timeline	Key action	Responsible stakeholders	Expected output
Days 1–20	Establish a National Stakeholder Working Group	Include pharmacists, pharmacy owners, patients, regulators, professional organizations, payers, and representatives of underserved communities.	Formal stakeholder framework and documented recommendations
Days 21–40	Develop a Pharmacist Compensation Framework	Define compensation according to professional responsibility, workload, risk, location, and service complexity.	Proposed compensation and workload matrix
Days 41–60	Define Safety Criteria for Shared Supervision	Establish workload limits, risk categories, escalation rules, technology requirements, and stop-dispense conditions.	Validated safety framework
Days 61–80	Develop Professional-Service Financing Mechanisms	Identify reimbursable medication-management and clinical pharmacy services that can be separated from medicine pricing.	Proposed service and reimbursement schedule
Days 81–100	Conduct a Controlled Regulatory Pilot	Test shared/digital supervision only in defined settings under regulatory oversight.	Medication-safety events, intervention rates, response times, patient satisfaction, pharmacist workload, access, and pharmacy financial sustainability

Note: This is a proposed policy roadmap, not a statement of existing government commitments or a claim that implementation can be completed within 100 days.

Final Leadership Reflection

Filipino society should pay pharmacists for the professional judgment and accountability required to ensure safe and effective medication use, not merely for physical presence in a pharmacy. Their value includes prescription assessment, dispensing oversight, patient counseling, medication-related problem identification, supervision, regulatory compliance, and risk management. Fair compensation should therefore be linked to professional services and responsibilities rather than treated solely as a cost to be minimized. As a national pharmacy leader, I would advocate for financing mechanisms that recognize these services without shifting the full burden to medicine prices or patients. This requires aligning pharmacist compensation with pharmacy viability, patient affordability, professional standards, and measurable pharmaceutical-care outcomes.

Conclusion

Pharmacist compensation is fundamentally a pharmacy-system sustainability problem, not simply a question of labor cost. When required professional services are financed primarily through medicine margins, compensation competes directly with other operating costs, creating pressure on both pharmacists and pharmacy viability. The appropriate response is to redesign financing and supervision rather than minimize professional value. A differentiated model that combines risk-appropriate onsite staffing, regulated shared supervision where justified, and identifiable financing for professional services provides the strongest balance among fair compensation, patient safety, pharmacy viability, and medicine affordability. Future research should examine pharmacist compensation, organizational determinants, regulatory enforcement, and the patient-safety consequences of alternative supervision models through empirical studies involving pharmacists, pharmacy owners, regulators, and patients.

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