Review article

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Community Pharmacist Roles in Thailand, The United Kingdom, The United States, and Australia: A Comparative Narrative Review

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Abstract: Community pharmacists contribute to primary care, but their roles differ across health systems. Comparative evidence on service scope, legal authority, reimbursement, and healthcare integration in Thailand and other established pharmacy systems remains limited. To compare community-pharmacist roles in Thailand, the United Kingdom (UK), the United States (USA), and Australia and examine how health-system arrangements relate to service delivery. A comparative narrative review with a structured literature search was conducted. PubMed, Scopus, ScienceDirect, Google Scholar, and Thai Journals Online were searched for English- and Thai-language sources published from 2016 to 2026. PubMed Central was used for full-text retrieval. The final evidence base comprised 29 sources: 18 direct country- or service-specific sources and 11 contextual, review, professional, policy, or service sources. Findings were synthesized by country and service domain. UK evidence focused on nationally commissioned services, US evidence on jurisdiction-specific preventive and harm-reduction activities, and Australian evidence on structured medication review. Thai evidence described smoking cessation, digital communication, and NHSO-supported minor-illness care. Direct evidence for routine pharmacist-administered vaccination, formal telepharmacy, independent prescribing, and structured mental-health services in Thai community pharmacies was limited. Differences in source type and evidence coverage restricted direct comparison. Community-pharmacy roles vary in scope and organization across the four countries. International models may inform service development in Thailand but require adaptation to local legal, financial, and primary-care systems. Existing NHSO-supported services should be evaluated for safety, outcomes, referral, workload, and cost-effectiveness before wider expansion.

Keywords*:* Community pharmacy, Community pharmacists, Primary healthcare, Scope of practice, Pharmacy services, Thailand

INTRODUCTION

Community pharmacists increasingly provide services beyond medicine dispensing, including medication support, preventive care, and selected primary-care activities [1-3].

The form of this expansion differs among health systems because service authority, reimbursement, referral pathways, and links with other healthcare professionals are organized differently [4-6]. Comparisons therefore need to distinguish specific

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national arrangements rather than treat established community-pharmacy systems as a single model.

In Thailand, community pharmacists provide accessible care for common health problems and contribute to smoking cessation, patient counselling, and health communication [7-10]. The National Health Security Office (NHSO) minor-illness service has extended this role in participating pharmacies through patient assessment, medicine supply, counselling, follow-up, and referral when symptoms do not improve [11-13]. These activities represent care delivered within defined service arrangements and should not be interpreted as independent pharmacist prescribing.

The United Kingdom (UK), United States (USA), and Australia offer relevant but distinct comparators. UK evidence includes nationally commissioned services such as the New Medicine Service and Pharmacy First [4,5]. US studies describe preventive services, behavioural-health support, naloxone access, and other harm-reduction activities within state- or locality-dependent practice arrangements [3,14-16]. Australian evidence includes structured medication-review services and ongoing development of community-pharmacy practice [17,18]. These differences make country-specific comparison more informative than a general comparison between Thailand and 'Western countries.'

Previous studies have mainly examined individual services or single-country settings. The available literature has not clearly synthesized how Thailand differs from these three countries in service scope, legal authority, reimbursement, referral arrangements, health-system integration, and outcome evidence. This review therefore aimed to compare the reported roles and scope of community-pharmacy practice in Thailand, the UK, USA, and Australia; examine how health-system arrangements are described in relation to service delivery; and identify evidence-informed priorities for developing and evaluating community-pharmacy services in Thailand.

METHODOLOGY

This comparative narrative review examined the roles and scope of community-pharmacy practice in Thailand, the United Kingdom (UK), the United States of America (USA), and Australia. A structured literature search was used to identify empirical studies, reviews, professional publications, and policy or service documents. The review was not conducted as a systematic review, and no protocol was registered. The three comparator countries were examined separately because they represent distinct community-pharmacy models.

PubMed, Scopus, ScienceDirect, Google Scholar, and Thai Journals Online (ThaiJO) were searched from 10 April to 30 May 2026. PubMed Central was used only for full-text retrieval. Reference lists and relevant journal, government, and professional websites were also examined, including the Thai Journal of Pharmacy Practice, The Pharmaceutical Journal, NHS England, NHS Business Services Authority, Thailand National Health Security Office, and Australian Government Department of Health.

The principal search strategy was ("community pharmacist" OR "community pharmacy") AND ("role" OR "service" OR "competency" OR "scope of practice") AND ("Thailand" OR "United Kingdom" OR "United States" OR "Australia"). Search syntax was adapted to each database. ThaiJO was searched using equivalent English and Thai terms relating to community pharmacists, pharmacy services, professional roles, and scope of practice. Searches were limited to English- and Thai-language sources published from 2016 to 2026. Full-text and publication-type filters were not applied because different source types contributed to different parts of the synthesis. Google Scholar was used as a supplementary source, and results were examined in relevance order. The number of Google Scholar results screened was not prospectively recorded. Database-specific strategies are presented in Supplementary Table S1.

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Sources were eligible if they addressed community-pharmacy roles, services, scope of practice, reimbursement, prescribing authority, referral pathways, or health-system integration in one of the four selected countries. Quantitative, qualitative, and mixed-methods studies, reviews, professional publications, and policy or service documents were considered. Studies involving pharmacy students or non-practising populations, drug-efficacy studies without a community-pharmacy component, hospital-only services, editorials, opinion articles, studies outside the four-country scope, and publications outside the specified period were excluded from the comparative synthesis. Older or geographically broader sources could be used as background but were not treated as direct comparative evidence.

Retrieved sources were assessed for relevance according to country, community-pharmacy setting, source type, service domain, and review objective. Titles and abstracts were examined before potentially relevant sources underwent full-text assessment. Complete records of database retrieval, duplicate removal, and independent reviewer involvement were unavailable; therefore, the selection process was reported descriptively rather than through a numerical flow diagram. The absence of independently documented screening was considered a review limitation.

Information was extracted on author and year, country, source type, study design, setting, service domain, pharmacist role, legal or protocol basis, reimbursement, referral arrangements, reported outcomes, principal findings, and limitations. The information was organized in a structured evidence table. Independent duplicate extraction was not documented, and the possibility of extraction or classification error was considered when interpreting the evidence.

The final evidence base comprised 29 sources. Eighteen provided direct country- or service-specific evidence, including 14 empirical studies, one practice-based source, and three official policy or service documents. The direct evidence included eight sources from Thailand, four from the UK, four from the USA, and two from Australia. The remaining 11 sources comprised reviews, professional publications, policy materials, and other contextual evidence used to support interpretation of specific service domains.

The evidence was synthesized narratively because the sources differed in design, purpose, setting, and reported outcomes. Sources were organized into 13 domains: minor-ailment management, medication review, chronic-disease management, vaccination, smoking cessation, public health, mental health, harm reduction, antimicrobial stewardship, complementary medicines, digital health, health-system integration, and prescribing authority. Findings were first summarized within each country and then compared across countries. Absence of an eligible source was interpreted as insufficient evidence rather than evidence that a service was unavailable.

No formal risk-of-bias assessment was conducted because the evidence included heterogeneous empirical, review, professional, policy, and service sources. Sources were not excluded solely on the basis of methodological quality. Source type, study design, directness, and reported limitations were considered during interpretation. Findings were presented as comparative trends rather than causal effects.

RESULTS

Characteristics of the evidence base

The final evidence base comprised 29 sources. Eighteen provided direct country- or service-specific evidence, including 14 empirical studies, one practice-based source, and three official policy or service documents. Eight direct sources concerned Thailand, four concerned the UK, four concerned the USA, and two concerned Australia. The remaining 11 sources comprised reviews, professional publications, policy materials, and other contextual evidence used to interpret individual service domains. Source characteristics and their contributions to the synthesis are presented in Table 1.

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Table 1. Separates direct evidence from contextual and policy evidence. This distinction prevents reviews, professional statements, and service specifications from being interpreted as equivalent to empirical evaluations.

Ref.	Country/scope	Design/source	Domain	Use in synthesis
1	UK	Longitudinal evaluation	Vaccination	Empirical direct evidence
2	International	Systematic review	Public-health interventions	Contextual
3	USA	Cross-sectional study	Preventive services	Empirical direct evidence
4	UK	Pragmatic RCT	New Medicine Service	Empirical direct evidence
5	UK	Service specification	Pharmacy First	Policy direct evidence
6	International	Systematic review	Quality framework	Contextual
7	Thailand	National survey	Smoking cessation	Empirical direct evidence
8	Thailand	Practice review	Acute diarrhoea	Direct service evidence
9	Thailand	Survey	Social media communication	Empirical direct evidence
10	Thailand	Practice study	Smoking cessation	Empirical direct evidence
11	Thailand	Qualitative study	NHSO minor ailments	Empirical direct evidence
12	Thailand	Qualitative study	NHSO minor ailments	Empirical direct evidence
13	Thailand	NHSO service document	Minor-illness service	Policy direct evidence
14	USA	Observational study	Naloxone	Empirical direct evidence
15	USA	Feasibility study	Behavioural health	Empirical direct evidence
16	USA	Descriptive survey	Harm reduction	Empirical direct evidence
17	Australia	Pharmacist survey	Implementation priorities	Empirical direct evidence
18	Australia	Government service document	Home Medicines Review	Policy direct evidence
19	International	Systematic review	Social prescribing	Contextual
20	UK	Service dashboard	AMS/Pharmacy First	Policy/contextual
21	Thailand	Workload study	Workforce/workload	Empirical direct evidence
22	UK	Practice article	Quality improvement	Contextual
23	International	Systematic review	Complementary medicines	Contextual
24	Thailand	Intervention study	Antibiotic use in primary care	Contextual; not community-pharmacy-specific
25	International	Systematic review	Telepharmacy	Contextual
26	International	Systematic review/meta-analysis	Counselling/adherence	Contextual
27	UK	Feasibility study	Community-pharmacy AMS	Empirical direct evidence
28	International	Professional statement	AMS	Contextual
29	International	Systematic review	Pharmacist prescribing	Contextual

United Kingdom

Four sources provided direct evidence from the UK. The New Medicine Service was evaluated through a pragmatic randomized controlled trial that examined community-pharmacy support for patients starting long-term medicines [4]. Pharmacy First was described through an official service specification that defined eligible conditions, clinical pathways, and mechanisms for medicine supply and referral [5]. Community-pharmacy influenza vaccination was supported by a longitudinal service evaluation [1], while antimicrobial stewardship was examined in a community-pharmacy feasibility study [27]. These sources documented specific commissioned services but did not establish that every service was available in all UK community pharmacies.

United States

Four empirical sources provided direct US evidence. Preventive services, including vaccination-related activities, were described in

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community-pharmacy practice [3]. Naloxone stocking and dispensing were examined following a statewide standing order in Indiana [14]. A Pittsburgh survey reported locality-specific harm-reduction practices [16], while a feasibility study evaluated community pharmacists as behavioural-health extenders [15]. These findings indicate expanded public-health roles in selected US jurisdictions but should not be generalized across all states.

Australia

Two sources provided direct Australian evidence. A pharmacist survey examined priorities for implementing community-pharmacy services [17], while an Australian Government service document described Home Medicines Review [18]. The medication-review model involved pharmacist assessment of medicines in the patient's home and communication of recommendations to support a medicine-management plan. The available evidence supported structured medication review but was insufficient for broad conclusions about Australian vaccination, smoking cessation, harm reduction, or prescribing services.

Thailand

Eight sources provided direct evidence from Thailand. Community-pharmacist involvement was reported in smoking-cessation services [7,10], social-media communication [16], management of acute diarrhoea [8], workload and service delivery [21], and NHSO-supported minor-illness care [11,12]. The NHSO service framework included patient assessment, medicine supply, counselling, follow-up, and referral when symptoms did not improve [26]. These activities represented protocol-based service delivery rather than independent prescribing. Direct evidence was not identified for routine pharmacist-administered vaccination, formal telepharmacy integrated with clinical systems, structured mental-health screening, alcohol screening, or pharmacy-based harm-reduction services in Thailand.

Comparison across service domains

Minor-ailment management was supported by formal service evidence from the UK and Thailand [5,11,12,26]. The UK model used defined clinical pathways, while the Thai NHSO service involved assessment, medicine supply, follow-up, and referral in participating pharmacies. Direct evidence for comparable services in the USA and Australia was not identified in the included sources.

Structured medication support differed across countries. The UK evidence concerned the New Medicine Service [4], while Australian evidence described Home Medicines Review [18]. International evidence supported pharmacist counselling and medication adherence more broadly [26], but direct community-pharmacy outcome evidence from Thailand and the USA was limited in the included set. Evidence for chronic-disease management was mainly indirect or embedded within medication-support services; therefore, firm country-level comparison was not possible.

Vaccination evidence was strongest for the UK, where influenza vaccination was evaluated longitudinally [1]. US evidence described vaccination within broader preventive community-pharmacy services [3]. Direct evidence for routine community-pharmacy vaccination in Thailand or Australia was not identified in the included set. These findings should be interpreted as differences in the available evidence rather than proof that services were absent.

Thai studies directly supported smoking-cessation counselling [7,10]. Public-health interventions involving alcohol reduction, smoking cessation, and weight management were also described in an international review [2], but this contextual evidence did not establish equivalent implementation across all four countries. Mental-health and harm-reduction evidence was concentrated in the USA [14-16]. These services should therefore be attributed to the jurisdictions in which they were studied.

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Table 2. Country-specific evidence matrix for community-pharmacy service domains

Service domain	United Kingdom	United States	Australia	Thailand	Number and type of supporting sources	Interpretation and limitations
1. First-contact care and minor-ailment management	Pharmacy First provides defined clinical pathways for selected common conditions, including assessment, advice, medicine supply, and referral [5].	No direct country-specific evidence was identified in the included sources.	No direct country-specific evidence was identified in the included sources.	NHSO-supported services involve assessment, medicine supply, counselling, follow-up, and referral in participating pharmacies [11-13]. Acute-diarrhoea management was also described [8].	UK: one official service specification. Thailand: two qualitative studies, one practice-based source, and one official service document.	UK and Thai services operate under different legal and organizational arrangements. Thai minor-illness management should not be described as independent prescribing.
2. Medication review and pharmaceutical care	The New Medicine Service supports patients starting medicines for long-term conditions [4].	International counselling evidence was relevant, but direct US medication-review evidence was limited in the included set [26].	Home Medicines Review involves pharmacist assessment and communication of recommendations to support a medicine-management plan [18].	Direct community-pharmacy outcome evidence was limited. Medication counselling was reported within minor-illness and other pharmacy services [11,12].	UK: one randomized controlled trial. Australia: one official service document. International: one systematic review and meta-analysis. Thailand: indirect evidence from two qualitative studies.	The services differ in purpose, eligibility, reimbursement, and outcome measurement. General counselling should not be treated as equivalent to a formal medication review.
3. Chronic-disease management	Medication support for people starting long-term treatment was documented through the New Medicine Service [4].	Direct evidence for pharmacist-led chronic-disease management was not identified in the included US sources.	Medication review and management planning may support patients with complex or chronic treatment needs [18].	Chronic-disease support was mentioned within broader pharmacy practice, but direct outcome evidence was not identified.	UK: one randomized controlled trial. Australia: one official service document. Thailand and USA: no direct domain-specific evidence.	Evidence was mainly embedded within medication-support services. Firm comparison of clinical outcomes across countries was not possible.
4. Vaccination services	A longitudinal evaluation examined community-pharmacy influenza vaccination [1].	Vaccination was included within broader preventive services provided by community pharmacists [3].	No direct Australian vaccination source was identified in the included evidence set.	No direct evidence supported routine pharmacist-administered vaccination in Thai community pharmacies.	UK: one longitudinal evaluation. USA: one cross-sectional preventive-services study. Australia and Thailand: no direct included source.	Differences reflect the available evidence and should not be interpreted as proof that vaccination services are absent in Australia or Thailand.
5. Smoking-cessation services	Smoking cessation was included in contextual evidence on community-pharmacy public-health interventions [2].	Smoking cessation was included within broader preventive-service evidence [3].	No direct Australian source was identified in the included evidence set.	A national survey and a real-world practice study documented community-pharmacy smoking-cessation services [7,10].	Thailand: two empirical studies. USA: one cross-sectional study. International/UK-related context: one systematic review. Australia: no direct source.	Thai evidence supports counselling and service provision but does not establish that all participating pharmacies provide comprehensive pharmacological treatment and follow-up.

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Table 2. Country-specific evidence matrix for community-pharmacy service domains (Continued)

Service domain	United Kingdom	United States	Australia	Thailand	Number and type of supporting sources	Interpretation and limitations
6. Public health and health promotion	Direct evidence included influenza vaccination and a community-pharmacy antimicrobial-stewardship intervention [1,27].	Preventive and behavioural-health services were reported [3,15].	Implementation priorities were examined, but direct evidence for specific public-health services was limited [17].	Smoking cessation and health communication were documented [7,9,10].	UK: two empirical studies. USA: two empirical studies. Australia: one pharmacist survey. Thailand: three empirical studies. International: one systematic review [2].	Public-health services differed considerably in definition and scope. Evidence of service availability does not establish national implementation or effectiveness.
7. Mental-health services	No direct UK mental-health source was identified.	A feasibility study examined community pharmacists as behavioural-health extenders [15].	No direct Australian mental-health source was identified.	No direct evidence supported structured mental-health screening or integrated mental-health services in Thai community pharmacies.	USA: one feasibility study. UK, Australia, and Thailand: no direct included sources.	Evidence was limited to one US feasibility study. Mental-health services should be distinguished from harm-reduction and general medication-counselling activities.
8. Harm reduction and substance-use services	No direct UK harm-reduction source was identified.	Naloxone stocking and dispensing were examined in Indiana [14], and broader harm-reduction practices were reported in Pittsburgh [16].	No direct Australian harm-reduction source was identified.	No direct evidence supported community-pharmacy harm-reduction services in Thailand.	USA: one observational study and one descriptive survey. Other countries: no direct included sources.	Findings are specific to selected US jurisdictions and should not be generalized to the entire USA or to the other comparator countries.
9. Antimicrobial stewardship	A feasibility study evaluated a community-pharmacy antimicrobial-stewardship intervention [27]. Pharmacy First policy information provided additional context [20].	A professional statement provided contextual guidance but was not community-pharmacy-specific empirical evidence [28].	No direct Australian source was identified.	A Thai primary-care intervention addressing antibiotic use was retained as contextual evidence because it was not specific to community pharmacy [24].	UK: one empirical feasibility study and one policy source. International/US A context: one professional statement. Thailand: one contextual primary-care study. Australia: no direct source.	The evidence does not support a broad conclusion that formal community-pharmacy AMS frameworks operate uniformly across the comparator countries.
10. Complementary medicines and dietary supplements	An international systematic review provided contextual evidence on community-pharmacist practices [23].	The same international review provided contextual evidence [23].	A pharmacist survey identified implementation priorities, but direct service-outcome evidence was limited [17].	No direct Thai community-pharmacy source was identified.	International: one systematic review. Australia: one pharmacist survey. No direct UK, USA, or Thai country-specific evidence.	The systematic review was contextual and should not be used to infer equivalent regulation or service implementation

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Table 2. Country-specific evidence matrix for community-pharmacy service domains (Continued)

Service domain	United Kingdom	United States	Australia	Thailand	Number and type of supporting sources	Interpretation and limitations
11. Digital health and telepharmacy	A systematic review provided contextual evidence on synchronous telepharmacy models [25].	A systematic review provided contextual evidence on synchronous telepharmacy models [25].	A systematic review provided contextual evidence on synchronous telepharmacy models [25].	A Thai survey described the use of social media for health information and medication communication [9].	International: one systematic review. Thailand: one empirical survey. No direct formal telepharmacy study from the three comparator countries in the included set.	Thai social-media communication is not equivalent to formal telepharmacy involving clinical records, remote monitoring, or integrated referral systems.
12. Health-system integration	The New Medicine Service and Pharmacy First operate through commissioned service arrangements and defined care pathways [4,5].	Evidence reflected state- and locality-dependent services rather than a single national integration model [3,14,15,16].	Home Medicines Review involves structured communication between pharmacists, patients, and other healthcare professionals [18].	NHSO-supported minor-illness services provide defined assessment, follow-up, and referral arrangements in participating pharmacies [11-13].	UK: one randomized controlled trial and one service specification. USA: four empirical studies providing indirect system context. Australia: one official service document. Thailand: two qualitative studies and one official service document.	Integration was inferred from service structures rather than measured using a common framework. Direct comparison of reimbursement, referral completion, and continuity-of-care outcomes was not possible.
13. Prescribing authority and scope of practice	Pharmacy First operates through specified clinical pathways and legal mechanisms for supplying medicines [5].	A systematic review provided contextual evidence that prescribing authority and medicines access vary across jurisdictions [29].	The same prescribing review provided contextual evidence, but direct Australian country-specific evidence was limited [29].	NHSO-supported care involves protocol-based assessment, medicine supply, counselling, follow-up, and referral [11-13]. It does not constitute independent prescribing.	UK: one official service specification. International: one systematic review. Thailand: two qualitative studies and one official service document. Australia and USA: limited direct country-specific evidence in the included set.	Prescribing, medicine supply under a protocol, collaborative practice, dispensing, counselling, and referral are legally distinct activities and should not be combined under one definition.

Community-pharmacy antimicrobial stewardship was directly examined in the UK [27]. A professional statement provided broader contextual guidance [28], while a Thai intervention concerning antibiotic use in primary-care units was retained only as contextual evidence because it was not specific to community pharmacy [24]. The telepharmacy review similarly provided contextual evidence [25] and was not used to support antimicrobial-stewardship claims.

Digital pharmacy evidence also differed in scope. Thai evidence described social-media use for health information and medication communication [9], whereas the international review addressed synchronous telepharmacy models [25]. Social-media communication was therefore not considered equivalent to formal telepharmacy integrated with clinical records, monitoring, or referral systems.

The strongest evidence of formal health-system integration came from commissioned or government-supported services, including Pharmacy First and the New Medicine Service in the UK [4,5], Home Medicines Review in Australia [18], and NHSO-supported minor-illness care in Thailand [11-13]. However, the evidence did not permit a direct comparison of reimbursement adequacy, referral completion, or clinical outcomes across countries.

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Prescribing authority also required careful interpretation. Pharmacy First operates through specified clinical and legal mechanisms [5], while broader pharmacist-prescribing models were described in contextual review evidence [29]. Thai NHSO-supported care involved protocol-based assessment, medicine supply, counselling, follow-up, and referral [13]. It should not be described as independent pharmacist prescribing.

DISCUSSION

The documented roles of community pharmacists varied across Thailand, the UK, USA, and Australia. UK evidence focused on nationally commissioned services, US evidence on jurisdiction-specific preventive and harm-reduction activities, Australian evidence on medication review, and Thai evidence on smoking cessation, digital communication, and NHSO-supported minor-illness care [3-5,7-18,21]. These differences reflect distinct service models but do not show that one country has a more advanced system.

Evidence coverage was uneven. Thailand contributed eight direct sources, the UK and USA four each, and Australia two. Several domains were supported by evidence from only one country or by contextual reviews. A lack of direct evidence should therefore be interpreted as an evidence gap rather than the absence of a service.

Formal service arrangements were most clearly described in the UK, Australia, and Thailand [4,5,11,-13,18]. Commissioning, documentation, and referral pathways may support implementation, but the evidence did not allow direct comparison of reimbursement, service coverage, clinical outcomes, or prescribing autonomy. Protocol-based medicine supply, dispensing, counselling, referral, and independent prescribing should also be treated as distinct activities.

Public-health evidence was country-specific. UK studies addressed vaccination and antimicrobial stewardship [1,27], US studies described preventive, behavioural-health, naloxone, and harm-reduction services [3,14-16], and Thai studies supported smoking-cessation activities [7,10]. These findings should not be generalized beyond the settings studied.

Thai evidence on digital services concerned social-media communication [9], whereas the broader review evidence addressed formal telepharmacy [25]. These service models are not equivalent. The review also did not compare pharmacist education or competency. It therefore suggests only that legal, financial, and organizational arrangements may shape service implementation; their relative influence remains uncertain.

Implications for Thailand

Existing NHSO-supported pharmacy services provide a practical foundation for development in Thailand. Their safety, effectiveness, referral outcomes, workload, reimbursement, and cost-effectiveness should be evaluated before expansion. International models may inform service design but must be adapted to Thai laws, financing, workforce capacity, and primary-care systems. New roles, including vaccination, telepharmacy, mental-health support, medication review, and prescribing-related services, require service-specific evidence before national implementation.

Limitations

This narrative review may have missed relevant evidence because of language, country, and search-record limitations. Heterogeneity, uneven evidence coverage, single-reviewer procedures, and the absence of formal quality assessment limited direct comparison. The findings should therefore be interpreted as comparative patterns rather than causal or comprehensive evidence.

CONCLUSION

Community pharmacists contribute to primary care in all four countries, but their roles are organized differently. The UK, USA, and Australia provide useful service models, although these cannot be transferred directly to Thailand. Further development in Thailand should build on existing NHSO-supported services and be guided by evidence on patient outcomes, referral, workload, and cost-effectiveness.

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Table S1. Search sources and strategies used in the narrative review

Database or source	Search period	Search strategy	Search fields	Limits and role in review
PubMed	10 April–30 May 2026	("community pharmacist"[Title/Abstract] OR "community pharmacy"[Title/Abstract]) AND ("role"[Title/Abstract] OR "service"[Title/Abstract] OR "competency"[Title/Abstract] OR "scope of practice"[Title/Abstract]) AND ("Thailand"[Title/Abstract] OR "United Kingdom"[Title/Abstract] OR "United States"[Title/Abstract] OR "Australia"[Title/Abstract])	Title and abstract	Publication period: 2016–2026; language: English or Thai. No full-text or publication-type filter was applied.
Scopus	10 April–30 May 2026	TITLE-ABS-KEY(("community pharmacist" OR "community pharmacy") AND ("role" OR "service" OR "competency" OR "scope of practice") AND ("Thailand" OR "United Kingdom" OR "United States" OR "Australia"))	Title, abstract, and keywords	Publication period: 2016–2026; language: English or Thai. No document-type filter was applied because empirical studies and reviews were eligible.
ScienceDirect	10 April–30 May 2026	("community pharmacist" OR "community pharmacy") AND ("role" OR "service" OR "competency" OR "scope of practice") AND ("Thailand" OR "United Kingdom" OR "United States" OR "Australia")	Title, abstract, and keywords, according to available search functions	Publication period: 2016–2026; language: English or Thai. No full-text or publication-type filter was applied.
Google Scholar	10 April–30 May 2026	("community pharmacist" OR "community pharmacy") (role OR service OR competency OR "scope of practice") (Thailand OR "United Kingdom" OR "United States" OR Australia)	All indexed text	Custom year range: 2016–2026. Results were examined in relevance order as a supplementary search. The number screened was not prospectively recorded.
Thai Journals Online (ThaiJO)-English search	10 April–30 May 2026	("community pharmacist" OR "community pharmacy") AND ("role" OR "service" OR "competency" OR "scope of practice") AND Thailand	Available title, abstract, keyword, or full-record fields	Publication period: 2016–2026; language: English or Thai. No publication-type filter was applied.
Thai Journals Online (ThaiJO)-Thai search	10 April–30 May 2026	("เภสัชกรชุมชน" OR "ร้านยา" OR "ร้านขายยา") AND ("บทบาท" OR "บริการ" OR "สมรรถนะ" OR "ขอบเขตการปฏิบัติงาน") AND ("ประเทศไทย" OR "ไทย")	Available title, abstract, keyword, or full-record fields	Publication period: 2016–2026. Used to identify Thai-language evidence concerning community-pharmacy practice.
PubMed Central	10 April–30 May 2026	No independent bibliographic search was counted	Full text	Used only to retrieve full-text articles identified through PubMed and other sources.
Reference-list searching	10 April–30 May 2026	Backward examination of reference lists from relevant sources	Reference lists	Used to identify additional empirical, review, professional, policy, or service sources relevant to the four-country comparison.
Targeted journal and website searching	10 April–30 May 2026	Targeted searching of the Thai Journal of Pharmacy Practice, The Pharmaceutical Journal, NHS England, NHS Business Services Authority, Thailand National Health Security Office, and Australian Government Department of Health	Journal websites and official government, professional, policy, and service resources	Sources were assessed using the same country, date, language, setting, and relevance criteria as the database searches. Policy and service documents were classified separately from empirical studies.

PPLEMENTARY MATERIAL

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