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Future pharmacy

A better deal for patients
and taxpayers

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Overview

Each year, community pharmacies dispense millions of scripts, give millions of vaccinations, and offer expert advice to most Australians, costing the federal government and patients almost \$4 billion a year.

Pharmacy policy is too important to be controlled by a powerful lobby group. But the Pharmacy Guild of Australia, which represents most pharmacy owners, is calling the shots.

The Guild negotiates funding and policy directly with the federal government. Unlike almost any other country, Australia's negotiations include no one else, and are based on almost no public evidence.

Bad governance has led to bad deals – unless you own a pharmacy. Profits have surged, while patients miss out on cheaper medicines and choices about where to get them, and taxpayers pay too much.

Dispensing fees are probably too high, and some payments aren't justified at all. If the number of scripts falls below a predicted level, government has to pay up anyway, as if the predicted level was met.

Unique regulatory protections dictate who can own pharmacies and where they can be set up. For most scripts, discounts are being banned or discouraged by financial penalties. Meanwhile, a discretionary surcharge is allowed on many scripts. All these rules choke off competition that would improve choice, increase opening hours, and cut prices.

Skilled and trusted pharmacists should provide more types of care. But medicine checks and dose administration aids are poorly targeted or overpriced, prompting blunt caps on their growth. For new services, dozens of trials have been too weak to prove they are cost-effective, leaving the sector in a purgatory of fragmented state programs.

Pharmacy policy is a shakedown that needs a shakeup. Five reforms can get better value for patients and taxpayers.

First, no more backroom deals. Negotiations should be replaced by independent decisions, as happens for other types of healthcare. If the federal government won't do that, at a minimum patients and pharmacists should be at the table, and there should be clear public evidence to justify decisions.

Second, dispensing fees should be streamlined and reset. Unjustified fees should be scrapped. Fees should be set independently, based on cost not bargaining. A fee for stocking high-cost medicines should be redesigned to work better, and save up to \$285 million a year.

Third, rules on pharmacy location and ownership should be removed immediately, and restrictions on discounts should be phased out.

Fourth, services must deliver value for money. The criteria for MedsChecks should be tighter and administration aids should be repriced. Pharmacists should be able to prescribe for urinary tract infection, but other services must wait for decisive evidence from national trials on the most cost-effective options.

Finally, the federal government should fund pharmacists in GP clinics, where evidence shows that their expertise can improve care.

Fairer fees and competition will change the sector. Some pharmacies may struggle, especially in rural areas. Some companies could dominate and raise prices or cut quality. But safeguards can prevent these risks: targeted financial support, scrutiny from the competition watchdog, and a better system to measure pharmacy quality.

Replacing bargaining with evidence, and protectionism with competition, will give patients lower prices and more choice, and taxpayers better value, while keeping pharmacies the accessible and trusted service Australians rely on.

Recommendations

1. Restore independent community pharmacy policy

- End Community Pharmacy Agreements.
- If the federal government will not do this, include pharmacists and patients in the agreements, and base them on public evidence.

2. Make dispensing fees simpler and fairer

- Expand and speed up price disclosure price cuts.
- Pay pharmacies sooner for very high-cost medicines.
- Automate the Safety Net recording process.
- Remove unjustified fees: the Safety Net recording fee, discretionary patient charges, and fees for 60-day dispensing.

3. Base pharmacy funding on cost and reasonable profits

- Make the Independent Health and Aged Care Pricing Authority (IHACPA) responsible for determining pharmacy remuneration, with pharmacies required to provide necessary data.
- Replace payment adjustment and the regional allowance with monitoring of pharmacy viability, targeted support, and reverse auctions in areas without a pharmacy.

4. End unfair protections and unleash competition

- Remove restrictions on where new pharmacies can be established, including allowing pharmacies in supermarkets.
- Remove restrictions on who can own pharmacies and how many they can own.
- Allow pharmacies to discount all medicines.

5. Safeguard competition and quality

- Direct the ACCC to do a market study of the community pharmacy sector and design appropriate safeguards to protect competition.
- Implement an independent quality and outcomes monitoring framework.

6. Ensure pharmacy services are good value

- Replace arbitrary caps on MedsChecks with tighter eligibility and information-sharing requirements.
- Reset pricing for dose administration aids to reflect increasing automation, and then remove caps.
- Fund pharmacist prescribing for urinary tract infections.
- Fund rigorous national trials of prescribing for other minor ailments, smoking cessation, and collaborative chronic disease management.
- Invest \$80 million in pharmacists in general practice and Aboriginal Community Controlled Health Organisations.

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1 Essential services are being held hostage

Community pharmacies perform vital services for Australians – dispensing medicines, advising patients, and providing one of the most accessible touchpoints in the health system. Governments and patients spend billions of dollars every year for these services, and they deserve good value.

But for decades, the Pharmacy Guild of Australia – one of the country's most powerful lobby groups – has shaped pharmacy policy to protect the interests of pharmacy owners, blocking reforms that would deliver better value to taxpayers and patients.

1.1 Pharmacies are a critical part of our health system

The government subsidises prescription medicines and pays pharmacists – the main health professionals in Australia allowed to dispense medicines – to supply them to patients and provide advice.¹ Pharmacies are essential to access to and safe use of prescription medicines.

In 2024-25, there were more than 6,000 community pharmacies in Australia, and they dispensed 335 million prescriptions under the Pharmaceutical Benefits Scheme (PBS) and Repatriation PBS (a dedicated scheme for veterans).² Community pharmacies provide the most common touchpoint that people have with the healthcare system.

1. Approved doctors practising in isolated areas without access to a pharmacy are also allowed to dispense medicines: Department of Health, Disability, and Ageing (2024a).
2. Department of Health, Disability, and Ageing (2026a, Tables 2a, 2c and 13). Community pharmacy refers to any pharmacy that dispenses medicines to the general public. It does not refer to a specific kind of ownership or operating model. The other kind of pharmacies are hospital pharmacies, which dispense medicines to patients in hospital. In this report we refer to the PBS and RPBS together as the PBS.

On average, each Australian visits a community pharmacy 18 times a year.³

Pharmacists are highly skilled health professionals with expert knowledge of medicines. In the community setting, they dispense medicines, counsel patients on how to take them safely, and flag medicine interactions and prescribing errors. They also provide informal health advice and increasingly deliver clinical services, such as vaccinations.

Community pharmacists are among the most accessible health professionals in Australia, and patients can seek their advice without an appointment.

Each year, pharmacies receive about \$3.8 billion for dispensing medicines and professional services.⁴ Taxpayers and patients need to be confident they are getting good service, and good value, from this spending.

1.2 Pharmacy policy is dominated by the Guild

The Pharmacy Guild of Australia (the Guild) is the peak body representing community pharmacy owners (Box 1). It is also one of the most powerful lobby groups in the country.

Its political influence is partly financial, thanks to its significant political donations to successive governments on both sides of politics.⁵

3. See Pharmaceutical Society of Australia (2024). By comparison, Australians visit a GP on average six times a year: AIHW (2026a).
4. This figure includes total spending on pharmacy remuneration and professional programs in 2025 dollars: Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024, Table 19). See Chapter 4 and Chapter 8 for more detail.
5. Grattan analysis of AEC (2026). See Box 1.

But the main source of the Guild's power is its ability and willingness to weaponise a highly valued part of the healthcare system. Pharmacists are among the most trusted professionals in Australia.⁶ The Guild has repeatedly leveraged this trust to mobilise patients against reforms that would, in many cases, benefit patients directly. This generally involves claiming that any such reform would put their local pharmacy out of business.

Table 1.1 summarises instances when the Guild has successfully blocked or watered down reform over the past three decades. Box 2 provides more detail on the most recent example: the scare campaign against 60-day dispensing.

The Guild has ensured that the evidence base needed to challenge its claims does not exist. Its ongoing refusal to provide pharmacy cost data has meant that no comprehensive costing study has been conducted since 1989 – almost four decades ago.⁷ Without cost data being public, the Guild can maintain the impression that the sector is perpetually on a knife's edge, making claims of catastrophic harm from reform impossible to test or refute.

1.3 Pharmacies seem to be getting a sweet deal

Thanks to its decades of political influence, the Guild has secured the best of both worlds. Pharmacies earn growing profits while

6. In a survey of 1,267 Australians, 76 per cent rated pharmacists 'high' or 'very high' for their 'ethics and honesty', behind only nurses and doctors: Roy Morgan (2021, p. 2).
7. In 1989, the Pharmaceutical Benefits Remuneration Tribunal (PBRT) evaluated pharmacy cost data: ANAO (2015, p. 25). During the 2017 Review of Community Pharmacy Remuneration and Regulation (the King Review) – which the Guild agreed to support – it discouraged members from participating in a financial survey, citing methodological concerns: King et al (2017a, pp. 70-71) and Pharmacy Guild of Australia (2017a, p. 5). Today, the Guild requires researchers to obtain its endorsement before members are advised to participate in any research: Pharmacy Guild of Australia (n.d.[a]).

Box 1: The Pharmacy Guild of Australia

Established in 1927, the Pharmacy Guild is the peak body representing community pharmacy owners in Australia. In 2023, it had 4,154 member pharmacies – about 70 per cent of community pharmacies.^a It doesn't include any Chemist Warehouse stores, which together account for about 9 per cent of all pharmacies and probably a larger share of the market.^b

The Guild is also a powerful lobby group. In the past five years, it has donated \$2.5 million to political parties.^c This makes it the largest donor from the healthcare sector over that period, and the 15th largest overall – larger than the Minerals Council of Australia.^d Over the past four years, the Guild has also spent \$16.3 million on public campaigns.^e

This political spending is funded in part by membership fees, and in part by the Guild's wholly owned insurance and professional services firm. This firm – Guild Group – has generated \$71 million in profits and has paid \$51 million in dividends to the Guild over the past three years.^f

- a. Department of Health, Disability, and Ageing (2024b, p. 5).
- b. Department of Health, Disability, and Ageing (ibid, p. 5), ACCC (2024, Table 1). The Guild and Chemist Warehouse disagree on key pharmacy policies, including location rules and discounting restrictions: Gance (2017).
- c. Figure includes donations from 2020-21 to 2024-25 and has been inflated to March 2026 dollars using the Consumer Price Index: AEC (2026).
- d. Grattan analysis of AEC (ibid). Over that same period, the Minerals Council donated \$2.2 million (March 2026 dollars).
- e. Figure includes spending from 2021-22 to 2024-25 and has been inflated to March 2026 dollars using the Consumer Price Index: Pharmacy Guild of Australia (2025a) and Pharmacy Guild of Australia (2023a).
- f. Figures have been inflated to March 2026 dollars using the Consumer Price Index: Guild Group (2025, p. 9), Guild Group (2024, p. 9), Pharmacy Guild of Australia (2025a, p. 34), and Pharmacy Guild of Australia (2023a, p. 34).

guaranteed government income insulates them from revenue declines. In effect, they profit as private businesses while shifting financial risk to taxpayers.

Pharmacy income extends well beyond PBS dispensing. Retail and over-the-counter medicine sales comprise about 30 per cent of the average Guild pharmacy's revenue, rising to about 67 per cent for Chemist Warehouse stores.⁸

Pharmacies also earn revenue from private prescriptions. These are medicines not listed on the PBS for which patients pay the full cost with no government subsidy.⁹ Unlike PBS prices, private prescription prices are entirely unregulated, meaning pharmacists can charge whatever they like. Two categories of medicine have turbocharged this revenue stream in recent years (Box 3).

The available evidence on pharmacy finances – limited as it is – suggests a highly profitable sector. Guild survey data suggest that average pharmacy profits have more than doubled over the past decade (Figure 1.1). This excludes Chemist Warehouse stores, but their rich valuation and surging sales suggest they're not struggling either.¹⁰

Pharmacy discounting could also be a sign of profitability. Pharmacies often discount medicines to win customers, surrendering 17 per cent of their remuneration on average (see Chapter 6).¹¹

8. Pharmacy Guild of Australia (2026a, Table 1) and Sigma Healthcare (2023, p. 22).

9. Department of Health, Disability, and Ageing (2024c).

10. Smith (2025) and Sigma Healthcare (2025, p. 4).

11. Grattan analysis of Department of Health, Disability, and Ageing (2026b) and Department of Health, Disability, and Ageing (2026c). Pharmacies may offer discounts to attract patients who then spend more on retail goods.

Table 1.1: The Guild has a track record of blocking reform

Date	Proposed reform	Guild action	Result
1989-1990 ^a	An independent pricing body found pharmacies were overpaid, and it cut fees.	Public protests, including pharmacy closures.	First CPA signed, ending independent fee determination.
2007-2013 ^b	Accelerated price disclosure to pass savings to taxpayers and patients.	Ran a <i>Pharmacy Under Threat</i> campaign during the 2013 federal election.	Reform passed but with pharmacy compensation.
2015 ^c	Competition Policy Review recommended abolishing location rules.	Threatened campaign against an unrelated pharmacy initiative.	Location rules extended by five years.
2023-2024 ^d	Introduction of 60-day dispensing.	Scare campaign threatened mass closures, shortages, and overdose risk.	Reform passed but 8CPA negotiated early to include compensation.

Notes: CPA = Community Pharmacy Agreement.

a. Department of Health, Disability, and Ageing (2024b, p. 6).

b. See McInerney (2013), Clarke (2015), and ANAO (2015). To compensate pharmacies, the sixth Community Pharmacy Agreement partially delinked pharmacy fees from medicine prices: Ley (2015).

c. See Recommendation 14 of Harper et al (2015). The Guild threatened to launch a campaign against the proposal to allow pharmacies to discount over co-payment PBS medicines by \$1 and only pulled back when the location rules were extended: Hurst (2015).

d. See Box 2.

Box 2: The 60-day dispensing scare campaign

Most medicines in Australia are dispensed for 30 days at a time. But in April 2023, Health Minister Mark Butler announced that more than 300 medicines for stable, chronic conditions would become eligible for 60-day dispensing, to be rolled out in stages from later that year.^a

This change would lead to significant savings for patients – halving the dispensing fees for these medicines – and bring Australia in line with countries including New Zealand, the UK, France, and Canada that had already offered 60- or 90-day dispensing.^b

The Guild opposed the change. Pharmacies would earn less from dispensing and lose retail revenue from reduced foot traffic. The Guild claimed this would result in mass pharmacy closures, commissioning modelling that projected up to 665 would shut within four years.^c

The Guild warned of medicine shortages, with president Trent Twomey declaring he didn't want to see 'a Hunger Games stand-off in any community in Australia where some patients get double the medicine they need, while others get nothing'.^d It also argued that larger medicine quantities in homes would increase the risk of accidental overdose by children. Both claims were widely disputed, and there are no reports of such problems in countries with 60- or 90-day dispensing.^e

Through billboards, television, radio, social media, phone calls, and encouraging direct conversations at the counter, the Guild tried to convince Australians that their local pharmacy would close and they would lose access to their medicines.^f

The government held firm. Stage one proceeded in September 2023. The Guild suspended its campaign soon after, having secured an agreement to bring forward negotiations for the eighth Community Pharmacy Agreement. That agreement began in July 2024 – a year earlier than planned – and included new payments that excessively compensate pharmacies for lost dispensing revenue (see Chapter 3).

In December 2024, stakeholders who opposed the Guild reportedly received a Christmas package from the Guild: a voodoo doll of Trent Twomey, some pins, and a packet of Glucogel jelly beans.^g

There have been no reports of medicine shortages or overdoses from 60-day dispensing.^h Meanwhile, the reform has delivered huge savings: in 2025 alone, patients saved \$222 million and the government \$252 million.ⁱ

a. Butler (2023a).

b. Butler (2023b) and Af Geijerstam et al (2024).

c. Ergas (2023, Table E-3). This modelling used government uptake projections only for its minimum scenario. The central scenario – from which headline findings were drawn – and the maximum scenario both assumed uptake 24-to-78 per cent higher than government projections in each year: Ergas (2023, Table 4-1) and Department of Health, Disability, and Ageing (2023a, p. 26). As it turned out, even the government's assumptions were too high: Breadon and Hu (2025).

d. Pharmacy Guild of Australia (2023b).

e. Butler (2023c), RMIT ABC Fact Check (2023), and Af Geijerstam et al (2024).

f. Chrysanthos (2023), McKenzie (2023), and Scholefield (2023).

g. As reported in The Australian Financial Review: Robin (2024).

h. One year after implementation, Payne (2024) found no evidence of negative outcomes, though analysis was constrained by data limitations.

i. Grattan analysis using the methodology outlined in Breadon and Hu (2025), for medicines in stage 1, 2, and 3 of the 60-day dispensing rollout.

1.4 What this report is about

It's clear that pharmacies are receiving substantial government funding and generating substantial profits. The combination of rising profits, opacity, and regulatory capture warrants scrutiny.

The following chapters identify the many policies that benefit pharmacy owners at the expense of patients and taxpayers, and how to fix them:

- An exclusive negotiating position to set policy and funding (Chapter 2);
- payments with no public justification for their structure or value (Chapter 3 and Chapter 4);
- unparalleled protection from competition through pharmacy ownership and location rules (Chapter 5);
- restrictions on discounting that increase costs for patients (Chapter 6);
- minimal monitoring and reporting of quality, efficiency, or results (Chapter 7); and
- funding for pharmacy services that haven't shown good value-for-money (Chapter 8).

This report does not cover the development, manufacture, or wholesale distribution of medicines in Australia, or the level and structure of patient payments or Safety Net thresholds.

Box 3: Private prescriptions are a lucrative revenue stream

Two types of medicine have boosted revenue from private prescriptions in recent years.^a

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) – such as Ozempic and Mounjaro – are used to treat type 2 diabetes and obesity. Since May 2020, total sales have increased almost 10-fold, with most of the growth in private prescriptions.^b

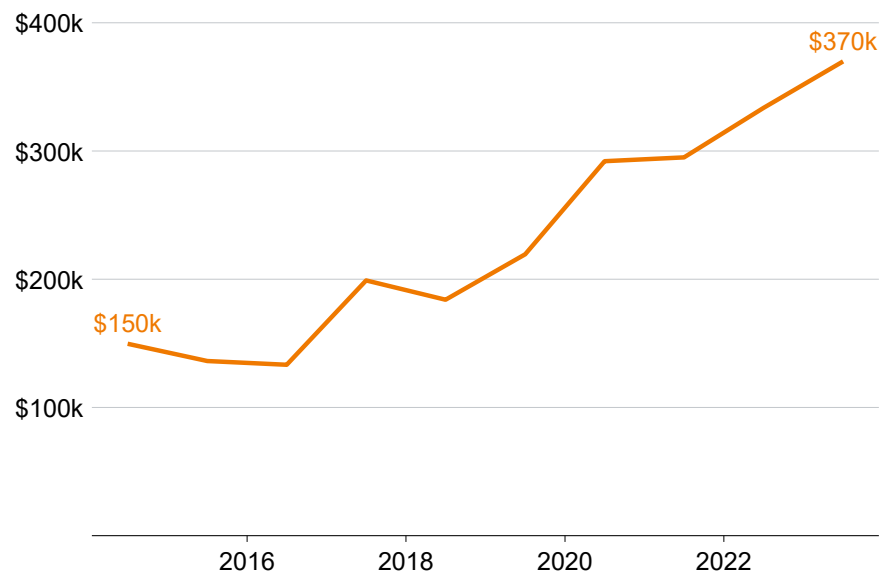
In the 12 months to April 2025, an estimated 2.9 million private prescriptions for GLP-1 RAs were accessed.^c Based on current Chemist Warehouse prices, this represents about \$83 million in pharmacy remuneration per year.^d The figure is conservative, because non-discount pharmacies probably charge even more.

Medicinal cannabis prescriptions are also increasing. In 2025, 6.35 million units were dispensed in Australia, almost entirely as private scripts.^e If pharmacies charged only the standard current PBS dispensing fee, this would represent an additional \$91 million to pharmacies each year. Again, the true figure is probably higher.

- Note that some of these scripts were probably dispensed online rather than through traditional pharmacies.
- In April 2025, 43.8 per cent of prescriptions were private: Falster et al (2025).
- This only includes GLP-1 RAs listed for type 2 diabetes. The true number of private GLP-1 RA prescriptions was probably higher: Falster et al (ibid).
- As of July 2026, Chemist Warehouse charged \$144.99 for a 1.34mg/mL 3mL pre-filled Ozempic pen: Chemist Warehouse (2026). On the PBS, the medicine and wholesale costs are \$116.23, meaning \$28.76 of pharmacy remuneration: Department of Health, Disability, and Ageing (2026b).
- See Penington Institute (2026, p. 3). Only cannabidiol, used to treat a rare form of epilepsy, is available on the PBS: Healthdirect Australia (2026). There were only 7,000 prescriptions for cannabidiol dispensed in 2025: Department of Health, Disability, and Ageing (2026c).

Figure 1.1: Pharmacy profit is increasing

Average profit (before tax) of Australian community pharmacies, adjusted for inflation



Notes: Net profit is total revenue minus total expenses, cost of goods sold, and notional proprietor's salary. Data from the Guild Digest, an annual survey of 300-to-600 pharmacies that is weighted to represent the Australian community pharmacy sector. Years refer to financial year (e.g. 2023-24 is shown as 2024). Values have been inflated to March 2026 dollars using Consumer Price Index: ABS (2026a).

Sources: 2015 to 2025 Guild Digests, available at Pharmacy Guild of Australia (n.d.[b]).

2 Restore independent pharmacy policy

Community pharmacies are funded and regulated through Community Pharmacy Agreements, which are negotiated between the federal government and the Guild. This arrangement has its roots not in policy design, but in a political crisis. The result is a process that is sheltered from outside scrutiny, dominated by a single interest group, and unlike any other major health funding arrangement in Australia.

The Community Pharmacy Agreement should be abolished and replaced with the more transparent, evidence-based alternatives proposed in this report. If the government won't do that, agreements should be based on public evidence, and negotiated with pharmacists and patients – not just pharmacy owners.

2.1 What is the Community Pharmacy Agreement?

Since 1990, the federal government has negotiated a series of five-year agreements with the pharmacy sector – Community Pharmacy Agreements – to govern how community pharmacies are funded and regulated. There have been eight agreements to date.¹² The sector is represented by the Guild (see Box 1 on page 7).¹³

Community Pharmacy Agreements are expensive. The current agreement is expected to cost \$25.8 billion over its five-year term.¹⁴

12. The eighth Community Pharmacy Agreement came into effect on 1 July 2024 and will run until 30 June 2029, after which the ninth Community Pharmacy Agreement is expected to supersede it. See Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024).

13. Section 98BAA of the *National Health Act* requires that the Community Pharmacy Agreement be with an organisation representing the majority of community pharmacy owners.

14. Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024).

2.2 The Agreement emerged from a political standoff, not a policy process

Before the first Community Pharmacy Agreement, in 1990, the sector looked very different. Pharmacy remuneration was determined independently by the Pharmaceutical Benefits Remuneration Tribunal (PBRT).¹⁵

Under this model, dispensing fees per script fell as the number of scripts dispensed by a pharmacy rose, which rewarded small, inefficient pharmacies. As a result, Australia had a high number of pharmacies by international standards, with many clustered together in urban areas.¹⁶

This was the case until 1989, when the PBRT concluded – based on surveys of dispensing costs – that pharmacies were being overpaid, and it moved to cut fees sharply.¹⁷ Pharmacists responded by holding public rallies, with some owners closing their pharmacies in protest.¹⁸ The then Health Minister intervened by negotiating directly with the Guild and bypassing the PBRT entirely.¹⁹

The result was the first Community Pharmacy Agreement, signed in 1990. It replaced the old funding structure with one that no longer gave higher funding per script to lower-volume pharmacies, introduced

15. The PBRT was established in 1981 to insulate funding decisions from political pressure: ANAO (2015, Table 1.1).

16. Department of Health (2014, p. 6).

17. The PBRT decided to abolish an existing 25 per cent mark-up and reduce the dispensing fee by 23 per cent: Department of Health, Disability, and Ageing (2024b, p. 6).

18. Ibid.

19. Ibid (p. 6).

location rules restricting where new pharmacies could open, and funded pharmacy buy-outs and mergers.²⁰

While the PBRT still exists, its only remaining roles are to give legal effect to the terms of the Community Pharmacy Agreement, and to step in and set remuneration if the parties fail to reach a deal.²¹

The precedent set by the first Community Pharmacy Agreement – a bilateral negotiation where politics pushed aside evidence – still haunts Australia today.

2.3 The Community Pharmacy Agreement is uniquely opaque and unrepresentative

The Community Pharmacy Agreement is determined through a process that is sheltered from outside scrutiny and dominated by a single interest group. No other major health funding arrangement in Australia works this way. Even compared to other countries with negotiated pharmacy agreements, Australia's stands out for its lack of transparency and representativeness.

2.3.1 The negotiation is a black box

The terms of each Community Pharmacy Agreement are determined through months of closed-door negotiations.²² There is no public documentation of the process and no empirical justification provided for the policies and spending agreed.²³ For an agreement governing

20. Department of Community Services and Health (1990).

21. Section 98B of the *National Health Act*.

22. For example, in the lead-up to the fifth agreement being signed, the Department of Health conducted dozens of meetings with the Guild – face to face, by email, phone, and teleconference – over more than six months: ANAO (2015, pp. 61, 83).

23. A 2015 Australian National Audit Office audit of the fifth Community Pharmacy Agreement is the most detailed public account available, but it revealed minimal detail on the negotiation process: ANAO (ibid).

billions of dollars of public spending, this is a remarkably low level of transparency.

It hasn't gone unnoticed. The Consumers Health Forum of Australia, the Pharmaceutical Society of Australia,²⁴ and other stakeholders not party to negotiations have repeatedly raised concerns.²⁵ Improved transparency was also recommended by the 2017 Review of Community Pharmacy Remuneration and Regulation (the King Review).²⁶

2.3.2 The right people aren't at the table

Since the first Community Pharmacy Agreement, negotiations have taken place solely between the government and the Guild. The Guild represents most pharmacy owners, but not the pharmacists who work in pharmacies or the patients who rely on them.

This is a significant gap. Many stakeholders – including some pharmacists – say they are dissatisfied with the arrangement, and question the Guild's ability to represent their interests.²⁷ This is unsurprising: the interests of pharmacy owners do not always align with the priorities of employed pharmacists, let alone patients.

The King Review recommended that the Pharmaceutical Society of Australia and the Consumers Health Forum of Australia be included as equal participants in negotiations.²⁸ For the past three agreements,

24. The peak body for the pharmacy workforce.

25. See Jackson et al (2023a, p. 8) and King et al (2017b, p. 81).

26. Recommendations 5.4 and 6.3: King et al (ibid).

27. Jackson et al (2023a) found broad dissatisfaction with the representativeness of negotiations. One pharmacist said: 'Having the [Community Pharmacy Agreement] negotiated by a small group of owners with a vested interest is quite insulting, and quite inappropriate. They have a vested interest in achieving commercial prosperity.'

28. Recommendation 8.4 of King et al (2017b). Chemist Warehouse has argued that this expanded signatory list would not adequately represent their interests as the largest banner group because they are not members of the Guild: Gance (2017).

stakeholder groups have had some formal participation in the lead-up to negotiations and in overseeing their implementation.²⁹ But this has not extended to the negotiations themselves. Apart from the Pharmaceutical Society of Australia – which was a signatory to a small professional services section of the seventh agreement – no one but the Guild and the Department has ever had a formal seat at the table.³⁰

2.3.3 Australian community pharmacy is an outlier

The Community Pharmacy Agreement is the only agreement of its kind for Australian healthcare services.³¹

GP, specialist, optometry, and allied health rebates are set through the Medicare Benefits Schedule by the government, with new items added on the recommendation of the independent Medicare Services Advisory Committee.³² Public hospital prices are set by an independent pricing authority, and calculated using cost data.³³ Bilateral funding agreements with other health sectors – for example, for pathology and diagnostic imaging – have not been continued.³⁴

29. This has consisted of stakeholder consultations and, for select groups, positions on oversight committees: Department of Health, Disability, and Ageing (2025a), Department of Health (2022), and Department of Health, Disability, and Ageing (2019). But some stakeholders reported consultations were inadequate and had little meaningful impact: Jackson et al (2023a, p. 8).

30. Department of Health and Pharmacy Guild of Australia (2020) and Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024).

31. A partial exception is the Pharmaceutical Wholesaler Agreement. This was previously included in the Community Pharmacy Agreement but has since been separated into its own agreement that suffers from many of the same shortcomings: Department of Health, Disability, and Ageing and National Pharmaceutical Services Association (2024).

32. Department of Health, Disability, and Ageing (2024d).

33. IHACPA (n.d.).

34. Pathology Funding Agreements (1996 to 2016) and Memoranda of Understanding with the diagnostic imaging sector (1998 to 2008) set negotiated spending targets, while individual services were paid for through fee-for-service Medicare payments: Jackson et al (2023b), Duckett and Romanes (2016), and ANAO (2014).

Table 2.1 rates pharmacy funding arrangements in comparable countries on three dimensions: the representativeness of the stakeholders in the negotiating room, the level of evidence they use to make their decisions, and how well their decisions are explained to the public.

Some other countries use sector-level negotiations to set pharmacy funding, but even among those, Australia stands out. No other jurisdiction combines such a narrow negotiating group with such a complete absence of public evidence and transparency. Wales comes close, but even there, all pharmacy owners are represented – not just a majority.

2.4 This Community Pharmacy Agreement should be the last

The key functions of the Community Pharmacy Agreement should be replaced with more transparent, evidence-based alternatives. Pharmacy remuneration should be set by an independent body (see Chapters 3 and 4), and funding for other community pharmacy services should be determined through a separate process (see Chapter 8).

That leaves little for Community Pharmacy Agreements to do, and no reason for them to continue. The current agreement should be the last.

If the agreements are retained, they should at least be reformed:

- Include the Pharmaceutical Society of Australia, the Consumers Health Forum of Australia, and other pharmacy owners;
- base decisions on cost data released before negotiations; and
- document the decision-making process and make outcomes subject to ongoing quality monitoring and reporting.

The Guild will probably oppose the recommendations in this report. It is likely to claim, as it has before, that reform threatens the viability of the sector and the communities that depend on it. The best response to these arguments is transparency, so that taxpayers and patients can know if these claims are accurate.

Table 2.1: International comparison of community pharmacy funding arrangements

Country	Process	Representativeness	Evidence base
Australia	Negotiation	Low: Government, pharmacy owners (majority)	Low: Limited available data
Wales	Negotiation	Low: Government, pharmacy owners (all)	Low: Limited available data
New Zealand	Negotiation	Low: Health service, pharmacy owners (majority)	Mid: Cost pressure surveys
Ireland	Negotiation	Mid: Government, pharmacists	Low: Limited available data
England	Negotiation	Low: Government, pharmacy owners (all)	High: Review of pharmacy profitability
France	Negotiation	Mid: Government insurer, pharmacists	High: Review of pharmacy profitability
Denmark	Hybrid	Low: Government, pharmacy owners (total sector funding negotiated, fee structure centrally regulated)	Low: Limited available data
Japan	Hybrid	High: Government, payers, pharmacies, public (final decision made by state but informed by representative deliberations)	High: Review of pharmacy profitability
Germany	Determination	NA: Government (sector consulted)	Low: Static, no published model
Finland	Determination	NA: Government regulator	Mid: International comparison of fees
Norway	Determination	NA: Government regulator, health ministry	Low: Fee based on medicine price, no published model
Sweden	Determination	NA: Independent government agency	High: Review of pharmacy profitability

Notes: Representativeness = the degree to which decision-makers reflect the interests of those affected by their decisions. Evidence base = the amount and quality of evidence used to inform decisions.

Sources: Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024), Community Pharmacy Wales (2025), Health New Zealand | Te Whatu Ora (2025a), Grant Thornton (2021), Department of Health Ireland (2025), Community Pharmacy England (2024), Fédération des Pharmaciens de France (2023), Andersen and Skov-Johansen (2024), Hansen et al (2021), Health and Global Policy Institute (n.d.), Health and Global Policy Institute (2019), Federal Union of German Associations of Pharmacists (ABDA) (2025), Sosiaali- ja terveystieteiden ministeriö (2020), Apotekforeningen (2024), and Tandvårds- & läkemedelsförmånsverket TLV (n.d.).

3 Make dispensing fees simpler and fairer

Community pharmacies exist, first and foremost, to dispense medicines. For PBS medicines, the cost of dispensing is shared between patients and the government. Many fees that add to that cost are poorly designed, and some are completely unjustified. Fixing these issues would deliver better value for taxpayers, cut patient fees, and support the delivery of high-cost medicines.

This chapter outlines how to address these structural flaws, and Chapter 4 covers how the value of the fees should be set.

3.1 How dispensing is funded

Community pharmacies receive a series of payments for dispensing PBS medicines, each ostensibly covering a different cost. The fees are paid by the government, the patient, or both. The following sections explain each component.

3.1.1 The Commonwealth Price

When a pharmacy dispenses a medicine, the total amount they receive in return is called the Commonwealth Price.³⁵ The Commonwealth Price has four components:³⁶

- **Medicine costs** – The *approved ex-manufacturer price* and *wholesale mark-up* (\$0.24 to \$223 depending on medicine price) reimburse the pharmacy for the price it has already paid to the manufacturer and wholesaler.

- **Handling and infrastructure** – The *administration, handling, and infrastructure fee* (\$5.12 to \$100.12 depending on medicine price) covers the costs of storing and handling the medicine and maintaining the required pharmacy infrastructure.
- **Dispensing services** – The *dispensing fee* (\$9.24 for ready-prepared medicines, \$11.28 for compounded medicines) covers dispensing – from receiving the prescription, verifying and preparing the medicine, to counselling the patient and handing it over.
- **Other** – Fees that vary by medicine type, patient circumstances, and pharmacist discretion, including the *dangerous medicine fee* (\$5.73), *Safety Net recording fee* (\$1.54 for ready-prepared medicines, \$1.99 for compounded medicines), and *allowable additional patient charge* (up to \$2.79).

The exact values of these payments are listed in Table A.1 in Appendix A.

The Commonwealth Price is split between the patient and the government, with patients paying up to the maximum co-payment (\$25 for general patients and \$7.70 for concession patients) and the government paying the rest.³⁷ Figure 3.1 provides an illustrative example using atorvastatin – a common, low-cost medicine for high cholesterol – of how this payment is split.

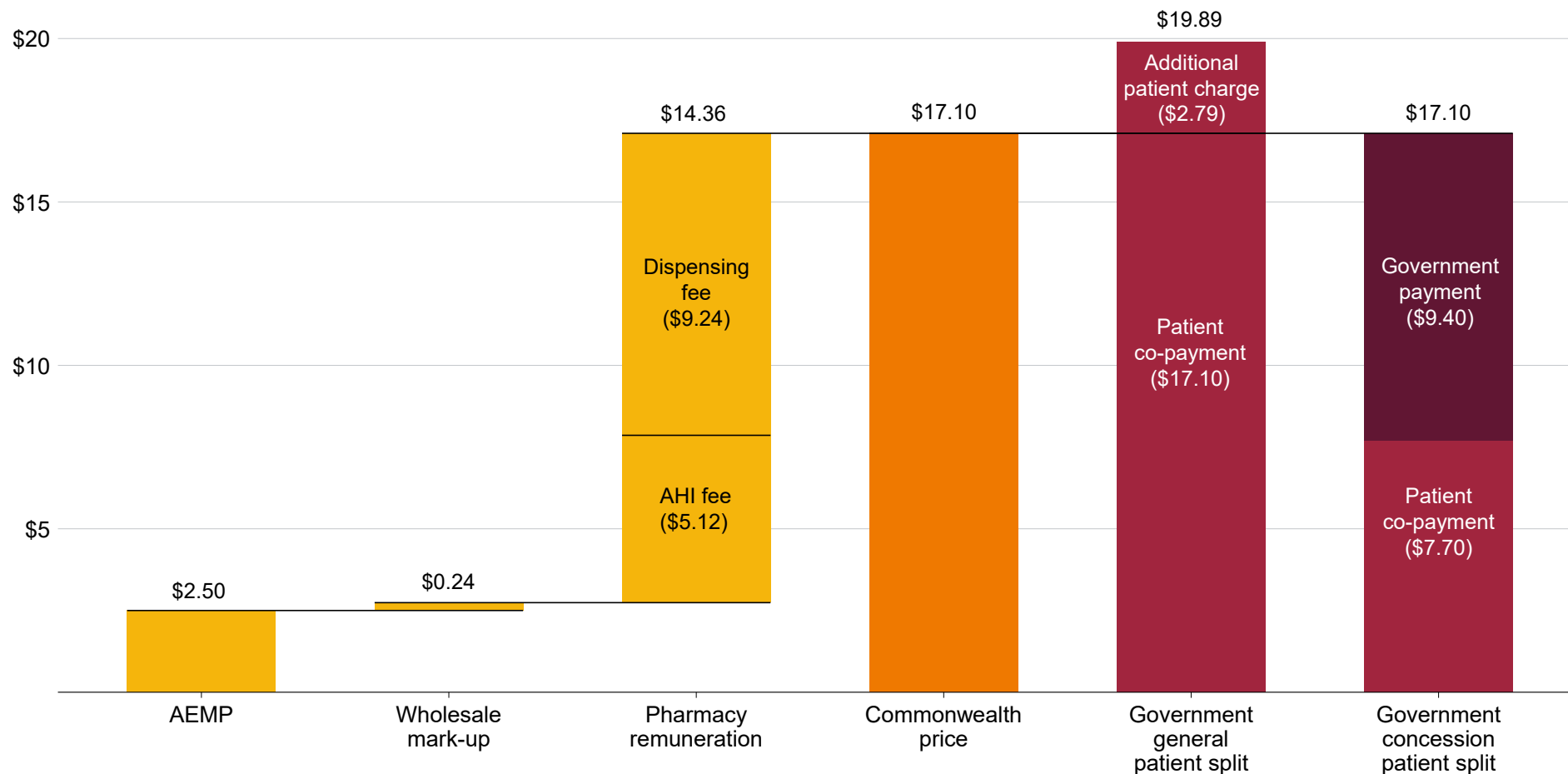
35. The Commonwealth Price is intended to cover the costs of dispensing PBS medicines, not any other pharmacy operations.

36. Department of Health, Disability, and Ageing (2026d).

37. On top of the maximum co-payment, patients may pay after-hours fees, brand or therapeutic group premiums, or special patient contributions: Department of Health, Disability, and Ageing (ibid).

Figure 3.1: Patients and the government split the cost of dispensing

Cost components of the Commonwealth Price of atorvastatin 10mg (pack of 30), July 2026



Notes: Atorvastatin 10mg (pack of 30) has the PBS item number 8213G. AEMP = Approved ex-manufacturer price. AHI = Administration, handling, and infrastructure. The full allowable additional patient charge (\$2.79) has been applied to the general patient fee here, but pharmacists may choose to apply part or none of this charge, provided the total patient cost does not exceed the general patient co-payment of \$25. No Safety Net recording fee or after-hours fees have been included. Atorvastatin does not attract any brand or therapeutic group premiums.

Sources: Department of Health, Disability, and Ageing (2026d) and Department of Health, Disability, and Ageing (2026b).

3.1.2 Additional funding for 60-day dispensing

The current Community Pharmacy Agreement introduced the *Additional Community Supply Support payments* to compensate pharmacies for income lost due to 60-day dispensing (see Box 2 on page 9).³⁸

These payments consist of two components:³⁹

- **Component 1:** \$5.12 for each over co-payment 60-day script dispensed.
- **Component 2:** \$0.13 for each over co-payment script dispensed.⁴⁰

Together these payments will cost \$2.1 billion from 2024 to 2029.⁴¹

3.2 Pharmacy funding has structural flaws

There are three main problems with the design of dispensing fees:

- Pharmacies are reimbursed above the prices they pay for medicines, and the policy to fix it isn't quick or precise enough;
- the financial risks from stocking high-cost medicines are addressed through a wasteful and ineffective mark-up; and
- pharmacies get several arbitrary, unfair, and costly fees.

38. Payments apply to over co-payment Section 85 medicines: Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024, p. 13) and Department of Health, Disability, and Ageing (2026e). Section 85 medicines cover most community pharmacy dispensing: Storen et al (2022).

39. Department of Health, Disability, and Ageing (2026e).

40. In 2024–25, this covered 67 per cent of PBS dispenses: Department of Health, Disability, and Ageing (2026a, Tables 2a and 3a).

41. This covers the term of the eighth Community Pharmacy Agreement: Department of Health, Disability, and Ageing (2026e).

3.2.1 Price disclosure works, but not well enough

When a new medicine is added to the PBS, the approved ex-manufacturer price is set through negotiations between the manufacturer and the government. This process takes into account the cost of manufacture, the type of medicine, and the prices of other similar medicines.⁴²

The approved ex-manufacturer price is the maximum price at which a manufacturer can sell the medicine for.⁴³ But they can – and often do – sell medicines to pharmacies for less than this price to gain market share.⁴⁴ Historically, this meant pharmacies could purchase medicines at discounted prices while being reimbursed the full ex-manufacturer price by the government, effectively profiting at taxpayers' expense.

In 2007, the government introduced a price disclosure policy to claw back savings for taxpayers.⁴⁵ Manufacturers are now required to report the actual prices at which medicines are sold, with reimbursement gradually reduced to reflect those prices.⁴⁶

Similar systems are used successfully in other countries, including in England⁴⁷ and in the Medicaid program in the US.⁴⁸

42. Department of Health, Disability, and Ageing (2017).

43. See Section 84 of the *National Health Act 1953*.

44. Department of Health, Disability, and Ageing (2025b).

45. Ibid.

46. Price disclosure applies to all multi-brand, off-patent, or generic medicines, unless specifically exempt: Department of Health, Disability, and Ageing (ibid).

47. In England, reimbursement prices for Category M medicines – which covers most generic medicines – are set using purchase and sales data reported by manufacturers and wholesalers: Community Pharmacy England (2026).

48. Medicaid provides health insurance for disadvantaged Americans. Pharmacies are regularly surveyed on prices and the results are used to calculate a national average price for each medicine. State Medicaid agencies can use these figures as the basis for pharmacy reimbursement. See Medicaid (2026).

In Australia, price disclosure has cut the price of many medicines. Over the past 10 years, there have been about 2,000 price reductions, averaging 21 per cent.⁴⁹ The prices of 251 medicines were cut in 2024, saving the government and patients about \$167 million in 2025.⁵⁰

But two flaws limit the effectiveness of price disclosure.

First, because data are collected over six months and then processed over a further six months, it can take up to a year for a fall in market prices to translate into a lower PBS price.⁵¹ Shortening this cycle to monthly – as in England and the US – would deliver savings sooner.⁵²

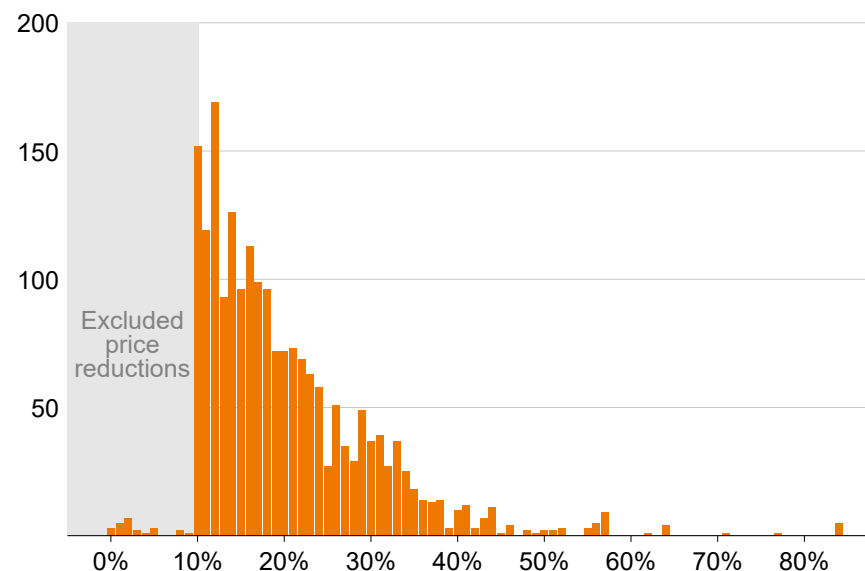
Second, price reductions only kick in if the discount is more than 30 per cent for some medicines and more than 10 per cent for others.⁵³

Smaller discounts have been more common than larger ones over the past decade (Figure 3.2). But the thresholds mean that discounts

49. Analysis includes the October 2017 cycle to the April 2026 cycle, and counts unique medicines (medicine and form) rather than item numbers: Department of Health, Disability, and Ageing (2025c).
50. Grattan analysis of Department of Health, Disability, and Ageing (2026c), Department of Health, Disability, and Ageing (2025d), and Department of Health, Disability, and Ageing (2024e). Savings are estimated by applying 2025 prescription volumes to the difference between prices before and after 2024 price disclosure reductions.
51. There are two overlapping, year-long cycles, with price reductions in April and October: Department of Health, Disability, and Ageing (2025b).
52. See Community Pharmacy England (2026) and Medicaid (2026). To smooth out short-term fluctuations, reductions could be made on an annual basis using several months of data.
53. *Designated brands* – generally low-cost medicines that have been subject to price disclosure for several years – receive certain protections against medicine shortages, including a 30 per cent threshold for price reductions and a \$4 price floor. An exception applies where discounting has averaged at least 12.5 per cent across the previous three data collection periods, in which case the standard 10 per cent threshold applies: Department of Health, Disability, and Ageing (2026f).

Figure 3.2: Patients and taxpayers are probably missing out on more discounts below the 10 per cent threshold

Number of price disclosure reductions by size, October 2017 to April 2026



Notes: Includes all price reductions from the October 2017 to April 2026 price disclosure cycles. Reductions below 10 per cent are due to medicines from designated brands hitting the \$4 price floor.

Source: Grattan analysis of PBS Brand Price Reductions Reports, available at Department of Health, Disability, and Ageing (2025c).

smaller than 10 per cent are ignored.⁵⁴ There is no good reason for these excluded discounts.⁵⁵

The threshold should be set to zero, so that each cycle the reimbursement price is simply reduced to match the average market price. Under this model, manufacturers would still have an incentive to discount to win market share, but those discounts would be passed on to taxpayers in full.

Since 2022, discounts have been ignored for some medicines that cost \$4 or less.⁵⁶ This is supposedly because shortages are more common for these medicines.⁵⁷ But no public analysis has been released to show this, or to enable assessment of whether the policy has worked.

Price reduction thresholds should be removed and the justification for, and level of, the \$4 price floor should be publicly reviewed.

3.2.2 A cheaper and better way to manage financial risk from high-cost medicines

Pharmacies receive an administration, handling, and infrastructure fee for every PBS medicine they dispense. One part of this is a fixed fee of \$5.12 for the physical infrastructure to store and supply medicines. The other part increases with the cost of the medicine, which is intended to compensate pharmacies for the financial cost of stocking high-cost

medicines, and reaches a maximum of about \$100 (Table A.1 in Appendix A).

These two components should be separated.

The physical cost of storing a medicine does not vary with its price,⁵⁸ so the fixed component should simply be absorbed into the dispensing fee. The dispensing fee would then cover all costs associated with stocking, handling, and dispensing a medicine.

Unlike storage costs, financial risk does vary with medicine price.

The number of high-cost medicines on the PBS is rising.⁵⁹ The King Review noted that current funding arrangements do not adequately support the supply of these medicines.⁶⁰

The problem is the structure of pharmacy reimbursement.⁶¹ Pharmacies purchase medicines and are reimbursed only after dispensing them. If they can't dispense a medicine – because a patient orders it specially and fails to collect it, or because it is damaged – the pharmacy has no reimbursement pathway and bears the full cost. Separately, pharmacies must pay GST at the point of purchase but cannot reclaim it until the end of the month. For most medicines, that

54. Except where the price floor is hit.

55. The distribution in Figure 3.2 probably understates the true cost of the thresholds. The visible gap below 10 per cent shows discounts that are never passed on, but medicines subject to the 30 per cent threshold can be discounted by up to 29 per cent without triggering any reduction at all. Those missed discounts are not visible in the chart.

56. Designated brands are subject to a price floor of \$4: Department of Health, Disability, and Ageing (2026f).

57. See the *National Health Amendment (Enhancing the Pharmaceutical Benefits Scheme) Act 2021*.

58. While some medicines are more expensive to store – for example those requiring refrigeration – price differences between medicines generally reflect patent status rather than storage requirements. For example, a brand-name medicine and its generic equivalent require identical storage but may be priced very differently.

59. The average dispensed price for over co-payment PBS prescriptions increased in real terms from \$55 in 2014-15 to \$95 in 2024-25: Department of Health, Disability, and Ageing (2016) and Department of Health, Disability, and Ageing (2026a). In 2024-25, just 10 medicines accounted for 30 per cent of all spending on over co-payment PBS medicines, with six of these medicines averaging more than \$1,000 per dispense: Department of Health, Disability, and Ageing (2026a, Tables 3a and 5a).

60. King et al (2017b, pp. 92-93).

61. All references in this and the following paragraph are from King et al (ibid).

is manageable, but for a medicine costing tens of thousands of dollars it may not be.

Pharmacies may choose not to stock these medicines at all, or to order them only after considerable delay.⁶² This could have real consequences for patients.

Until now, the financial risk associated with high-cost medicines has been managed through the administration, handling, and infrastructure fee, with more expensive medicines attracting a higher fee. But even the highest level is low compared to the cost of some medicines, only covering a tiny fraction of the potential financial loss. For the 217,000 PBS scripts dispensed in 2025 with a wholesale cost greater than \$5,000, it covered less than 2 per cent of these costs.⁶³

With the fixed component of this fee moved into the dispensing fee, the variable component should be abolished and replaced with a risk-sharing mechanism that pays pharmacies faster for these high-cost medicines.

For medicines with an ex-manufacturer price above a defined level, the government should pay pharmacies a fixed proportion – say, 80

per cent – of the purchase price when the pharmacy purchases the medicine, rather than waiting until dispensing.⁶⁴

Almost none of this would be new expenditure: it's money the government would pay anyway once the medicine is dispensed, just brought forward to give pharmacies security when they stock high-cost medicines. By covering most, but not all, of the upfront cost, the government would reduce the financial risk of stocking these medicines without eliminating the incentive not to waste them.

The cost to government of paying for medicines that are not dispensed would probably be small. And the savings would probably be substantial: in 2024-25, pharmacies received almost \$285 million in variable, cost-linked administration, handling, and infrastructure fees on over co-payment scripts alone.⁶⁵

This reform would reduce a barrier to patient access to high-cost medicines, and deliver savings to taxpayers in the process.

3.2.3 Some smaller fees are unjustified and unfair

Pharmacy remuneration includes many small fees. Three of them cannot be justified: the allowable additional patient charge and the

62. The interim report of the King Review observed that this was already happening in some instances, referencing a survey of pharmacies conducted by the Australian Journal of Pharmacy that found that 22 per cent were not stocking high-cost hepatitis C treatments due to cash-flow issues: King et al (2017a, p. 130).

63. Grattan analysis of Department of Health, Disability, and Ageing (2026c) and Department of Health, Disability, and Ageing (2026b). Wholesale cost here is approved ex-manufacturer cost plus wholesale mark-up, reported as 'Price to Pharmacists'. Note that some highly specialised medicines attract a different handling fee instead of the standard administration, handling, and infrastructure fee, but this fee is even lower: the maximum is \$40, compared to about \$100 for standard medicines: Department of Health, Disability, and Ageing (2024f).

64. The optimal threshold and proportion would need to be determined carefully, taking into account the distribution of medicine prices, pharmacy cash-flow patterns, and the risk of stock management distortions at the boundary.

65. Figure reported in 2024-25 dollars. Calculated by multiplying the number of over co-payment prescriptions dispensed by the baseline fee – \$4.79 at the time – and then subtracting that amount from total administration, handling, and infrastructure fees received by community pharmacies in 2024-25: Department of Health, Disability, and Ageing (2026a, Tables 3a and 17a) and Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024). The number of over co-payment prescriptions dispensed was found by multiplying the total PBS scripts from Table 15a by the ratio of prescriber's bag to non-prescriber's bag prescriptions from Table 3a and then adding the total RPBS scripts from Table 15a: Department of Health, Disability, and Ageing (2026a).

Safety Net recording fee, which are charged to patients, and the Additional Community Supply Support payment, which is paid by the government.

The allowable additional patient charge

When a medicine costs less than the maximum patient co-payment, pharmacists may charge general patients an additional fee of up to \$2.79, provided the patient's total out-of-pocket cost does not exceed the maximum co-payment amount.⁶⁶

This fee doesn't compensate for a service. If dispensing fees are set to cover the full cost of dispensing (see Chapter 4), then it's just a government-sanctioned surcharge on patients buying cheap medicines.

The cost to patients adds up. No data are reported on how often the fee is charged. But in 2025, if all eligible prescriptions had attracted the maximum fee, it would have cost patients up to \$347 million.⁶⁷

The discretionary nature of the fee is also unfair. Pharmacists will be more likely to waive it if they face price competition from nearby pharmacies. In areas with less competition – for example, rural and regional areas with limited pharmacy access – patients may have no choice but to bear the full additional charge. This means the fee falls most on those with the least ability to shop around.

The solution is simple: the fee should be removed.

66. Department of Health, Disability, and Ageing (2026d).

67. Grattan analysis of Department of Health, Disability, and Ageing (2026c) and Department of Health, Disability, and Ageing (2026b). This figure is calculated using an allowable additional patient charge of \$3.45, which was its value in 2025. It has since fallen to \$2.79 in line with a reduction in the maximum patient co-payment. In 2025, about 80 per cent of the 127 million non-Safety Net scripts dispensed for general patients were eligible.

The Safety Net recording fee

The PBS Safety Net allows patients who spend above a certain amount on medicines in a calendar year to pay less for their remaining prescriptions that year.⁶⁸

To access the scheme, patients must have their spending on prescriptions recorded. This is done either by attending the same pharmacy each time – which keeps a digital record – or by the patient physically carrying a paper record to present at each pharmacy they visit.⁶⁹

The clunkiness of this system is limiting its effectiveness. While no official data are available, in 2025 the ABC reported that almost 500,000 Australians who qualify for the Safety Net each year do not access it, potentially forgoing hundreds of dollars in savings each.⁷⁰

Pharmacies can choose to charge the Safety Net recording fee – \$1.54 for ready-prepared medicines and \$1.99 for compounded medicines – as compensation for the administrative work of recording prescriptions.⁷¹

But there are two problems with this fee.

First, the task it compensates for is trivial. Recording a prescription involves filling out a simple table.⁷² But dispensing involves many small

68. The threshold is currently \$1,748.20 for general patients, after which they pay the concessional co-payment rate, and \$277.20 for concession patients, after which their medicines are free: Department of Health, Disability, and Ageing (2026g).

69. Department of Health, Disability, and Ageing (2026g) and Services Australia (2026).

70. Branley and Lloyd (2025).

71. See Department of Health, Disability, and Ageing (2026d). No data are available on how often pharmacies choose to charge this fee.

72. Pharmacists must enter the date, their signature, and three clinical details – all of which are typically automatically generated by pharmacy software. Some pharmacies use software that automatically prints a label with this information, which can then be stuck directly onto the form: Department of Health, Disability, and Ageing (2026g).

administrative steps – not all of which apply to every medicine – so there is no reason to pay a discrete fee for this one and not the others.

Second, the fee applies to some patients and not others. As with the allowable additional charge, pharmacists can apply it only to general patients, for under co-payment medicines, where the fee doesn't push the patient's out-of-pocket cost above the co-payment cap.⁷³

These conditions shield concession-cardholders from extra costs and prevent fees from exceeding the maximum co-payment. But if the purpose is to compensate pharmacists for a service they perform, limiting the scripts that attract the fee makes little sense. The administrative work of Safety Net recording does not vary by concession status or medicine price.

The solution is to abolish the fee and automate PBS Safety Net recording entirely, as is already done for Medicare Safety Nets.⁷⁴ This would eliminate the administrative burden for pharmacists and ensure no patient misses out.

Additional Community Supply Support payments

Unlike the other two unjustified fees, which are paid entirely by patients, Additional Community Supply Support payments are paid by the government.

The payments are intended to compensate pharmacies for lost dispensing revenue from 60-day dispensing (see Box 2 on page 9).⁷⁵

There are three problems with this justification.

73. Department of Health, Disability, and Ageing (2026d).

74. For individuals, Services Australia automatically records Medicare expenses and applies the benefit once the threshold is reached: Department of Health, Disability, and Ageing (2025e).

75. Pharmacy Guild of Australia (2024a).

First, uptake of 60-day dispensing has been much slower than expected. In 2025, only about half of the 60-day prescriptions that were forecast in the eighth Community Pharmacy Agreement actually materialised (Figure 3.3).⁷⁶

Yet pharmacies were compensated as if the forecast had been met. The Community Pharmacy Agreement guarantees pharmacies the full \$2.1 billion regardless of actual dispensing volumes.⁷⁷

Second, the payments are poorly targeted. Compensation should have been tied only to the number of 60-day scripts dispensed, since they reduce dispensing volume and revenue. Instead, most standard 30-day scripts attract small compensation payments too, meaning pharmacies are compensated regardless of whether they are affected by the policy change at all.

The third problem is that, like all components of pharmacy remuneration (see Chapter 4), the values of the payments lack any transparent or evidence-based justification. There is no public documentation of how the values were determined or whether they bear any relationship to actual losses incurred.

Additional Community Supply Support payments should be removed.

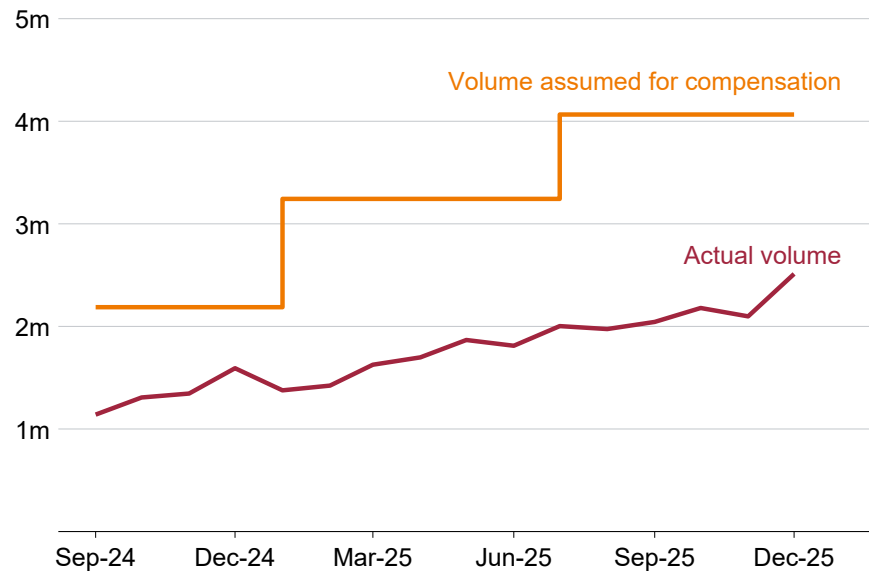
The right way to maintain sector viability is with fair dispensing fees that cover the cost of dispensing, and focused support for struggling pharmacies. The next chapter shows how to do it.

76. In 2025, actual 60-day prescriptions made up only 51.6 per cent of those forecast: Grattan analysis of Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024) and Department of Health, Disability, and Ageing (2026c).

77. Where over co-payment 60-day prescription volumes fall short of forecasts, Additional Community Supply Support unit payments are increased to make up the difference: Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024, Appendix A). See Box 5 on page 31 for detail.

Figure 3.3: Compensation for 60-day dispensing losses was based on overestimates of uptake

Forecast and actual monthly volume of over co-payment PBS medicines dispensed from 60-day prescriptions



Notes: Medicines were added to the eligibility list for 60-day dispensing in three stages, with the final stage commencing in September 2024. Volume forecasts are from half-yearly forecasts provided in the eighth Community Pharmacy Agreement, which have been divided by the number of months to convert them to average monthly rates. Actual volumes are calculated using the methodology outlined in Breadon and Hu (2025).

Source: Grattan analysis of Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024) and Department of Health, Disability, and Ageing (2026c).

4 Set the right price

Not only is pharmacy remuneration poorly structured – as the previous chapter showed – the level is also set the wrong way.

Community pharmacies exist to ensure all Australians have adequate, safe, and equitable access to medicines. Achieving that requires dispensing fees that fairly compensate pharmacists – while also ensuring public money is spent wisely.

But dispensing fees are set through negotiation and not grounded in real-world evidence, so there is no way to know whether they represent fair value – for patients, taxpayers, or pharmacies themselves.

Fees should instead be based on the actual cost of dispensing, with ongoing monitoring of pharmacy profitability.

4.1 Dispensing fees are a stab in the dark

Pharmacy remuneration is the largest financial component of the Community Pharmacy Agreement.⁷⁸ In 2024-25, pharmacies were paid about \$3.4 billion (Figure 4.1).⁷⁹

Community pharmacies dispensed 335 million prescriptions in 2024-25, so even a small increase quickly adds up: each additional cent per script translates to \$3.4 million for pharmacies.⁸⁰ Even overpaying slightly has big budget consequences. Yet fee levels have been determined through successive Community Pharmacy Agreement negotiations, with no public justification.⁸¹

78. Ibid (pp. 8-9).

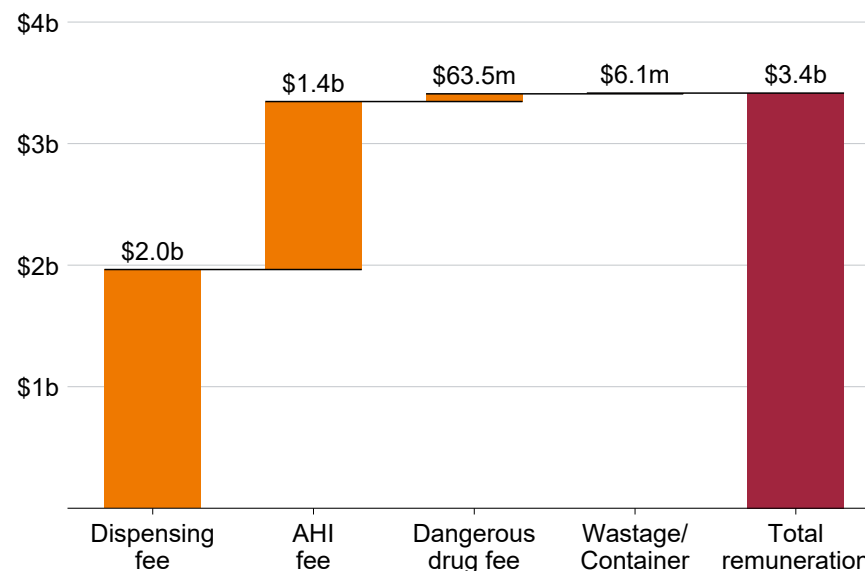
79. Figure is in 2025 dollars.

80. Department of Health, Disability, and Ageing (2026a, Tables 2a and 2c).

81. By contrast, the English government has commissioned two independent studies of the costs and profitability of community pharmacies in the last 15 years to

Figure 4.1: Pharmacy remuneration costs billions each year

Pharmacy remuneration for over co-payment dispensing by cost component, 2024-25



Notes: AHI = Administration, handling, and infrastructure. Values include total government and patient funding for over co-payment Section 85 and Section 100 PBS items dispensed by community pharmacies. Wastage fees compensate pharmacies for medicines that cannot be dispensed because a pack had to be opened to supply a smaller quantity than the standard pack size, and container fees cover the cost of any additional packaging supplied with a dispensed medicine: Department of Health, Disability, and Ageing (n.d.).

Source: Department of Health, Disability, and Ageing (2026a, Table 17a).

inform contractual negotiations: PricewaterhouseCoopers (2011) and Frontier Economics (2025).

4.2 We might be paying too much for dispensing

No one knows what it actually costs to dispense a prescription in an Australian community pharmacy.⁸² And it's no accident. Unlike in other countries, efforts in Australia to establish the real cost of dispensing have been blocked by the Guild, forcing the government to negotiate fees in the dark (Section 1.2 on page 6).

But while there is currently no way to know if pharmacies are being overpaid, or underpaid, there are signs that the sector may be over-compensated.

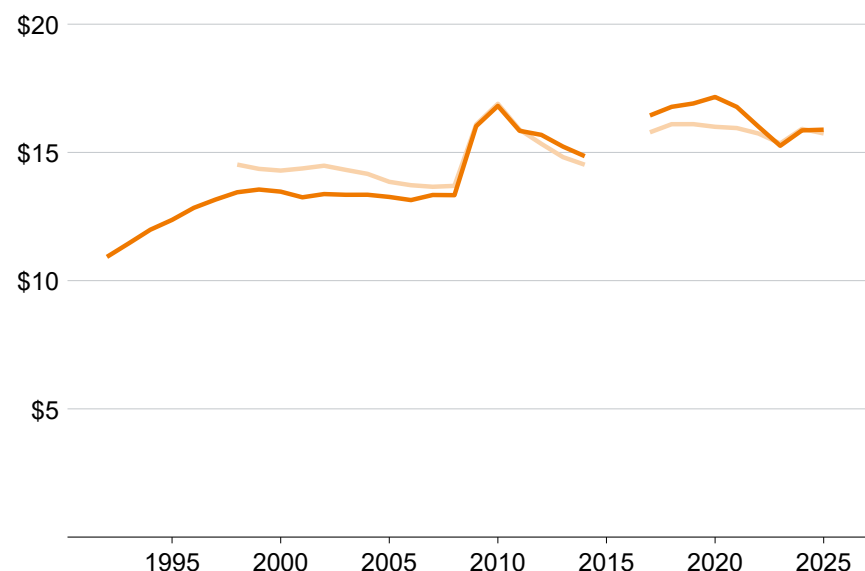
4.2.1 Funding has grown despite efficiency gains

Dispensing payments for each over co-payment script have risen by 45 per cent since the first Community Pharmacy Agreement was signed in 1990, after accounting for inflation (Figure 4.2).⁸³ Some of this increase may reflect legitimate cost pressures – an older, sicker population and growing polypharmacy may place greater demands on pharmacists' time.⁸⁴

But over the same period, technology has substantially reduced the labour required to dispense a standard script. PBS Online Claiming and ePrescribing have replaced labour-intensive, paper-based systems.⁸⁵ Automated dispensing robots – already common in Australian

Figure 4.2: Pharmacy remuneration has increased since the first Community Pharmacy Agreement

Average pharmacy remuneration per over co-payment script, adjusted for inflation using **CPI** and **WPI**



Notes: CPI = Consumer Price Index. WPI = Wage Price Index. Average remuneration per script is calculated as total pharmacy remuneration (excluding ex-manufacturer costs, wholesale remuneration, Additional Community Supply Support program, cost Funding of Chemotherapy, and funding for pharmacy professional programs) divided by total pharmacy prescription volume and inflated to March 2026 dollars using both the CPI and WPI: ABS (2026a) and ABS (2026b). WPI was first reported in 1997. Years refer to the end of the financial year (e.g. 1991-92 is shown as 1992). Data for 2014-15 and 2015-16 are not available. The jump in 2008-09 is partially due to the introduction of the Premium Free Dispensing Incentive and PBS online payments: ANAO (2015). Sources: Data for 1991-92 to 2013-14 from ANAO (ibid, Appendix 10); for 2016-17 to 2024-25 from Tables 15a and 17a of the PBS Expenditure and Prescriptions reports, available at Department of Health, Disability, and Ageing (2026a), though table numbers vary across editions.

82. This was a key call-out in the King Review: King et al (2017b, p. 62).

83. Growth in pharmacy remuneration has outpaced both the Consumer Price Index (CPI) and Wage Price Index (WPI) – rising from \$10.90 in 1991-92 to \$15.90 in 2024-25 in today's dollars. We use CPI rather than WPI because productivity gains from automation over that period mean labour costs per script should have risen more slowly than wages.

84. For trends in polypharmacy, see Lee et al (2026). Polypharmacy is the simultaneous, regular use of multiple medications, often defined as five or more, by an individual: RACGP (2019).

85. Online claiming was introduced in 2005 and ePrescribing in 2020: ANAO (2024) and Pharmaceutical Society of Australia (n.d.). As of December 2024,

hospitals⁸⁶ – are increasingly being used in community pharmacies,⁸⁷ further reducing physical labour. And online dispensing (see Box 4) will only continue to streamline dispensing.

Yet negotiated fees have never been adjusted to reflect these efficiency gains, meaning all the cost savings have flowed to pharmacies, and none to patients or taxpayers.

4.2.2 Pharmacists may be paid for time they don't spend

Some pharmacy payments – the dispensing fee, dangerous medicine fee, and Safety Net recording fee – pay for a pharmacist's time and related overheads rather than infrastructure.

For these payments, we can work backwards from the fee levels and the typical pharmacist's hourly pay rate to calculate how many minutes of pharmacist time each fee implicitly funds (Table 4.1).⁸⁸ On this basis, for example, it would take a community pharmacist about eight minutes to dispense a ready-prepared prescription.⁸⁹

99.9 per cent of claims were processed online. In a 2022-23 survey of 120 Australian community pharmacies, 40 per cent reported a reduced workload due to ePrescribing and Electronic Health Records: Hareem et al (2024). A time-and-motion study of five NSW and Queensland pharmacies identified similar efficiencies: ADHA (2023).

86. See Levy (2022). A systematic review of automated dispensing in hospitals identified significant efficiency gains: Batson et al (2021).

87. Numerous manufacturers now market automated dispensing systems specifically to community pharmacies, advertising significant efficiency gains. For example Willach Pharmacy Solutions (n.d.) and Meditech (n.d.).

88. In 2025, the median hourly pay rate for pharmacists more broadly – including hospital and industrial pharmacists – was \$52: Jobs and Skills Australia (2025). This method uses 2024-25 fees for consistency, and assumes they cover only pharmacist labour and related on-costs, and no profit. These estimates are therefore indicative only: in practice, the dispensing fee covers the full labour chain – including assistants and technicians.

89. This also implies that compounded medicines take less than two minutes longer to dispense than ready-prepared medicines – almost certainly too low. Compounded

Box 4: Online dispensing

Online dispensing involves patients having their prescription medicines delivered, with written medicine information supplied, and pharmacist advice available by phone or online.^a

Online dispensing offers patients greater convenience and access to medicines, and demand will probably grow over time.^b

Pharmacy policy needs to adapt to support the benefits of online dispensing while addressing the potential risks:

- **Quality and safety:** International evidence suggests online dispensing can improve medicine adherence relative to in-person dispensing.^c Quality and outcomes of online dispensing should still be monitored.
- **Pricing:** To ensure patients and taxpayers don't over- or under-pay for online dispensing, the Independent Health and Aged Care Pricing Authority should consider whether a different remuneration structure is needed.
- **Equitable access to pharmacies:** Online dispensing may increase access to medicines for those who cannot easily visit a pharmacy, but this may also reduce the need for some brick-and-mortar pharmacies.^d Resulting pharmacy closures could threaten medicine access for patients who do not use online options, and reduce locations delivering pharmacy services. This risk should be assessed as part of the proposed viability monitoring scheme.

a. Pharmacy Board of Australia (2023, p. 6) and Pharmaceutical Society of Australia (2019).

b. Limbu and Huhmann (2024).

c. Schwab et al (2019), Schmitt diel et al (2011), and Khandelwal et al (2011).

d. Jervelund et al (2025).

Unfortunately, there is little research on how long these tasks actually take. The only available Australian evidence – a time-and-motion study of 15 community pharmacies in WA and NSW – found that across almost 100 hours of observed dispensing time, there were about 5,700 prescriptions dispensed.⁹⁰ That's one every 62 seconds, on average.

This evidence isn't definitive – it draws on a small sample of pharmacies and may not be nationally representative. It also probably understates total dispensing time, since pharmacy assistants and other pharmacists often handle parts of the process and their time may not have been captured. Even so, the total labour time per prescription – across all staff involved – is probably far less than the eight minutes the dispensing fee implicitly funds.

4.3 Dispensing fees should reflect the cost of dispensing

In Chapter 3, we made the case for a simpler dispensing fee that no longer includes unjustified payments. Critically, the level of this fee should be grounded in actual cost data.

In a well-functioning pharmacy sector, the dispensing fee should cover the cost of dispensing a medicine plus a reasonable profit margin.⁹¹

Fortunately, an institution already exists with relevant expertise for setting this fee.⁹² The Independent Health and Aged Care Pricing

medicines comprise a tiny minority of total prescriptions, so this barely affects overall fee adequacy – but for specialised compounding pharmacies, fees may significantly undercompensate the labour involved.

90. Total dispensing time taken from Karia et al (2022, Table 2), and includes time spent solely on dispensing as well as multi-tasking time. Number of prescriptions provided to Grattan by the author on request.
91. For example, this margin could be set equal to the average return on capital across the community pharmacy sector – that is, for each dollar of capital invested in a business, how much profit it earns.
92. While the Pharmaceutical Benefits Remuneration Tribunal (PBRT) still technically exists, it has only five members, one of whom requires Guild approval before

Table 4.1: Implied time taken for components of dispensing

Task	Time
Dispense (ready-prepared)	7m 42s
Dispense (compounded)	9m 30s
Dispense (dangerous medicine, additional time)	4m 46s
Safety Net recording (ready-prepared)	1m 17s
Safety Net recording (compounded)	1m 40s

Notes: Calculated using an estimated hourly pay rate of \$52 for community pharmacists, with a 1.3 multiplier applied to capture related on-costs: ANU (2015).

Source: Grattan analysis of Department of Health, Disability, and Ageing (2026d) and Jobs and Skills Australia (2025).

appointment: Department of Health, Disability, and Ageing (2025f) and section 98 of the *National Health Act 1953*. It lacks both the resources and the independence required for this task.

Authority (IHACPA) is an independent statutory body that already develops evidence-based pricing advice for government. Most relevantly, it uses detailed cost data from aged care providers to calculate funding rates.⁹³

IHACPA will need to determine the most appropriate method for calculating the baseline cost of dispensing.

One approach is calculating the actual average cost of dispensing a medicine.⁹⁴ This will require data on cost inputs – including labour and infrastructure – as well as the time taken to dispense. IHACPA could gather these data as part of a broader time-and-motion study of community pharmacy covering dispensing and other professional services.⁹⁵ These data could be collected from a representative sample of community pharmacies each year, and the dispensing fee updated to reflect changes in technological efficiency, medicine complexity, and patient mix. Pharmacy participation should be mandatory, as a condition of receiving PBS payments.

Where cost data reveal a type of dispensing that is significantly more or less expensive and unevenly distributed across pharmacies, IHACPA

should set an additional targeted fee. This may include compounded medicines,⁹⁶ complex or dangerous medicines, or in-person dispensing as opposed to online.

We estimate that expanding IHACPA's role to include community pharmacy would cost about \$9.8 million per year, with any necessary primary data collection adding a further \$3.3 million a year.⁹⁷

Implementing this change will require amending the *National Health Act 1953* to give IHACPA responsibility for advising on community pharmacy dispensing fees.

4.4 A better approach to protecting sector viability

Setting fees that cover costs is the best way to ensure the sector as a whole is financially viable. Instead, the government gives the sector a blanket revenue guarantee. Rural subsidies take the same unfocused and wasteful approach, providing extra funding whether a pharmacy needs it or not.

Policy should focus on the real goal: maintaining patient access to medicines. Financial viability should be actively monitored using administrative tax data to identify pharmacies that genuinely need support, and make sure they get it.

93. Registered aged care providers are required to submit quarterly financial reports to government: Department of Health, Disability, and Ageing (2026h). IHACPA draws on this data alongside its own cost collections to develop pricing advice: IHACPA (2025a).

94. The King Review proposed a similar approach to calculate best-practice dispensing costs: King et al (2017b, Recommendation 5.2).

95. A similar time-and-motion study existed for general practice. The Bettering the Evaluation and Care of Health (BEACH) study ran from 1998 to 2016, with a nationally representative sample of GPs: University of Sydney (n.d.). This model has since been adapted for general practice nurses, nurse practitioners, physiotherapists, and Aboriginal and/or Torres Strait Islander Health Workers through the new Occasions of Care Explained and ANalysed (OCEAN) study: University of Sydney (2025). Similar large-scale studies have been conducted on community pharmacies in the US to inform Medicaid pricing: Shoemaker-Hunt et al (2020).

96. Compounded medicines are more labour-intensive to dispense than ready-prepared medicines and are concentrated among specialist pharmacies: Cooper et al (2025). Without a targeted fee, these pharmacies would be systematically undercompensated.

97. See Appendix D for the methodology used to estimate these costs.

4.4.1 Replace a blanket guarantee with targeted support

Community Pharmacy Agreements guarantee a total amount of pharmacy remuneration. Under the current agreement, it is \$24.6 billion over five years.⁹⁸

That funding is locked in through the payment adjustment mechanism (Box 5). If there are fewer scripts than expected, the fees paid for each script are adjusted up, to ensure pharmacies still receive the promised total. And the opposite is true if there are more scripts than expected. This reduces the risk of unexpected government spending while securing pharmacy income.

The goal of ensuring pharmacies can viably and safely dispense medicines is legitimate, but the payment adjustment mechanism is the wrong instrument, for four reasons.

First, it is skewed in pharmacies' favour. If prescription volumes exceed forecasts by more than 10 per cent, fees are reduced to claw back the overpayment. But if volumes fall short by any amount – even by 1 per cent – fees are increased to make up the shortfall.⁹⁹ Taxpayers have got the short end of the stick.

Second, locking in funding five years in advance makes it difficult for the system to respond to changing circumstances, such as improvements in efficiency driven by technological advances.

Third, the payment adjustment mechanism compensates all pharmacies equally regardless of individual circumstances. Dispensing volumes will not fall uniformly – some pharmacies will have increases,

others decreases – yet the mechanism adjusts remuneration sector-wide, meaning pharmacies who haven't suffered any adverse impacts will benefit alongside those who have.

Fourth, even where dispensing volume does fall, viability is not necessarily threatened. Pharmacies with high margins or strong non-dispensing revenue (Box 3 on page 10) can absorb modest volume reductions without any risk to survival.

Instead of guaranteeing a fixed pot of money to the sector regardless of need, the government should monitor viability and respond accordingly. It should use existing administrative tax data to assess pharmacy profitability across location types, ownership models, and pharmacy formats. If parts of the sector are struggling, affected pharmacies should be able to seek support if they provide additional financial information demonstrating genuine need. But support should be provided only if a closure would leave a community without equitable and adequate access to medicines. If that can be achieved by other pharmacies in the area, or by online dispensing, additional support should not be provided.

4.4.2 Payments to support struggling pharmacies should be better targeted

The government already provides some targeted funding to support the viability of pharmacies through the Regional Pharmacy Maintenance Allowance (RPMA). This program distributed \$48 million to pharmacies in 2024-25.¹⁰⁰

But the RPMA is poorly targeted. Eligibility depends on the remoteness of the pharmacy – as defined using the Modified Monash Model¹⁰¹ – and its dispensing volume, with more funds available to pharmacies

98. Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024, Table 2). This includes the Additional Community Supply Support payments but excludes funding for pharmacy programs.

99. Pharmacy Guild of Australia (2024a).

100. Department of Health, Disability, and Ageing (2026i).

101. The Modified Monash Model classifies regions from 1 (metropolitan) to 7 (very remote) based on geographical remoteness and town size: Department of Health,

that are more remote and dispense fewer prescriptions.¹⁰² There are two problems with this.

First, the Modified Monash Model is a poor guide to profitability. It groups areas by remoteness, but this can mask significant variation within categories. For example, two regional pharmacies classified identically may face vastly different infrastructure, connectivity, and local economic conditions.¹⁰³

Second, dispensing volumes are also an imperfect guide. While higher volumes reduce per-prescription costs through economies of scale, profitability is also determined by other cost structures, such as non-dispensing revenue.

These funds would be better directed toward pharmacies that are genuinely unprofitable and operating in under-served areas.

A harder problem arises in areas where no pharmacy can viably operate in the first place. In these areas, the government should take a more active role in commissioning pharmacy services directly.

One way to do this is a reverse auction: pharmacies submit applications demonstrating their proposed business model and the minimum grant funding required to establish a viable service, with the contract awarded to the applicant requiring the least public subsidy.¹⁰⁴ This would ensure that government support is targeted, competitive, and no greater than necessary to deliver access.

Disability, and Ageing (2025g). RPMA funds are available from category 3 (large rural towns) and increase with remoteness.

102. Pharmacy Programs Administrator (2025a).

103. See, for example, Murray City Country Coast GP Training (2021).

104. See Queensland Government (2025). If no bids are received, or only unacceptably costly ones, the government should step in and provide the service directly. All contracts awarded through reverse auctions should be regularly reviewed to ensure they remain competitive.

Box 5: The Community Pharmacy Agreement payment adjustment mechanism

The seventh Community Pharmacy Agreement introduced a payment adjustment mechanism^a to keep total pharmacy payments broadly in line with the amount agreed. Roughly once a year, forecast prescription volumes were compared with actual dispensing volumes. If the difference was too large, pharmacy remuneration was adjusted to offset the gap.^b

Over the life of the seventh Community Pharmacy Agreement, the payment adjustment mechanism identified only one required adjustment: a \$0.21 reduction in the Commonwealth Price, scheduled to take effect on 1 July 2024. However, this change was never implemented because the seventh Community Pharmacy Agreement was terminated early and superseded by the eighth.^c

The eighth Community Pharmacy Agreement updated the payment adjustment mechanism, which also incorporated the new payments for 60-day dispensing. Adjustments are now made every six months rather than annually, making the mechanism more responsive, and the tolerance band for payment adjustments has been widened in pharmacies' favour.^d

a. Department of Health and Aged Care (2022). This is referred to as the remuneration adjustment mechanism in the seventh Community Pharmacy Agreement, but we have referred to it as the payment adjustment mechanism here for consistency.

b. Department of Health and Pharmacy Guild of Australia (2020, pp. 37–40).

c. See Box 2 on page 9. For a detailed explanation of the calculations involved in the payment adjustment mechanism, see ANAO (2024, Appendix 7).

d. Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024, p. 26).

5 Unleash competition

Incumbent pharmacy owners benefit from generous and unique protections that limit who can own pharmacies and where they can be located. The result is less competition, and less incentive to improve services and innovate.

5.1 Competition is good for patients

Competition drives lower prices, higher service quality, better access, and faster innovation.

Competing for consumers motivates businesses to reduce costs, improve quality, and find new ways to meet consumer needs.¹⁰⁵ Competition also promotes new business models, unlocks new sources of capital, and attracts managers with skills that existing businesses may lack.

As this chapter explains, evidence from pharmacy markets overseas shows the benefits of competition.

5.2 Location rules benefit pharmacy owners, not patients

Strict rules in Australia dictate where new pharmacies can open. The Guild claims these rules encourage pharmacies to set up in under-served areas.¹⁰⁶ In practice, they shield pharmacy owners from competition while doing little to improve people's access to pharmacy services.

105. The productivity boom of the 1990s and early 2000s was driven in large part by deregulation and pro-competition reform: Bruno et al (2023).

106. Pharmacy Guild of Australia (n.d.[c]).

5.2.1 New pharmacies are blocked from opening

The first Community Pharmacy Agreement in 1990 included a major boon for existing pharmacy owners: strict regulations stopping new pharmacies setting up shop nearby.¹⁰⁷ Box 6 summarises these rules.

A decade later, the National Competition Policy Review of Pharmacy recommended these rules be abolished.¹⁰⁸ Despite many subsequent reviews also recommending their removal, the rules have not only been retained but enshrined in federal legislation.¹⁰⁹

Today, applications for new pharmacies are submitted to the Australian Community Pharmacy Authority, which makes a recommendation to the Secretary of the Department of Health, Disability, and Ageing.¹¹⁰ A recommendation is necessary for approval, but an application can still be rejected even after being recommended.¹¹¹

Location rules also prohibit any new pharmacy that can be accessed through a supermarket.¹¹²

These rules stop new pharmacies being opened, shielding existing pharmacies from incentives to better serve patients. The King Review

107. Department of Community Services and Health (1990, pp. 10-11).

108. Wilkinson (2000).

109. Location rules are now codified under the *National Health (Australian Community Pharmacy Authority Rules) Determination 2018*. For examples of reviews recommending their removal see: National Commission of Audit (2014), Harper et al (2015), Productivity Commission (2017), and Productivity Commission (2023).

110. Department of Health, Disability, and Ageing (2026j).

111. Ibid.

112. Department of Health, Disability, and Ageing (2026j).

received numerous reports of pharmacists wanting to open pharmacies but being unable to because of location restrictions.¹¹³

5.2.2 Scrapping location rules can bring benefits

In the late 1990s and early 2000s, several European countries removed regulations on pharmacy locations, including Norway, Iceland, Ireland, and the Netherlands.¹¹⁴

Deregulation consistently led to a substantial increase in the number of pharmacies.¹¹⁵ In the three years after the rules were removed in Norway in 2001, 128 new pharmacies were established (nearly double the number established in the previous nine years).¹¹⁶ In Iceland, the number of pharmacies rose from 43 to 61 in the two years after deregulation.¹¹⁷

In Australia, the Guild claims the location rules are required for a well-distributed geographic spread of pharmacies, especially outside major cities.¹¹⁸

International evidence does not support this. After deregulation, more pharmacies open in urban areas, but rural areas benefit too.¹¹⁹ In Norway, the number of local government areas without pharmacies reduced after location rules were removed.¹²⁰ The number of pharmacies in Reykjavik, Iceland, grew by 67 per cent within two-and-a-half years of

113. King et al (2017a).

114. Vogler et al (2014).

115. Australia would probably see a smaller increase in pharmacy numbers, because many European countries had very low pharmacy numbers before deregulation.

116. Anell (2005, p. 13).

117. Deregulation occurred in 1996. There were 43 pharmacies in 1997 and 61 in 1999: Hämeen-Anttila et al (2025, Table 2).

118. Pharmacy Guild of Australia (2015).

119. Anell (2005) and Rudholm (2008).

120. Anell (2005).

Box 6: Rules on the location of new pharmacies

Generally, a new pharmacy must be at least 10km from the nearest approved pharmacy. But there are exceptions:^a

- A pharmacy can be within 1.5km of another if it is within 500m of either a full-time prescribing medical practitioner and a supermarket with at least 1,000m² of leased area, or a supermarket with at least 2,500m² of leased area.
- A pharmacy can be in the same town as another if it is 200m from the nearest pharmacy in town and 10km from any other pharmacies. There must also be four full-time-equivalent prescribing medical practitioners and supermarkets with at least 2,500m² of leased space.
- A pharmacy can be established in a small shopping centre if the centre has no other pharmacies and is 500m from another pharmacy.
- A pharmacy can be established in a large shopping centre, depending on how many the centre already has.
- A pharmacy can be established in a large medical centre if the medical centre operates for 70 hours a week and has eight full-time-equivalent PBS prescribers. The medical centre must also be 300m from the nearest pharmacy.

So why are there still pharmacy clusters? Some areas have many pharmacies because they existed before location rules were introduced, or because there are many medical practitioners, shopping centres, and supermarkets nearby.

a. Department of Health, Disability, and Ageing (2026j).

deregulation, but pharmacy numbers also increased by 17 per cent in the rest of the country.¹²¹

There is some evidence that deregulation improves convenience for patients beyond simply increasing the number of pharmacies. Pharmacy opening hours increased in some countries after deregulation.¹²² In Norway, despite lowering the required hours for pharmacies, average opening times increased by two hours.¹²³ Accessibility in Norway also improved through innovations spread by the newly formed pharmacy chains.¹²⁴

The evidence on prices is more mixed, indicating either no effect or some price declines from deregulation.¹²⁵

In Ireland, the Netherlands, and Norway, there is evidence that prices for over-the-counter medicines – those not requiring a prescription – did not meaningfully change after deregulation.¹²⁶ In Norway, there is

additional evidence from an independent evaluation that deregulation did not lower prices.¹²⁷ In England, there is evidence that supermarket pharmacies, which increased in number due to changing regulations, offered over-the-counter medicines at lower prices, but there no evidence of over-the-counter price reductions elsewhere.¹²⁸

In Iceland, it was reported that prices for patients, including for prescription medicines, fell after deregulation, but little measurement of these decreases.¹²⁹ There is stronger evidence from Portugal that allowing new pharmacies lowered the costs of over-the-counter medicines in areas where new pharmacies set up.¹³⁰

121. Ibid (p. 12).

122. Vogler et al (2012) and Vogler et al (2014).

123. Econ Analyse (2004, pp. 47–48).

124. Rather than handing in prescriptions to be collected later, patients increasingly had them dispensed while they waited, and self-service sections for over-the-counter medicines were near-universal: Econ Analyse (ibid, pp. 48–49).

125. The most widely cited systematic reviews analyse Sweden, England, the Netherlands, Ireland, and Norway: Vogler et al (2012) and Vogler et al (2014). This section does not include Sweden because it had a very different form of deregulation (transitioning from a nationalised to a privatised system). These reviews also do not include Iceland and Portugal, which are included here. In general, studies of deregulation on prices focus on over-the-counter medicines because prescription medicine prices are strictly determined.

126. Ireland revoked the establishment rules for opening new pharmacies in 2002; the Netherlands abolished restrictions on the establishment of new pharmacies in 1998. The study is based on annually tracking the highest and lowest observed prices for three medicines (paracetamol, ibuprofen, and aciclovir) after deregulation. While this measure finds some increases in the highest or lowest observed price for some of these medicines, it is not strong evidence of overall increases: Vogler et al (2006).

127. Norway removed restrictions on location and ownership of pharmacies in 2001. These findings are based on voluntary surveys of 130-to-140 pharmacies from 1999 to 2002 and on compulsory surveys of 22 pharmacies in 2003 and 2004. They find that a basket of 10 common over-the-counter medicines increased in price after deregulation, but that this increase was no faster than the rate of increase pre-deregulation and was probably not caused by the regulation changes: Econ Analyse (2004, pp. 73-74, 89–90).

128. In 2005, England relaxed its restrictive rules on establishing pharmacies by exempting certain new pharmacies, including large supermarkets. The assessment of this policy in 2010 used price-differential analyses between different pharmacy types based on compiled price data from pharmacies. It found that supermarket pharmacies were about 10 per cent cheaper than independents on pharmacy-only medicines: DotEcon (2010, pp. 94-103).

129. Iceland removed restrictions on location and ownership of pharmacies in 1996. The only concrete available finding is that the pharmaceutical factor in the Icelandic CPI fell by about 20 per cent after deregulation: Almarsdóttir et al (2000, p. 110). Anell (2005) describes the co-payment discounts offered by new pharmacy chains after deregulation, but notes these were confined to urban areas with greater competition and applied to patients' co-payments rather than medicine prices. The government subsequently raised co-payments in 1997 to reduce government spending of medicines.

130. In 2005, Portugal allowed over-the-counter medicines to be sold in outlets other than pharmacies. Using price data on five popular over-the-counter medicines for all Lisbon retailers at three points in time (2006, 2010, 2015), Moura and Barros (2020) found supermarkets charged 20 per cent less and that pharmacies near supermarkets reduced prices by 4-to-6 per cent in response.

The Australian picture looks more promising. The interim report of the King Review found that pharmacies in urban areas with high competition were much more likely to discount medicines (in the limited circumstances where discounting was allowed).¹³¹

On balance, greater competition in Australia should lower prices.

5.2.3 Location rules do not improve access to pharmacies

The strongest argument for location rules is that they increase access to pharmacies in rural areas. But the rules were not designed for that purpose, evidence that they achieve it is weak, and other policies would do the job better.

The rules were not designed to increase rural access

One argument for location rules is that they protect access to pharmacies, particularly in rural areas.¹³² But that was never their purpose.

Before 1990, very small pharmacies were clustered in urban areas.¹³³ This was the result of a dispensing fee structure that paid higher rates to smaller pharmacies, creating an incentive to stay small.¹³⁴

To reduce the oversupply of small, inefficient pharmacies, the government flattened the dispensing fee across all pharmacies and offered payments to pharmacies to close or amalgamate. From 1990 to 1995 – when payments were offered – there were 630 pharmacy closures and 64 amalgamations.¹³⁵

131. King et al (2017a, Figure 8).

132. Pharmacy Guild of Australia (2017a).

133. In 1988, 25 per cent of pharmacies were within 100m of another pharmacy and 62 per cent were within 1km of another pharmacy: Department of Health (2014, p. 6).

134. Ibid (p. 6).

135. Department of Health (ibid, p. 13) and Department of Community Services and Health (1990).

Location rules were introduced to complement these payments. They were designed to stop a new pharmacy opening up in the same spot the government had just paid another to leave.¹³⁶

The policies aimed to reduce an oversupply of pharmacies in cities, not boost access elsewhere.

There is little evidence that location rules boosted rural access

Since then, location rules have been repositioned as an incentive for pharmacies to open in regional and rural areas.

The Guild points to independent analysis showing that, after the rules took effect, pharmacy numbers fell in cities and rose in smaller centres.¹³⁷ That comparison is misleading. Urban pharmacy numbers fell because the government stopped paying extra for small, inefficient pharmacies, and paid urban pharmacies to close. Growth in rural pharmacy numbers outside cities was modest, and in line with population growth.¹³⁸

Pharmacies can be trusted to pick viable locations

An even weaker claim is that location rules ensure pharmacies are commercially viable when they set up.¹³⁹ Otherwise, goes the argument, pharmacies would cluster and compete each other into closure.

136. Jackson et al (2023a).

137. Pharmacy Guild of Australia (2017a, p. 16).

138. From 1990 to 2014, the number of people per pharmacy in major cities increased sharply, from 2,892 to 3,997. Outside of major cities, there were a similar number of people per pharmacy before and after location rules (3,773 in 1990 and 3,893 in 2014): Lange and Franzon (2016, Tables 5 and 6). These data are limited because they do not capture hours, size, or convenience of pharmacies.

139. Pharmacy Guild of Australia (n.d.[c]).

But this logic applies to any retail business, and no other sector (including in healthcare) is regulated this way. Operators are trusted not to set up where they cannot sustain themselves, and when new entrants do compete with incumbents, consumers benefit: prices fall, quality improves, and product ranges expand.¹⁴⁰

There are better ways to improve access

Even if location rules did improve access, they are far from the best tool for the job. The Guild regularly touts that 96 per cent of Australians in capital cities and 74 per cent outside of capital cities live within 2.5km of a pharmacy.¹⁴¹ This is a meaningful sign of access. But equivalent shares of Australians live within 2.5km of a GP clinic.¹⁴²

The government supports GP access with workforce incentives and rural subsidies. These tools target the real constraints on rural healthcare: small populations and difficulty attracting staff.¹⁴³

Pharmacies that provide an essential service in places that cannot sustain a normal business should be supported directly. Chapter 4

140. See, for example, the analysis by Gravelle et al (2016) of competition among GP clinics.

141. Westpac and The Pharmacy Guild of Australia (2026) and Pharmacy Guild of Australia (2025b).

142. Grattan analysis found that in capital cities, 96 per cent of Australians live within 2.5km of both a GP clinic and pharmacy, while outside capital cities 73 per cent are within 2.5km of a GP and 72 per cent within 2.5km of a pharmacy. Access is measured as the straight-line distance from populated Mesh Block centroids to the nearest GP and pharmacy, so figures are approximate: ABS (2022) and Geoscience Australia (2024). This mirrors, but may not exactly replicate, analysis commissioned by the Guild, as only a short summary of its methodology is public: Macroplan (2023).

143. See Department of Health, Disability, and Ageing (2025h). Grattan has argued these subsidies should be better targeted: Breadon and Chapman (2026). But even imperfectly targeted, they address the underlying problem more directly than entry restrictions, and do not impose nationwide constraints on competition.

sets out how. Direct support can improve access to medicines without constraining competition across the whole sector.

5.3 Rules on pharmacy ownership are poorly designed

Australia's ownership rules restrict who can own a pharmacy and how many they can own. Neither restriction is needed.

5.3.1 Ownership rules aren't needed for quality and safety

In Australia, only registered pharmacists are allowed to have a financial stake in a pharmacy.¹⁴⁴ This rule is ostensibly to ensure pharmacies prioritise the care and well-being of patients over profits, but it is not an effective way of ensuring high quality service.¹⁴⁵

Australians access many healthcare services in their daily lives: GPs, optometrists, dentists, and specialists. Other businesses also provide advice on potentially dangerous goods and services (such as car mechanics and hardware stores). None of these services have ownership rules.

Similar ownership regulations for dental practices were removed from 2010,¹⁴⁶ and there is no evidence that the quality of care declined.

144. These requirements are in state and territory legislation. See: Australian Medical Association (2021). There are some minor exceptions to this rule. In some jurisdictions non-pharmacist immediate family members can have minority shares in a pharmacy with their relative who is a registered pharmacist: Hattingh (2011). About 115 of the 6,000 current pharmacies are owned by non-pharmacists through organisations known as 'friendly societies': Australian Friendly Societies Pharmacies Association (2023). Friendly societies are member-owned, not-for-profit societies that were established to provide affordable pharmaceuticals to members in the 19th and 20th Centuries. Friendly societies are not allowed to own pharmacies in the ACT: Australian Friendly Societies Pharmacies Association (ibid).

145. Pharmacy Guild of Australia (2024b).

146. Australian Dental Association (2025).

There is also no evidence that pharmacies owned by non-pharmacists (those owned by friendly societies) provide service that is less ethical or professional.¹⁴⁷

Ownership restrictions are unnecessary because Australia already has regulatory frameworks designed to ensure high standards.¹⁴⁸ And removing ownership rules would not affect registration and accreditation requirements for people working as pharmacists.¹⁴⁹

5.3.2 Ownership rules aren't stopping market concentration

State rules also limit one person to having a financial interest in no more than six pharmacies.¹⁵⁰

In theory, ownership restrictions oxygenate a pharmacy sector where competition is choked off by restrictive location rules. Location rules may reduce (or entirely remove) the chance that any individual pharmacy faces competition from another but, to balance this out, ownership limits aim to stop a few businesses from dominating the

147. Harper et al (2015, p. 180).

148. Pharmacists are required to accord with professional registration requirements administered by the Pharmacy Board of Australia under the Australian Health Practitioner Regulation Agency. Pharmacists can also be assessed against the Professional Practice Standards set by the Pharmaceutical Society of Australia: Pharmaceutical Society of Australia (2023) and Pharmaceutical Society of Australia (2021). These standards apply regardless of who owns the pharmacy.

149. Removing ownership requirements would make it easier for one person to own both the pharmacy and the GP clinic in the same medical centre. This is currently possible only where the owner is a pharmacist, since pharmacists can own GP clinics but not vice versa. Such co-ownership could increase incentives to over-prescribe, and should be monitored by professional standards bodies and through the quality and outcomes monitoring framework proposed in Chapter 7. If prescription rates are higher in jointly-owned businesses, the Australian Competition and Consumer Commission should advise on potential remedies.

150. Some states have a less generous limit of four or five, while the NT and ACT do not have any limit: ACCC (2024, pp. 11-12).

Box 7: Buyers, banners, and franchises

The pharmacy sector is shaped by three overlapping forms of collective organisation:^a

- **Buying groups** negotiate the cost of medicines and products with wholesalers or manufacturers. By pooling their purchasing power, member pharmacies can secure lower costs. Members of a buying group typically remain independent and do not share common branding.
- **Banner groups** are networks of individually owned pharmacies under the same brand. Banner group owners provide a range of services to member stores, which may include advertising, pricing systems, and lease management. Banner groups can be, but are not necessarily, franchises.
- **Franchises** are a form of banner group. Under a franchise agreement, a franchisor provides services such as branding, advertising, corporate systems, stock management, and pricing frameworks to an individual pharmacy, which in return agrees to operate on the franchisor's terms.

a. ACCC (2024) and Victorian Pharmacy Authority (2019).

sector and potentially using their market power to the detriment of patients.¹⁵¹

In practice, ownership limits do not prevent market consolidation, and so Australia has both significant corporate concentration and limited local competition. The ways that large corporations coordinate independently-owned stores are described in Box 7.

About 60 per cent of community pharmacies are part of a banner group, and most are in one of the four large groups (Figure 5.1).¹⁵² These businesses also represent a disproportionately large part of the market. The Productivity Commission has cited 2018 estimates that the then four major banner operators held a 73 per cent market share.¹⁵³ That is a similar market share to that held by the big four banks.¹⁵⁴

Banner groups typically have standardised purchasing, customer experience, pricing frameworks, loyalty programs, and promotional campaigns. That reduces the scope for innovation and competition.

Many franchises take this further with strict conditions on how pharmacies can operate. In 2021, current and former Priceline Pharmacy owners took their banner group operator to court for exerting excessive control over how pharmacies operated.¹⁵⁵ Separately, the Australian Competition and Consumer Commission determined that Chemist Warehouse probably has a ‘particularly strong’ level of control over its franchise stores.¹⁵⁶

151. Pharmacy Guild of Australia (2024b).

152. ACCC (2024, p. 7).

153. Productivity Commission (2023, Volume 1, p. 33).

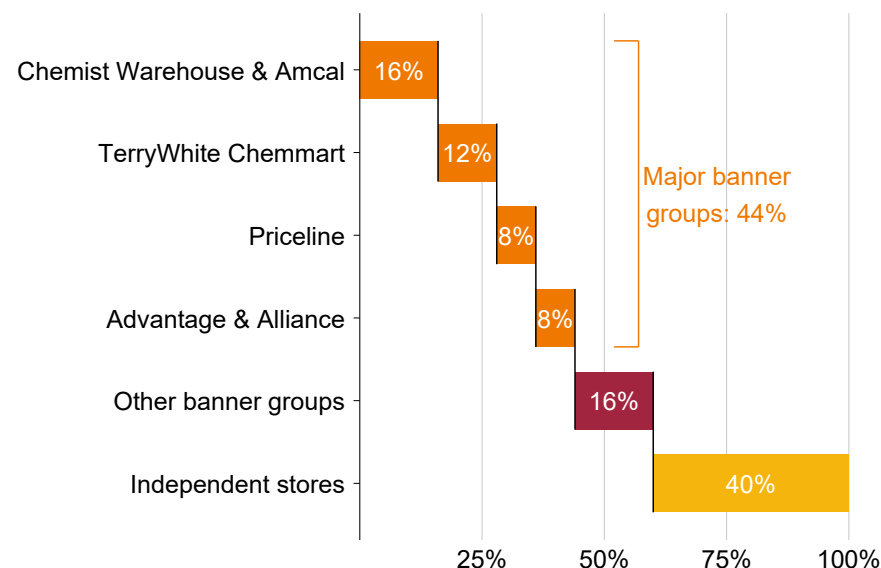
154. The big four banks (Commonwealth Bank, Westpac, NAB, and ANZ) had a 72 per cent market share in 2023: ACCC (2023, p. 1).

155. LaFrenz (2021).

156. See ACCC (2024). Most Chemist Warehouse franchisees are also shareholders in the parent company: Sigma Healthcare (2024, p. 182). While there are no data available on the extent to which pharmacies within the same banner group

Figure 5.1: The four major banner groups make up nearly half of all pharmacies

Approximate proportion of pharmacies under each banner group



Notes: Banner groups are represented here by the most notable brands, but most banner groups also operate lesser known brands. Reported proportions reflect all pharmacies under all brands of the banner group. Proportions are approximate. Chemist Warehouse and Amcal brands are owned by Sigma, which also owns MyChemist, Discount Drug Store, and PharmaSave.

TerryWhite Chemmart brand is owned by EBOS, which also owns Cincotta Discount Chemist, Good Price Pharmacy Warehouse, and healthSAVE.

Priceline brand is owned by Australian Pharmaceutical Industries (API), which also owns Soul Pattinson and Pharmacist Advice.

Advantage and Alliance brands are owned by Independent Pharmacies of Australia (IPA), which also owns Chemist Discount Centre.

Source: ACCC (2024).

The result is a sector where ownership is nominally dispersed but competition is constrained.

In addition, loopholes in personal ownership restrictions allow expansive empires.

The number can be stacked across family, friends, and business partners.¹⁵⁷ For example, four key managers of Sigma (owner of Chemist Warehouse) and their families had an ownership interest in 182 franchisee pharmacies in 2025.¹⁵⁸

The limits are set at a statewide level, which does little to encourage competition in regional areas that have few pharmacies. For example, of the four pharmacies in Broome, WA, in 2017, three were owned by the same group.¹⁵⁹

This misguided and ineffective policy should be replaced. Protections should move from counting the number of stores someone owns to tracking measures of market power, and managing threats to a competitive sector. Chapter 7 shows how.

5.4 Supermarket pharmacies would be good for patients

Location and ownership rules, taken together, rule out a model of pharmacy retail that is normal overseas: supermarket pharmacies.

In Australia, supermarkets cannot own pharmacies, and pharmacies cannot be located in or accessible through a supermarket.¹⁶⁰

The pharmacies-in-supermarkets model works elsewhere. In the UK, supermarkets dispense prescriptions through hundreds of

compete with each other, these indicators suggest they are more coordinated than competitive.

157. Harper et al (2015, p. 180).

158. Sigma Healthcare (2025, p. 66).

159. Martin (2024, p. 182).

160. Department of Health, Disability, and Ageing (2026j).

in-store pharmacies that provide the same suite of clinical services as standalone community pharmacies.¹⁶¹ In Canada, the three largest grocery businesses run in-store pharmacies.¹⁶² New Zealand retains pharmacist-ownership rules broadly similar to Australia's, but allows pharmacies inside supermarkets.¹⁶³ In these countries, patients can get their medicines while picking up groceries for dinner.

The Guild's strongest argument against this reform in Australia is about market power: the Coles-Woolworths supermarket duopoly should not, it says, be allowed to dominate the community pharmacy sector.¹⁶⁴ Large supermarkets could, in theory, amass significant market share and use it to squeeze suppliers and, eventually, raise prices or reduce service quality for patients.¹⁶⁵

But international evidence suggests there is a low risk of aggressive supermarket expansion.

Supermarket-owned pharmacies make up about 5 per cent of community pharmacies in the UK.¹⁶⁶ In Canada, about 15 per cent of pharmacies are embedded in food and mass merchandisers.¹⁶⁷ Both of these countries have less concentrated supermarket sectors than Australia.¹⁶⁸ But in New Zealand, which has a more concentrated

161. Mortimer and Grimmer (2019). Also see, for example, Tesco (n.d.).

162. Pukhov et al (2026).

163. New Zealand Medicines and Medical Devices Safety Authority (2025). See, for example, Woolworths (n.d.).

164. Pharmacy Guild of Australia (2016a).

165. Notably, the suppliers for prescription medicines are large wholesalers and multinational pharmaceutical companies, who also hold significant negotiating power.

166. Tesco, Asda, and WM Morrison operated 723 pharmacies in 2024, of a total of 13,822 pharmacies in the UK: Christie & Co (2024).

167. In Ontario, 7 per cent of pharmacies are in grocery stores: Pukhov et al (2026, Table 2).

168. Elías (2024, Figure 1a).

sector, Woolworths only has about 40 in-store pharmacies (less than 4 per cent of pharmacies).¹⁶⁹

Supermarket pharmacies that use their economies of scale to pass savings onto patients should be encouraged. Potential harms to consumers from concentrated market share should be monitored and addressed if needed, but do not justify blanket ownership restrictions.¹⁷⁰

Pharmacists working in supermarket pharmacies are bound by the same registration, ethical, and professional obligations as any other pharmacist. International evidence suggests that patients trust and get good service from supermarket pharmacies.¹⁷¹

Pricing Authority should reduce the dispensing fee to account for the additional profits pharmacies gain due to the lack of competition.

5.5 Location and ownership rules should be abolished

The location and ownership rules, including those banning supermarket pharmacies, should be removed in favour of more targeted and effective safeguards (see Chapter 7).

Removing these regulations will face strong opposition and require both legislative change and reforms to state and territory policies. If these reforms are blocked, patients and taxpayers should not be left paying high prices due to lack of competition. So, if these anti-competitive protections are not removed, the Independent Health and Aged Care

169. Asher (2024) and Woolworths (n.d.).

170. Supermarket pharmacies may offer some medically important services such as methadone dispensing and needle exchange programs at lower rates than other pharmacies. In Ontario, only 1 per cent of supermarket pharmacies dispense methadone or Suboxone, versus 8 per cent of independents: Pukhov et al (2026, Table 2). If supermarket pharmacies meaningfully reduce access to these services for patients, these services should potentially be required as a condition of operation.

171. There is limited data on supermarket pharmacy quality, but the most recent JD Power US Pharmacy Study found supermarket pharmacies outperform other chain pharmacies on staffing, prescription speed, and patient trust: JD Power (2025).

6 Let pharmacies discount prescriptions

Pharmacies are willing to cut prices, and patients want cheaper medicines, but a tangle of rules blocks discounting. These rules are not needed to ensure quality services and only lead to higher prices.

6.1 Complex rules block discounting

Countries with highly regulated pharmacy margins – as in most of Europe – don't allow pharmacies to discount what patients pay for prescription medicines.¹⁷² But countries with systems more similar to Australia's – such as New Zealand and Ontario in Canada – do.¹⁷³ Australia is unusual in combining unregulated pharmacy profits with complex rules that prevent pharmacies from passing savings on to patients.

In Australia, prescription medicines below the maximum co-payment can be discounted by any amount.

Allowing pharmacies to discount these medicines has produced real savings for patients.¹⁷⁴ Each year, general patients save about 17 per cent of the cost of these medicines.¹⁷⁵ In 2025, these savings were \$319 million (or about \$3 off every script).¹⁷⁶

172. Patient charges are typically a fixed fee, either a flat fee per item (e.g. England, Austria) or a regulated share of a centrally set price (e.g. Norway). See World Health Organization (2018, Table A5.5).

173. Pukhov et al (2026), Health New Zealand | Te Whatu Ora (2012), and Health New Zealand | Te Whatu Ora (2025b).

174. Only general patients receive discounts on under co-payment prescriptions because no medicines are below the concession maximum co-payment.

175. Grattan analysis of Department of Health, Disability, and Ageing (2026b) and Department of Health, Disability, and Ageing (2026c).

176. This is a conservative estimate, because when a patient pays additional fees or pays for brand premium, this amount is subtracted from the calculated discount. The data available do not show what proportion of medicines are discounted.

But for medicines that cost more than the maximum co-payment – which make up 69 per cent of all scripts – discounts are heavily penalised or outright prohibited.¹⁷⁷ While two policies technically allow pharmacies to discount these medicines, one policy is being phased out, and the other imposes stiff financial penalties for discounting.

6.1.1 The \$1 discount

From 2015, pharmacies were allowed to offer patients up to a \$1 discount on PBS medicines above the maximum co-payment.¹⁷⁸ The primary goal was to increase competition on price.¹⁷⁹ The discount was supported by discount pharmacies and opposed by the Guild.¹⁸⁰

The death knell for the \$1 discount sounded when the eighth Community Pharmacy Agreement was signed.¹⁸¹ From 2025, it was reduced to 10 cents for general patients – going to zero from 2026 – and to 80 cents for concession patients – going to zero from 2029.¹⁸²

6.1.2 The discretionary discount

Discounts on medicines that cost more than the maximum co-payment are banned (besides the diminishing \$1 discount).¹⁸³ That means when the maximum co-payment is reduced, the ban applies to more medicines.

177. Department of Health, Disability, and Ageing (2026a, Table 2a).

178. Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2015).

179. Department of Health (2015).

180. Pharmacy Guild of Australia (2019).

181. Pharmacy Guild of Australia (2024a).

182. Department of Health, Disability, and Ageing (2026e), and Department of Health and Aged Care (2025a).

183. Department of Health, Disability, and Ageing (2026e).

In 2023, the maximum co-payment fell from \$42.50 to \$30, restricting discounting on many medicines. Previously, a pharmacy could offer any discount on a medicine that cost \$40, for example. But after the change, such a medicine was above the new maximum co-payment, so the pharmacy could only offer the doomed \$1 discount.

In response, the government allowed medicines priced between the new and old maximum co-payments (\$30 and \$42.50) to be discounted by any amount. The thresholds have been updated, and now apply to medicines priced between \$25 and \$51.10.¹⁸⁴ Unlimited discounts on medicines in that price band might sound like a win for patients, but there is a big catch.

If a pharmacy offers such a discretionary discount, it forgoes the government funding it would otherwise get.¹⁸⁵ This gives pharmacies a strong incentive not to discount and, where they do, to limit discounts to cheaper medicines so they give up less government funding. Patients saved \$8.8 million from these discounts in 2025, and pharmacies gave up a further \$4.3 million in government revenue to offer them.¹⁸⁶

As all medicines for concession patients are above the maximum co-payment,¹⁸⁷ once the \$1 discount has been fully abolished in 2029 (see Section 6.1.1) it will be impossible to discount concession medicines. This deprives concession patients of potentially cheaper medicines.

184. See Department of Health, Disability, and Ageing (2026e). The original upper bound is indexed based on inflation each year, and the lower bound drops when maximum co-payments are reduced.

185. Department of Health, Disability, and Ageing (2022).

186. Grattan analysis of Department of Health, Disability, and Ageing (2026b) and Department of Health, Disability, and Ageing (2026c). See Appendix B for methodology.

187. The standard dispensing fees alone – \$9.24 for ready prepared and \$11.28 for compounded medicines – are higher than the concession patient maximum co-payment.

6.2 Patients are missing out on big savings

Preventing discounting is withholding cheaper prices from patients.

In 2022-23, the \$1 discount saved patients about \$48 million.¹⁸⁸ One in five eligible prescriptions was discounted, with patients saving the full \$1 in 98 per cent of cases. The vast majority of savings were for concession patients.¹⁸⁹

In 2025, about 14 per cent of eligible medicines received a discretionary discount and the average saving was \$7.72.¹⁹⁰ But the savings could be much greater if pharmacies weren't penalised for discounting.

About 70 per cent of medicines receiving a discretionary discount were priced within \$5 of the maximum co-payment (Figure 6.1).¹⁹¹ At that price pharmacies surrender at most \$5 in government funding. Understandably, as the penalty increases, discounting declines sharply.

If the \$1 discount was reinstated, patients might save an additional \$32 million a year.¹⁹² Higher discount limits could save patients more: a \$2 discount might save patients an additional \$60 million a year and a \$5 discount an extra \$137 million a year.¹⁹³ Concession and Repatriation PBS patients collect about 77 per cent of the savings from discounting, because most prescriptions are dispensed to concession patients.

188. The discount was last fully in place in 2023-24, but these data appear to duplicate the 2022-23 figures so have been excluded: Department of Health and Aged Care (2024a) and Department of Health, Disability, and Ageing (2025i).

189. Department of Health, Disability, and Ageing (2025i, Tables 15a and 15b).

190. Grattan analysis of Department of Health, Disability, and Ageing (2026b) and Department of Health, Disability, and Ageing (2026c). See Appendix B.

191. Concession patients cannot benefit from the discretionary discount.

192. This refers to savings in 2029, after the \$1 discount is scheduled to be removed, and is on top of projected savings under the discretionary discount.

193. These figures are in 2025 dollars and probably underestimate true savings because they are based on uptake of the discretionary discount mechanism, which requires pharmacies to forfeit government income. See Appendix B.

The \$1 discount should be reinstated immediately and increased to \$5 over the next five years, with full deregulation of discounting after that, subject to advice from the Australian Competition and Consumer Commission.¹⁹⁴

6.3 The reasons to restrict discounting do not stack up

There are concerns that discounting leads to unfair differences in prices, because discounts are more likely in areas with more pharmacies, and more competition.¹⁹⁵ But discounts in one area don't come at the expense of patients in another.¹⁹⁶

Another Guild objection is that discount pharmacies operate with lower service levels that can reduce quality and increase professional risks.¹⁹⁷ The evidence for these claims is inconclusive, at best.¹⁹⁸ Quality must be taken seriously and would be monitored through the safeguards we propose in Chapter 7. But throttling discounting that pharmacies are willing to do, and that saves patients money, is the wrong way to address these risks.

194. Once discounting is fully deregulated, the current discretionary discount could be removed. Replacing the discretionary discount would remove current government savings of about \$4.3 million per year that come from non-payment of subsidies on discounted medicines.

195. King et al (2017b, p. 33).

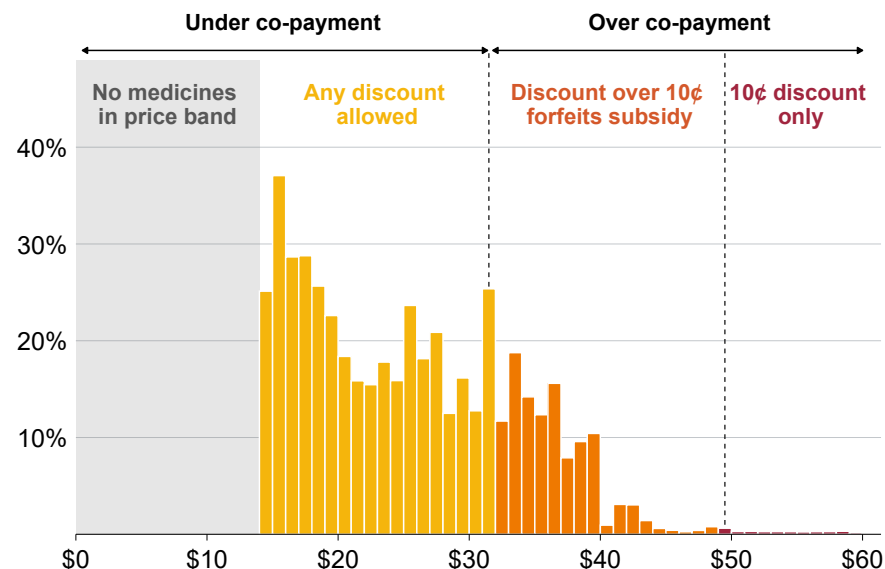
196. It is notable that the Guild opposes price discounting on equity grounds but supports the allowable additional patient charge, which is more likely to be levied in regional areas with less competition (see Section 3.2.3 on page 22).

197. Pharmacy Guild of Australia (2024b).

198. A small 2021 study found that attending a discount pharmacy was associated with lower perceived service quality and medicine adherence: Carter et al (2021). A 2022 meta-study was unable to substantiate a difference in medication adherence rates between the users of independent and chain pharmacies: Nind et al (2022). There also may be factors that make someone more likely to visit a discount pharmacy and less likely to be adherent, such as socio-economic status.

Figure 6.1: Pharmacies will reduce their profit to provide discounts, when allowed

Discounts as a share of pharmacy remuneration, by dispensed price, 2025



Notes: Pharmacy remuneration is defined as the maximum price a medicine can be sold for minus the price the pharmacy paid for it. Data include only general patients under Section 85 (excluding Section 100 and prescriber's bag medications) and exclude premium-loaded scripts and Safety Net prescriptions. In 2025, pharmacies could choose from potential discounting options, depending on medicine price: (1) for medicines below the maximum general co-payment of \$31.60, there were no restrictions on discounting;

(2) for medicines priced above \$49.50, pharmacies could only discount by 10 cents (the reduced \$1 discount); and

(3) for medicines priced between \$31.60 and \$49.50, pharmacies could choose to either discount by only 10 cents and still receive the government subsidy (equal to the gap between the maximum co-payment and the dispensed price), or discount by more than 10 cents and forgo that subsidy.

Source: Grattan analysis of Department of Health, Disability, and Ageing (2026b) and Department of Health, Disability, and Ageing (2026c). 2025 thresholds from Department of Health and Aged Care (2025b).

7 Monitor market concentration and quality of care

Removing restrictions on location, ownership, and discounting will lead to more competition. But there is a risk that a few large companies could dominate and use market power to reduce quality or increase cost for patients.

Government can unlock the benefits of competition while avoiding the potential harms of market concentration, and promoting quality care.

7.1 Competition policy should be more targeted

In other countries where the pharmacy sector was deregulated, large pharmacy chains (often vertically integrated with pharmaceutical wholesalers) have established large market shares.¹⁹⁹ In Norway, three chains controlled about 81 per cent of the pharmacy sector after deregulation.²⁰⁰ In Iceland, three chains accounted for 72 per cent, and in Ireland, 79 per cent.²⁰¹ But consolidation is not an inevitable consequence of deregulation. After regulations were loosened in the Netherlands, the top three chains held only 20 per cent of the market.²⁰²

Consolidation is also not always harmful. Larger chains can achieve economies of scale, invest in better infrastructure and technology, and pass some savings to consumers. International experience shows that high market concentration is compatible with better access, longer opening hours, and – in some circumstances – lower prices (Chapter 5).

Concentration should be monitored for any negative impacts, such as on pharmacist workloads. But policy should target the harms that consolidation can cause, not consolidation itself.

Competition policy is the best way to prevent harmful effects of market concentration. In 2025, the Australian Competition and Consumer Commission (ACCC) gained new roles and powers to review corporate acquisitions.²⁰³ They include assessing the cumulative effect of serial acquisitions and requiring approval before firms above certain thresholds complete acquisitions. This increases oversight of consolidation trends, and can help prevent rapid conglomeration.

Overseas, deregulated pharmacy markets consolidated through horizontal integration: existing pharmacies bought or merged with their competitors.²⁰⁴ This is precisely the dynamic the ACCC is well-equipped to police. If a few players try to buy up large slices of the sector, this can be stopped if there is a harm to competition.

Given international experience, the Treasurer should direct the ACCC to do a market study of the pharmacy sector, and report regularly.²⁰⁵ The ACCC should review consolidation in the pharmacy sector and design appropriate safeguards, potentially including mandatory review of acquisitions, requirements to separate wholesale and retail businesses, or limits on maximum market share.

199. Vogler et al (2014, p. 321).

200. Ibid (p. 321).

201. Hämeen-Anttila et al (2025, Table 2) and Vogler et al (2014, Table 1).

202. Ibid (Table 1).

203. ACCC (2025a).

204. Anell (2005).

205. For example, the ACCC produces an annual market report of the communications sector. See the 2024-25 version: ACCC (2025b).

7.2 It's not clear how deregulation will affect quality

The effect of increased competition on quality is uncertain. Pharmacies may compete by providing higher-quality offerings to attract patients.²⁰⁶ Alternatively, competition may encourage pharmacies to spend less time with patients to increase turnover.

International evidence suggests workload increases in pharmacies after deregulation, and that pharmacists working in chain and discount pharmacies feel greater pressure to dispense quickly and spend less time with patients.²⁰⁷

However, anti-competitive protections are an ineffective way to guarantee quality, and there is no evidence they do so. Instead, Australia should implement a new quality and outcomes monitoring scheme.

7.2.1 Improve quality and outcomes monitoring

There is no comprehensive system to measure the quality of community pharmacies in Australia, and the outcomes they achieve.

Instead, the only program for assessing pharmacy quality is run by the lobby group representing pharmacy businesses.

Accreditation for pharmacies is exclusively assessed through the Quality Care Pharmacy Program (QCPP).²⁰⁸ The Guild is responsible for developing QCPP standards and governing the scheme, and it partners with private assessors who accredit pharmacies.²⁰⁹

206. For example, a 2023 study found that high-quality service was more important than price for generating patient loyalty: Carter et al (2023).

207. Rudholm (2008, p. 259) and Vogler et al (2014).

208. Quality Care Pharmacy Program (n.d.[a]).

209. Quality Care Pharmacy Program (ibid). The QCPP is seemingly a big earner, with the 2024-25 financial report showing \$13.3 million in QCPP income and only \$4.2 million in QCPP expenses: Pharmacy Guild of Australia (2025a).

The QCPP should be redesigned to avoid any conflicts of interest.²¹⁰

The scheme should instead be governed by the Australian Commission on Safety and Quality in Health Care, with standards developed by the Pharmaceutical Society of Australia. Multiple organisations should be approved to accredit pharmacies' compliance with these standards.²¹¹

Australia should comprehensively measure pharmacy quality.

The QCPP has limited scope and does not provide data on outcomes. It focuses primarily on whether pharmacies have the required policies, equipment, and systems in place.²¹² It does not track specific data on quality or outcome indicators.²¹³ In October 2026, the QCPP will transition to the Quality and Safety Pharmacy Program (QSPP), but this will not substantially change the program.²¹⁴

The QCPP has included a 'mystery shopper' component to assess the quality of dispensing.²¹⁵ This involved random assessment visits conducted by a contracted mystery shopper, accompanied by a QCPP representative. This program assessed compliance with the sale of

210. The Guild has qualified for relevant accreditation with Standards Australia, and the QCPP aligns with the National Safety and Quality Primary and Community Healthcare Standards. The Guild also consults widely in developing the standards and has an impartiality committee to oversee program independence. See: Pharmacy Guild of Australia (2024c), Quality Care Pharmacy Program (n.d.[a]), Quality Care Pharmacy Program (2026), and Pharmacy Guild of Australia (2024d).

211. Currently only Ernst & Young provides assessors: Quality Care Pharmacy Program (n.d.[b]). These changes would align pharmacy accreditation practices with those for GP clinics: Australian Commission on Safety and Quality in Health Care (2026).

212. Pharmacy Guild of Australia (2016b).

213. Ibid.

214. The QSPP will have four domains of assessment rather than five and will focus more on pharmacy services, rather than mainly on dispensing: Quality Care Pharmacy Program (n.d.[a]) and Quality and Safety Pharmacy Program (2026).

215. Pharmacy Guild of Australia (2012).

schedule two (pharmacy only) and schedule three (pharmacist only) medicines – not prescription medicines.²¹⁶

Several countries have developed quality measurement regimes for community pharmacies, with varying designs and results (Table 7.1). Their experience points to three clear lessons: indicators must measure what matters, tied payments can distort pharmacy behaviour, and public information holds pharmacies accountable.

Australia should use these lessons to design a system that tracks the quality of pharmacy dispensing and services, and monitors patient outcomes.

Many of these indicators could be built from existing linked administrative data.²¹⁷ These data could track medicine adherence, problematic polypharmacy, and dispensing of contraindicated medicines.²¹⁸

Drawing on existing data, rather than requiring new reporting, would reduce costs and increase accuracy. Some potentially valuable indicators, such as patient reported outcome measures, would require additional data collection from pharmacies.

We estimate this scheme would cost about \$6.4 million to set up, with ongoing costs of about \$1.7 million per year.²¹⁹

Over time, transparent reporting would help improve care and inform patient choice. It would also enable the government to monitor whether different types of pharmacy are providing lower-quality care.²²⁰

216. Ibid.

217. This could include PBS dispensing records, Medicare Benefits Schedule (MBS) claims, and hospital data. See AIHW (n.d.).

218. Contraindicated medicines are those that should not be taken because a medical condition, or another medicine the person is taking, would make them potentially harmful.

219. See Appendix D on page 70 for the methodology we used to estimate this.

220. This would require linking patients' PBS and MBS administrative data to the pharmacy that dispensed their medicines.

Table 7.1: Examples of pharmacy quality monitoring schemes

Location	Program	Description	Lessons learnt
England	Pharmacy Quality Scheme	Points are awarded for performance on quality measures. A funding pool (£30 million in 2025-26) is distributed to pharmacies based on accumulated points, subject to a gateway criterion.	Having few indicators may incentivise selective compliance. Large chain pharmacies are more likely to participate (99 per cent) than independent pharmacies (83 per cent), raising equity concerns.
Ontario, Canada	Quality indicator scheme	Measures pharmacy quality using a set of indicators not tied to payment. Has been found to improve some patient outcomes.	Quality monitoring need not be linked to financial incentives to be effective; collecting and publishing data has independent value.
Netherlands	Community pharmacy indicators	Data are collected on 52 indicators covering medicine-specific measures (e.g. avoidance of medicine interactions) and operational measures (e.g. annual evaluation of patient experience).	Only 13 indicators passed tests for content validity, selection bias, measurement bias, and statistical reliability. Rigorous indicator design is critical for program success.

Sources: NHS Business Services Authority (2026), Schafheutle et al (2025), Torabi et al (2025), and Schoenmakers et al (2015).

8 Ensure services are good value

Pharmacists are medicines experts, with the skills to do more than just dispense medicines. Community pharmacies offer a growing range of services, and the sector is advocating to do more – which could provide accessible healthcare and take pressure off other providers.

But services have not been immune from the failures of community pharmacy governance. Reform is needed to ensure that services are governed appropriately, and that two of the biggest services, MedsChecks and dose administration aids, provide value-for-money and get to the patients who need them most.

And trials here and overseas show government should be cautious about funding new pharmacy services. Among new services, only prescribing for uncomplicated urinary tract infections is ready to roll-out.

For other promising services, government should build the evidence base by funding rigorous, independent trials designed to measure cost-effectiveness. These include care for other minor ailments, oral contraceptive prescribing, smoking cessation, and collaboration with GPs on chronic disease management for specific conditions.

The government should also embed pharmacist expertise in general practice by funding integrated non-dispensing pharmacists in GP clinics and Aboriginal Community Controlled Health Services.

8.1 Pharmacies offer important services beyond dispensing ...

Federal, state, and territory governments fund pharmacies to provide a range of services beyond dispensing, and the scope of these services has grown over time.²²¹

221. Jackson et al (2023b, p. 9).

For example, pharmacies have become a cornerstone of Australia's vaccination program since the COVID pandemic, now delivering 26 per cent of adult flu vaccinations, up from almost none a decade ago.²²² Patients value the convenience and accessibility of pharmacist vaccination, and there is evidence it can increase vaccination rates.²²³

And pharmacies play an important role in harm minimisation for drug users through opioid pharmacotherapy, needle and syringe programs, and take-home naloxone – evidence-based services that have been shown to reduce drug-related harms.²²⁴

Pharmacies may also choose to provide other services, such as informal health advice or health checks.²²⁵

8.2 ... but services are poorly managed

Funding and rules for most pharmacy services are set in the Community Pharmacy Agreements.

Under the current agreement, for the first time, some services are moving into a new Pharmacy Programs Agreement. This is being negotiated with the Pharmaceutical Society of Australia. Other services will remain in the eighth Community Pharmacy Agreement.²²⁶

It is a positive development that the Pharmaceutical Society is involved. But negotiation is not the right way to decide how health services are

222. Hull et al (2025, Figure A8). See also Patel et al (2024).

223. Spinks et al (2020), Le et al (2022), and Isenor et al (2016).

224. Nielsen et al (2017), Kwon et al (2012), and University of Queensland (2022).

225. These services are currently provided without government funding or oversight. As discussed later in this chapter, specific services that have been shown to be effective and cost-effective should be formalised with government-regulated pricing and quality monitoring.

226. Butler (2025).

chosen, designed, and funded. As with dispensing fees, negotiating service funding with industry groups risks paying too much (see Chapter 4).

Negotiation has also led to services diverging from evidence-based models, under pressure from the Guild.²²⁷

And currently, there is no consistent requirement that pharmacists communicate service outcomes to a patient's GP or the government.²²⁸ This risks fragmenting and duplicating care, and also reduces oversight of pharmacy services.²²⁹

These services should be treated as the important health services they are, and governed accordingly. Program rules should be set independently, rather than through negotiated agreements.²³⁰ And the Independent Health and Aged Care Pricing Authority (IHACPA) should be given responsibility for determining prices.

The government should not sign the first Pharmacy Programs Agreement until these governance arrangements are in place. For pharmacy

services that remain in the eighth Community Pharmacy Agreement, this transition should take place when that agreement expires.

The government should also expand the 'Sharing by Default' requirement to encompass pharmacy services, requiring pharmacists to upload documentation of their consultation and recommendations to a patient's My Health Record.²³¹

And, to enable evaluation and outcomes monitoring, the government should link service data for pharmacy services to other administrative data.²³²

8.3 Some existing services are poorly targeted or mispriced

Spending on some of the biggest services – medication reviews and dose administration aids – has grown substantially over the past 15 years (see Figure 8.1).

But despite technology reducing costs, and worrying evaluation findings in that period, governments have not reformed these services to ensure they are effective and good value.

227. For example, a diabetes management and assessment service was successfully trialled in Australia under the third Community Pharmacy Agreement. But during negotiations for the fifth Community Pharmacy Agreement, the Guild instead secured funding for Diabetes MedsChecks, which had much less evidence of value, hadn't been tested in Australia, and didn't include the training, credentialing, or repeat consultations required by the original service: Yong et al (2021, p. 3). See also Hermansyah et al (2017, p. 10).

228. Deloitte was commissioned to review the effectiveness and cost-effectiveness of some existing pharmacy services under the eighth CPA, and in doing so noted that a lack of data on expenditure, output, and outcomes meant they could not measure health-system or economic benefits: Deloitte Access Economics (2025).

229. For example, MedsChecks require pharmacists to put together an Action Plan and provide it to the patient – but this could simply mean handing them a paper form, even if they recommend changes to prescriptions that would need to be made by the patient's doctor.

230. This is already the case for some other community pharmacy programs, such as vaccination.

231. A patient's My Health Record is a secure online portal through which the patient, and healthcare providers they give permission to, can access key patient health records. Currently, providers and patients can choose whether they upload results. 'Sharing by Default' legislation, due to take effect from July 2026, will require providers to upload all pathology and diagnostic imaging results to a patient's My Health Record. There are limited exceptions, such as for patients who don't have a My Health Record or don't provide consent: ADHA (2026).

232. The Pharmacy Programs Administrator already collates service data including patients' Medicare numbers, which would enable linkage to other data sources such as the National Health Data Hub: see Pharmacy Programs Administrator (2025b) and AIHW (n.d.). My Health Record data isn't currently available for secondary uses, such as research and public health, but work is underway to change this: Department of Health, Disability, and Ageing (2024g). When it becomes available for these purposes, this should also be linked.

8.3.1 MedsChecks are poorly targeted

The federal government pays pharmacies to deliver MedsChecks and Diabetes MedsChecks: brief, one-off medication reviews.²³³

Almost a decade ago, a review of these services by the Medical Services Advisory Committee²³⁴ found there was not enough evidence to demonstrate their effectiveness or value-for-money.²³⁵ But MedsChecks have been retained in two subsequent Community Pharmacy Agreements, costing taxpayers a further \$356 million.²³⁶

Subsequent international evidence shows that some medication review services in community pharmacies are cost-effective. But they have tighter eligibility, more intensive service models, and stricter requirements for GP collaboration than Australia's MedsChecks.²³⁷

MedsCheck eligibility criteria are broad and open to interpretation. To be eligible, a patient must take five or more prescription medicines, have recently had a significant medical episode, or be taking high-risk medicines.²³⁸

These criteria don't ensure services are provided to patients with high risk of medication-related harm. There is still no evidence that

233. A medication review is a structured assessment of all of the medicines a patient is taking, intended to identify issues, optimise medicine use, and improve health outcomes: Rose et al (2020).

234. MSAC is an independent scientific advisory committee that provides evidence-based advice to government to inform funding decisions about new medical services, including their safety, clinical effectiveness, and cost-effectiveness: Department of Health, Disability, and Ageing (2024d).

235. MSAC (2017).

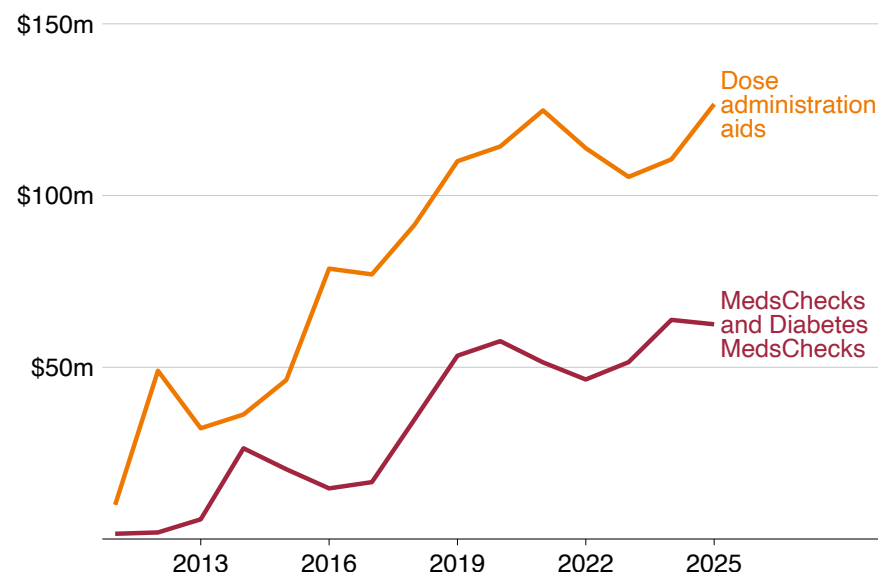
236. Captures expenditures on MedsCheck and Diabetes MedsCheck services between June 2019 and December 2025: Department of Health, Disability, and Ageing (2025k). Past years' expenditure has been inflated to March 2026 dollars using the Consumer Price Index: ABS (2026a).

237. Dawoud et al (2019) and Price et al (2023).

238. Pharmacy Programs Administrator (n.d.).

Figure 8.1: Australia is spending more than ever on dose administration aids and MedsChecks

Expenditure, adjusted for inflation



Notes: Expenditure has been inflated to March 2026 dollars using the Consumer Price Index: ABS (2026a). Years refer to financial year (e.g. 2024-25 is shown as 2025).

Source: Table 18 of the PBS Expenditure and Prescriptions reports from 2011-12 to 2024-25, available at Department of Health, Disability, and Ageing (2025j), though table numbers vary across editions.

medication reviews with criteria this broad are cost-effective.²³⁹ And because Australian pharmacies can offer MedsChecks opportunistically and are paid per service, they have an incentive to deliver more services regardless of patient need.

When the program was launched, claims quickly exceeded expected volumes, and there were reports of pharmacy chains pressuring staff to conduct as many MedsChecks as possible.²⁴⁰

To deal with surging costs, the government introduced caps on MedsChecks. Currently, each pharmacy is able to claim a maximum of 20 services per month.²⁴¹ This is a blunt way to manage costs, which doesn't address the underlying targeting problem. The number and needs of a pharmacy's patients vary, and a cap doesn't ensure that the 20 services are delivered to the 20 people with the greatest need.

Instead, the government should tighten eligibility in line with international best practice, targeting only older patients with specific conditions.²⁴² International models that have achieved cost-effectiveness

target older adults and/or those with specific conditions, such as cardiovascular disease, or diabetes.²⁴³ With these tighter eligibility requirements in place, government should remove the cap for MedsChecks, as well as equivalent caps for Home Medicines Reviews.²⁴⁴

Pharmacists providing MedsChecks are not required to directly report back to a patient's prescribing doctor. This reduces the chance that a MedsCheck results in changes to a patients' prescriptions, probably makes reviews less effective,²⁴⁵ and increases the risk of duplicated care. The requirement for service outcomes to be uploaded to My Health Record proposed in Section 8.2 would improve this information sharing, ensuring that the patient and their GP, as well as other health-care providers, could see and act on MedsCheck recommendations.²⁴⁶

8.3.2 Dose administration aid prices should be updated

Community pharmacies are paid to pack medicines in dose administration aids, such as Webster-paks,²⁴⁷ for patients who have

239. A recent scoping review shows that targeting interventions aimed to address problematic polypharmacy using a count of medicines taken is too broad: Tsang et al (2024). An older systematic review similarly found limited evidence to show that medication reviews were effective, and suggested that this reflected commonly used selection criteria, such as polypharmacy or age, being insufficient to identify patients with a genuine risk of medication-related harm that a medication review might avert: Huiskes et al (2017).

240. ANAO (2015) and Metherell (2014).

241. Pharmacy Programs Administrator (n.d.). After that, they are able to continue providing MedsChecks by charging patients, but don't receive government funding.

242. The Diabetes MedsCheck already has a diagnosis requirement: Pharmacy Programs Administrator (ibid). This should be the case for both MedsCheck services. Pharmacists should use patients' My Health Record, where available, to assess their eligibility. Innovative approaches, using algorithms to identify patients with certain conditions and a high risk of medication-related harms, could also improve targeting, pending results of an ongoing trial using similar methods in general practice: Spinks et al (2023).

243. Price et al (2023, p. 465). Dawoud et al (2019) also finds that services including medication reviews in community pharmacy settings can be cost-effective, and all of the studies included in their review targeted based on age and/or condition.

244. Home Medicines Reviews already have more stringent eligibility requirements, including a GP referral, and from 1 July 2027 an additional requirement for patients to have a current Chronic Disease Management Plan is being added: Department of Health, Disability, and Ageing (2025l, AN.0.52). Unlike MedsChecks, expenditure has not significantly increased in real terms in recent years: Department of Health, Disability, and Ageing (2026i) and Department of Health, Disability, and Ageing (2025k).

245. Kolhatkar et al (2016, p. 517).

246. The recommendations in this section align with the 2017 MSAC review, which recommended that targeting services to more appropriate patient populations and requiring formal collaboration with GPs and other providers could improve the value of MedsChecks: MSAC (2017).

247. Webster-paks are a widely used range of dose administration aids, manufactured by Webstercare.

difficulty managing their medication.²⁴⁸ These aids improve medication adherence.²⁴⁹

Dose administration aids have been funded under the Community Pharmacy Agreement since 2007.²⁵⁰ Since 2017, pharmacists have been paid a flat fee for each dose administration aid.²⁵¹

But, as with other payments to pharmacies, there is no publicly available evidence to suggest that the current fee reflects the actual cost of providing the service.

The most recent available estimates of the cost of providing a dose administration aid are from 2010.²⁵² A lot has changed since 2010. But, despite some fluctuations, the price that government pays is very similar, after accounting for inflation, to what it was in 2012 (Figure 8.2).

Pharmacies are now allowed to provide up to 90 dose administration aids per month, up from 30 in 2010.²⁵³ And there are now a range of

248. This includes patients with literacy or language issues, physical disabilities, cognitive difficulties, or patients who are taking more than five prescription medicines and have difficulty managing them. Patients must hold a concession card to be eligible.

249. Chaudhri et al (n.d.).

250. Haywood et al (2011).

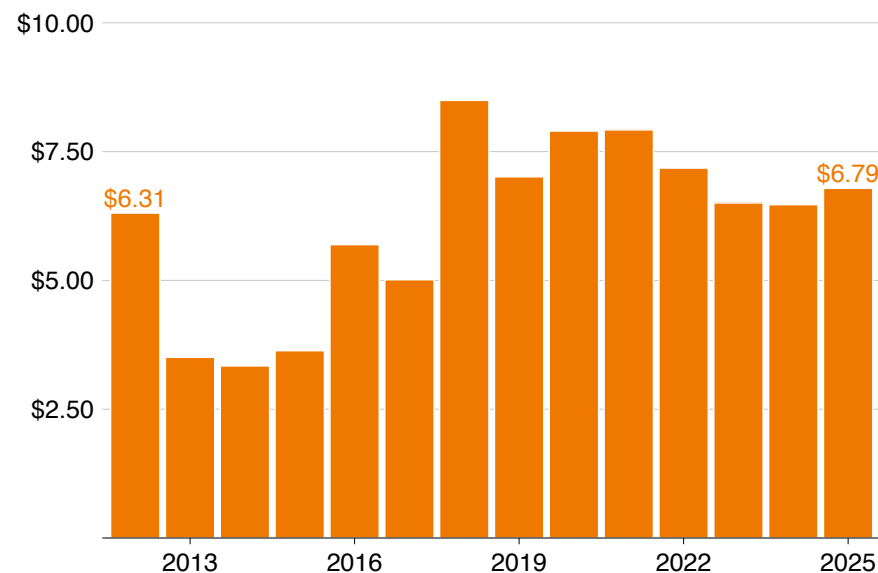
251. Pharmacy Guild of Australia (2017b). Before then, services were funded under a practice incentive payment, with payments made to pharmacies periodically based on the volume of services they provided and the number of prescriptions dispensed by the pharmacy: Health Consult (2016, p. 1). Pharmacies are also able to charge patients a fee for providing a dose administration aid, and there is some evidence to suggest that most pharmacies do. But there is no available data showing if this fee has changed over time, and there are signs that patients have a poor understanding of when they are being charged a fee and how much it is: Aslani et al (2024, p. 9).

252. 2010 Evaluation of Dose Administration Aid program, cited in: Health Consult (2016). In one more recent study, pharmacists claimed the average cost was between \$10 and \$14, depending on packaging type. But this was not independently validated: Aslani et al (2024).

253. Health Consult (2016) and Pharmacy Programs Administrator (2025b).

Figure 8.2: The payment per dose administration aid has stayed high despite increasing automation

Expenditure per dose administration aid, adjusted for inflation



Notes: The structure of payments has changed over time. For comparison purposes, this chart shows total expenditure divided by total services delivered, which may not match other published estimates. Expenditure has been inflated to March 2026 dollars using the Consumer Price Index: ABS (2026a). Years refer to financial year (e.g. 2024-25 is shown as 2025).

Sources: Expenditure data are sourced from Table 18 of the PBS Expenditure and Prescriptions reports from 2011-12 to 2024-25, available at Department of Health, Disability, and Ageing (2025j), though table numbers vary across editions. Service counts are sourced from Department of Health, Disability, and Ageing (2026i) and Department of Health and Aged Care (2024b).

automated packing options explicitly advertised as a way to cut packing time and increase profit, so costs have probably fallen over time.²⁵⁴

As with dispensing fees, government should set the fee for a dose administration aid to cover the cost of providing an aid, plus a reasonable profit margin.²⁵⁵ To do so, it should collect up-to-date data on the cost of providing these services that takes into account increasing scale and automation of packing.

And as with MedsChecks, government should abolish caps on how many dose administration aids services each pharmacy can provide.

8.4 Expanding services seems like a good deal ...

The pharmacy industry has called for expansion beyond these longstanding services. The Guild and the Pharmaceutical Society have called for services such as community pharmacy prescribing, diagnosis, and disease management, which are traditionally the remit of general practice. They claim this would take pressure off GPs and improve health outcomes.²⁵⁶

At first, the case seems strong. Pharmacists have extensive training and already provide some of these services overseas.²⁵⁷ And community pharmacies are well-located, accessible, and highly trusted.²⁵⁸

Against this backdrop, many Australian states are trialling, or permanently expanding, pharmacy services.²⁵⁹

254. See, for example, Willach Pharmacy Solutions (n.d.) and Omnicell (n.d.).

255. See Chapter 4.

256. See Pharmacy Guild of Australia (2025c) and Pharmaceutical Society of Australia (2026).

257. Dineen-Griffin et al (2020b) and Price et al (2023).

258. See Chapter 1.

259. All states and territories have either trialled or permanently expanded pharmacy services in recent years, and many have directly funded these services and/or implementation costs, such as training: Pharmacy Guild of Australia (2026b).

8.5 ... but the evidence on cost-effectiveness is sobering

Evidence suggests that pharmacy services are safe and effective.²⁶⁰ Consumers also find pharmacy services convenient, and express high satisfaction.²⁶¹ But evidence about the cost-effectiveness of pharmacy services is weak.²⁶²

Government should only fund health services that are good value-for-money in the context of the broader health system. With rising demand for care, and government budgets under strain, this is more important than ever. And even where patients pay for services directly, government should still consider if those services are cost-effective.²⁶³

In 2025-26 alone, Victoria, Tasmania, WA, and SA all announced funding for pharmacist service expansion in their state budgets, totalling \$26.6 million: Victorian Department of Treasury and Finance (2025, p. 50), Government of South Australia (2025, p. 41), Premier of Tasmania (2025), and Government of Western Australia (2025, p. 307).

260. A 2025 systematic review found that pharmacy prescribing (and associated treatment, testing, and collaboration) had been successfully operationalised internationally, with evidence of clinical safety and patient satisfaction, based on 23 studies published between 2015 and 2025: Clemens et al (2025, p. 19). A recent Australian rapid review about community pharmacist prescribing, commissioned by the Royal Australian College of General Practitioners, found little strong evidence about clinical, cost, or safety outcomes – but this review was limited to only primary studies published between 2021 and 2025: Raghunandan et al (2026).

261. Health New Zealand | Te Whatu Ora (2024) and Victorian Department of Health (2025).

262. Lewis and Williams (2023), Sanyal and Husereau (2020), Sanyal and Husereau (2019), Paudyal et al (2018), Ou et al (2024), Ayorinde et al (2013), and Gudka et al (2013).

263. It is difficult for patients to assess the necessity or quality of the services they are offered by a pharmacist. And pharmacies are heavily subsidised by government. Government should ensure this platform isn't used to promote services which aren't evidence-based, so patients aren't left paying for services that aren't beneficial.

Systematic reviews show mixed results for cost-effectiveness of extended-scope pharmacy services.²⁶⁴ Findings vary significantly by type of service, health system context, and implementation approach.²⁶⁵ They suggest that some services are more effective and cost-effective than others, and point to specific risks to achieving value.

8.5.1 Community pharmacy services face risks to value

International evidence shows that pharmacy services can duplicate GP care, with the government (and possibly also the patient) paying twice.²⁶⁶

And the community pharmacy setting increases the risk of low-value care. Usually an appointment isn't needed, so patients may seek care for issues that would have resolved on their own.²⁶⁷ And fee-for-service funding encourages pharmacies to provide more services, even if they aren't necessary (see Section 8.3.1). There is international evidence that when the same provider both prescribes and dispenses medicines, they prescribe more, and more expensive, medicines.²⁶⁸

264. Dawoud et al (2019), Price et al (2023), and Phimarn et al (2023). See Appendix C for a summary of the evidence.

265. Sanyal and Husereau (2020), Sanyal and Husereau (2019), Price et al (2023), and Newman et al (2020).

266. This can occur where pharmacists are unable to fully resolve a patient's health concern (see, for example, Gauly et al (2025)), or where protocols require pharmacists to refer patients with specific symptoms onto GPs (see, for example, Amador-Fernández et al (2022)).

267. This has played out overseas. A Spanish randomised controlled trial showed that people receiving pharmacy minor ailment services didn't get better more often or more quickly than people who didn't get the service: Amador-Fernández et al (2023).

268. For example, Austrian GPs who gained the right to dispense medicines from an in-house pharmacy showed a 9.2 per cent increase in antibiotic dispensing rates, with the change driven by prescribing behaviour rather than patient mix: Stacherl et al (2023). English GPs in dispensing practices are more likely to prescribe higher-cost medicines even where there is no clinical evidence that

The cost-effectiveness evidence in Australia is also weak, and shows mixed results.²⁶⁹ There are reasons community pharmacy services might be less cost-effective here than overseas: a poor track record of managing existing services, broader health system problems, and emerging alternatives that may offer better value.

There has been sustained funding for poorly targeted and mispriced services in successive Community Pharmacy Agreements, despite independent reviews (see Section 8.3). That suggests new services are likely to be poorly designed and badly implemented.

The wider context matters too. Australia's health system is fragmented and relies heavily on fee-for-service payments.²⁷⁰ The incentives and information gaps this creates make duplication between pharmacy and GP services more likely.

And cost-effectiveness must be assessed against the alternatives, some of which have momentum. Designated registered nurses now have expanded prescribing powers.²⁷¹ Significant investment and reform is focused on urgent care centres and multidisciplinary general practice, including pharmacists working in general practices.²⁷² If they

those medicines are better than cheaper alternatives: Goldacre et al (2019). And when Taiwan introduced reforms separating prescribing and dispensing roles, medicine expenditure and prescribing volumes both fell: Chou (2003).

269. Much of our evidence comes from the Pharmacy Trials Program, a range of large, government-funded trials, including for chronic disease management, medication management, and screening and referral. The program was designed to generate an evidence base about cost-effectiveness, and the findings were not promising: Department of Health (2019) and Department of Health, Disability, and Ageing (2023b). Of the eight services trialled, the Medical Services Advisory Committee didn't support any that were based in community pharmacy: Department of Health, Disability, and Ageing (2023b).

270. Breadon et al (2022).

271. In 2025, a new registration standard for designated registered nurse prescribers was introduced: Nursing and Midwifery Board of Australia (2025).

272. Urgent care clinics were introduced as a pilot program in 2023 and were made permanent in the 2026 Budget: Butler (2026a). The 2023 Budget funded

prove cost-effective, the case for providing overlapping services in community pharmacies will get weaker.

8.6 Focus on the most promising new services

Given weak evidence and risks to value-for-money, the federal government should take a cautious and selective approach to expanding community pharmacy services. Only one proposed new service type – prescribing for uncomplicated urinary tract infections (UTIs) – has a strong enough evidence base to justify rolling it out at scale.

8.6.1 Fund pharmacists to treat uncomplicated UTIs

Government should fund pharmacists to treat uncomplicated UTIs in women aged 18 to 65, including through prescribing antibiotics.²⁷³ This has been shown to reduce overall costs and improve access to care.²⁷⁴ The evidence for this service is strong, but does not prove that other services will also be cost-effective.²⁷⁵

Primary Health Network commissioning of multidisciplinary teams and increased Workforce Incentive Payments to encourage multidisciplinary primary care, and Minister Mark Butler has signalled commitment to further reform: Commonwealth of Australia (2023, p. 148), Butler (2024a), and Butler (2024b).

273. 'Uncomplicated' UTIs occur in people who are otherwise healthy and have a normal urinary tract. UTIs in males, older people, pregnant women, children, and people with specific risk factors require further investigation: Jarvis et al (2014).
274. A recent, high-quality evaluation of pharmacist prescribing for uncomplicated UTIs shows that the service is cost-effective. The PATH-UTI study estimates that the service could reduce total federal and state expenditure on care for uncomplicated UTIs in NSW by up to \$4.6 million per year. But this estimate does not take into account the costs of training or implementation. See Dineen-Griffin et al (2026a).
275. PATH-OC was a trial of oral contraceptive repeat prescribing run at the same time as PATH-UTI. It was a much smaller trial and so was unable to produce the same level of high-quality evidence of cost-effectiveness. The study finds a much bigger saving, but this is more uncertain: Dineen-Griffin et al (2026b). The third arm of that study, on skin conditions, is yet to be released.

In funding pharmacists to treat uncomplicated UTIs, government should enable pharmacists to provide PBS prescriptions, subsidise services for concession card holders, and introduce caps on how much pharmacists can charge patients for a consultation, based on independent IHACPA pricing. Trials have shown that, without these settings in place, pharmacy services are disproportionately accessed by wealthier patients.²⁷⁶

We estimate that this would cost up to \$2 million per year, if government chose to cover the cost for all eligible patients.²⁷⁷

8.6.2 Fund trials to test other services

Other pharmacy service types don't yet have enough evidence to justify making them permanent. But some are promising enough that government should invest in large-scale trials, with carefully designed safeguards, to test their cost-effectiveness in the Australian context.²⁷⁸

276. Under the PATH-UTI and PATH-OC trials, where most patients didn't have to pay a consultation fee, but did have to pay the full cost of their medicine, services were disproportionately accessed by women from wealthier areas and with higher levels of education: Dineen-Griffin et al (2026a) and Dineen-Griffin et al (2026b).
277. This number assumes that uptake is 13 per cent among all Australian women aged 18 to 65 who experience a UTI, and that pharmacies are paid \$21.52 per consultation, based on Dineen-Griffin et al (2026a), but the actual price should be independently determined by IHACPA. The government may choose to require all, or some, patients to pay a co-payment, which would reduce the cost to government. See Appendix D for further detail about how we've costed this service.
278. The federal government has announced a trial of subsidised pharmacy services, due to commence on 1 January 2027: Butler (2026b). This trial should be used to test cost-effectiveness, as described in this section. Currently, the scope of the trial is care for UTIs, and contraceptive prescribing for female concession card holders aged 18 to 55. But given the strong evidence base for UTI care, the government should not focus there, and instead use this opportunity to trial other services.

The services the government should focus on are: prescribing for other minor ailments beyond uncomplicated UTIs, oral contraceptive prescribing, smoking cessation, and chronic disease management for specific conditions such as diabetes and hypertension (see Box 8). International evidence suggests they are safe, effective, and probably cost-effective.²⁷⁹ Early findings from Australian trials also suggest they are safe and can be implemented here.²⁸⁰

Services without enough evidence to justify a large-scale government-funded trial include: screenings for chronic diseases or risk factors, and lifestyle change services for weight loss or reduced alcohol use.²⁸¹

Get trials right this time

There have been more than 20 government-funded trials of new community pharmacy services in Australia over the past decade.²⁸² But almost none provided the information needed to expand, or rule out, new services.²⁸³ And many new and ongoing trials appear to be repeating this pattern, focusing on measures of patient satisfaction and safety, without rigorous evaluation of effectiveness and cost-effectiveness.²⁸⁴

279. See Appendix C for a summary of cost-effectiveness evidence. Similar services have been safely implemented overseas: Wu et al (2021), Clemens et al (2025), and Chisari et al (2025).

280. See, for example, Victorian Department of Health (2025) and Nissen et al (2022).

281. See Appendix C for a summary of the evidence.

282. This includes trials under the Pharmacy Trials Program: Department of Health, Disability, and Ageing (2023b), and a range of state and territory government trials.

283. MSAC assessments of previous pharmacy trials have identified small size, insufficient data collection, and inappropriate comparators as barriers to conclusive clinical and cost-effectiveness findings: MSAC (2023a), MSAC (2022), MSAC (2021a), and Department of Health (2019). See also Raghunandan et al (2026).

284. See, for example, Victorian Department of Health (2025). An exception is the recent PATH-UTI trial, which should be used as an example of what a sufficiently large, rigorous trial design looks like: Dineen-Griffin et al (2026a)

Box 8: Promising services that government should trial

Minor ailments services, which involve consulting with a patient, making a diagnosis, and potentially prescribing for minor, short-term ailments.^a

Pharmacists are generally required to follow a protocol^b outlining which data they must collect, medications they can prescribe, and risk factors that trigger referral for further assessment and treatment.^c

Prescribing oral contraception, which similarly involves consulting with a patient, following a protocol, and where appropriate either initiating or continuing a prescription.

Smoking cessation services, which involve education, advice, and pharmacotherapy to help patients quit smoking.

Chronic disease management services, which focus on:

- Specific conditions, including diabetes and hypertension.
- Specific functions, such as education, medication management, repeat prescribing, and monitoring.
- GP collaboration, requiring a referral or periodic review.

See Appendix C for a summary of the evidence.

- This commonly includes conditions such as impetigo, mild plaque psoriasis, shingles, nausea, hay fever, and minor wounds.
- e.g. the protocol for shingles in Queensland: Queensland Health (2025).
- This differs from 'standard of care' prescribing arrangements, which allow medical practitioners (such as GPs) to flexibly exercise clinical judgment based on available evidence: Mesbahi et al (2025).

New trials must be different. They should be designed to test specific service models and generate evidence of effectiveness and cost-effectiveness sufficient to inform a health technology assessment.²⁸⁵ That assessment should be the threshold for introducing a new service into usual pharmacy practice.

That means trials should follow Australian Centre for Evaluation (ACE) and Medical Services Advisory Committee guidelines. ACE should also peer review and approve the trial designs before they start.²⁸⁶ These guidelines specify how to choose appropriate patient health outcome measures and how to design a trial and recruitment strategy that minimises bias and facilitates economic analysis.

8.7 Integrated pharmacists are good value

Embedding pharmacists in general practices and Aboriginal Community Controlled Health Services is a different way to have pharmacists provide more services.

Integrated pharmacists don't directly sell medicines to patients. Instead, they provide medicine reviews, education, and monitoring as part of a patient's multidisciplinary care team. This includes providing patient services, as well as participating in case conferences and providing advice to other staff.

Integrated pharmacists in primary care are widespread overseas, particularly in the UK and, to a lesser extent, Canada.²⁸⁷ In England,

285. A health technology assessment is a formal assessment of the safety, effectiveness, and cost-effectiveness of a new health technology or service, designed to provide advice to government about whether it should be government-subsidised: Department of Health, Disability, and Ageing (2025m). The Medical Services Advisory Committee is responsible for health technology assessments of new services.

286. See Australian Centre for Evaluation (n.d.) and MSAC (2021b). ACE offers peer review of pre-analysis plans for impact evaluations run by the federal government.

287. Tan et al (2014a) and Sudeshika et al (2023).

pharmacists in general practices have been common for more than a decade.²⁸⁸

They improve the clinical outcomes for people with chronic disease.²⁸⁹

Integrated pharmacists in general practices have been successfully trialled in Australia.²⁹⁰ And in 2023, the Medical Services Advisory Committee supported public funding for integrated pharmacists in Aboriginal Community Controlled Health Services, following a 15-month trial that found the model was safe, effective, and good value-for-money.²⁹¹

8.7.1 Integrated pharmacists provide expertise with fewer risks

Integrated pharmacists would increase access to the unique medicines expertise of pharmacists, while avoiding many of the risks from offering services in a community pharmacy, which were discussed in Section 8.5.1.

The duplication risk is reduced because integrated pharmacists have highly collaborative relationships with GPs.²⁹² They share a physical clinic, and all the record-keeping and care coordination infrastructure that sits within it.

288. Bradley et al (2018). More than 20 per cent of English general practices employ a pharmacist as part of their multidisciplinary team, for an average of eight hours per week: Chopra et al (2022).

289. See Tan et al (2014a). The best results were observed where pharmacists spoke directly to GPs, and where pharmacists provided not only medicine reviews but also lifestyle advice, adherence support, and medication monitoring and adjustment.

290. See, for example, Tan et al (2014b) and Benson et al (2018).

291. MSAC (2023b).

292. Sudeshika et al (2023).

The risk of low-value care is reduced by locating pharmacists within a clinic, rather than a shopfront. Typically, a patient would be referred to the pharmacist or explicitly make an appointment.²⁹³

And integrated pharmacists do not have the conflicts of interest that come with a retail setting.

8.7.2 Invest in integrated primary care pharmacists

The federal government should get Primary Health Networks to commission integrated pharmacists in general practices. Primary Health Networks should assess proposals for integrated pharmacists from general practices, make funding decisions informed by their population's health needs, and support continuing improvement.²⁹⁴

We estimate that this would cost about \$57 million per year.²⁹⁵ This could support about one in every eight Australian general practices (about 900 clinics) to employ a pharmacist for two days each week.²⁹⁶

293. See Tan et al (2014b). A large trial now running in Queensland uses algorithms applied to a patient's clinic records, alongside their My Health Record, to automatically flag for pharmacist consultation patients who are at risk of medication-related harm. Should this trial's findings be positive, similar approaches could be expanded to improve targeting of integrated pharmacist services: Spinks et al (2023).

294. Primary Health Networks are already required to conduct regular Needs Assessments using qualitative and quantitative evidence to identify the needs of their region's population. These form the basis of commissioning decisions: Department of Health (2021a). Primary Health Networks already support continuing improvement for integrated pharmacists through the Aged Care On-site Pharmacy Program: Department of Health, Disability, and Ageing (2026k).

295. See Appendix D for an explanation of our estimate.

296. Note that the actual number of clinics and working hours might vary, as Primary Health Networks and general practices identify their specific needs. Our costings are based on two days a week of pharmacist time per general practice, which is equivalent to trials run by the ACT, North Western Melbourne, and South Eastern

The government should also fund the National Aboriginal Community Controlled Health Organisation (NACCHO) to commission the model of integrated pharmacists in Aboriginal Community Controlled Health Services that the Medical Services Advisory Committee supported in 2023, which would cost about \$23 million per year.²⁹⁷

This could support every Aboriginal Community Controlled Health Service to employ a pharmacist for at least one day each week. At full scale, this would mean an additional 500 pharmacists working across general practice and the ACCHS.²⁹⁸

Melbourne Primary Health Networks: Deeks et al (2018), Ball et al (2021), and South Eastern Melbourne PHN (2024).

297. MSAC (2023b).

298. The government should do modelling to plan for the establishment of this workforce, including its implications for the supply of pharmacists working in other sectors. Grattan has previously recommended the establishment of an independent health workforce planning body that could undertake this analysis: Breadon et al (2025, pp. 22–23).

9 Build a better future for pharmacy

Community pharmacy is a crucial part of Australia's healthcare system, and it will only get more important. Every year, Australia's population gets older and sicker, new medicines are added to the Pharmaceutical Benefits Scheme (PBS), more scripts are dispensed, and government healthcare spending rises.

Australia has trusted medicines experts in almost every community, available without an appointment. It's vital that we make the most of them. The reforms in this report would do that. Together, they would build a sector that delivers three things Australians should be able to expect.

The first is affordable medicines.

Patients would stop paying fees that buy nothing. They could get a discount on any medicine, at any pharmacy that wants to compete for their business. And the Safety Net would kick in automatically, so no one misses out on savings they're entitled to. Taxpayers would pay dispensing fees based on what dispensing actually costs, and get the full benefit of manufacturer discounts.

The second is competition that drives innovation and cuts prices, like it does in the rest of the economy.

New pharmacies could open where patients are. The best operators could grow. Longer opening hours, home delivery, and lower prices would spread because they win customers, not because an agreement allows them. Rural Australians would get guaranteed access to medicines, not subsidies that don't go where they're needed.

The third is pharmacists doing more of what they are trained for.

Pharmacists would treat uncomplicated urinary tract infections, with PBS prescriptions and capped fees. Within a few years, rigorous

national trials would settle which other services are worth rolling out at scale. 500 pharmacists would work in general practice and in Aboriginal Community Controlled Health Services, where the evidence shows their expertise improves care.

With these reforms, the sector will give some things up: guaranteed revenue, protected locations, and fees set by bargaining. But it will get more in return.

Owners would get fees that cover their costs, faster payment for expensive stock, freedom to grow, and targeted funding if they serve communities that can't sustain a business without government support.

Pharmacists would get a bigger clinical role, in a system that measures and values the quality of their work.

The current Community Pharmacy Agreement expires in mid-2029. Three years is enough time to collect cost data, start trials, legislate competition reforms, and set up quality monitoring. If the federal government acts now, the eighth agreement can be what it should be: the last.

Appendix A: Community pharmacy dispensing remuneration

Table A.1: Cost components of community pharmacy dispensing remuneration (July 2026)

Approved ex-manufacturer price (AEMP)^a	The amount agreed between the government and the manufacturer as the maximum price the manufacturer can charge.	<i>Differs by medicine type and volume</i>	
Wholesale mark-up^b	An amount to cover the wholesaler's costs.	AEMP ≤ \$5.50 \$5.50 < AEMP ≤ \$1,000 \$1,000 < AEMP ≤ \$10,000 AEMP > \$10,000	\$0.24 per dispense 4.3% of AEMP per dispense \$43 + 2% of AEMP over \$1,000 per dispense \$223 per dispense
Administration, handling, and infrastructure fee	A fee to cover the costs of handling, storage, and the pharmacy infrastructure required to supply the medicine.	PtPMQ < \$100 ^c \$100 ≤ PtPMQ ≤ \$2,000 PtPMQ > \$2,000	\$5.12 per dispense \$5.12 + 5% of PtPMQ over \$100 per dispense \$100.12 per dispense
Dispensing fee	A fee to account for the pharmacist's services in dispensing the medicine.	Ready-prepared medicines Compounded medicines ^d	\$9.24 per dispense \$11.28 per dispense
Safety Net recording fee[*]	A fee paid by general patients who elect to have their PBS expenditure recorded for Safety Net purposes, covering administrative costs.	Ready-prepared medicines Compounded medicines	\$1.54 per dispense \$1.99 per dispense
Dangerous medicine fee	An additional fee to account for the increased regulatory, storage, and record-keeping requirements involved in dispensing highly regulated medicines, such as opioids.		\$5.73 per dispense
Allowable additional patient charge[*]	An optional fee that pharmacists can charge general patients when a medicine costs less than the maximum co-payment.		Up to \$2.79 per dispense

a. Applies for ready-prepared medicines only. For compounded medicines, pharmacists are reimbursed for ingredient costs instead: Department of Health, Disability, and Ageing (n.d.).

b. Applies for ready-prepared medicines only: Department of Health, Disability, and Ageing (ibid).

c. PtPMQ = price to pharmacist (AEMP + wholesale mark-up) for maximum quantity. This is the price the pharmacy pays for the largest standard pack size of a medicine.

d. Compounded medicines are less than 0.03 per cent of PBS medicines: Department of Health, Disability, and Ageing (2026a, Table 11).

*Note: Fees marked * apply to general patients, are charged at pharmacists' discretion, can't raise the total charge above the maximum co-payment, and don't count towards the Safety Net.*

Source: Department of Health, Disability, and Ageing (2026d).

Appendix B: Methodology for estimating savings from discounting

In Chapter 6, we recommend that pharmacies should be allowed to discount over co-payment prescriptions. We recommend allowing them to discount prescriptions by \$1 initially, and then gradually increasing that to \$5 over the next five years, with full deregulation of discounting after that, subject to ACCC advice.

To estimate the impact of increased discounting, we model what patients would save in 2029 if pharmacists were able to discount over max co-payment prescriptions by \$1, \$2, or by \$5. Throughout this section, we refer to these three values as ‘caps’ on discounting.

B.1 Data and scope

We have calculated the historical uptake of under co-payment discounting and the discretionary discount mechanism using PBS date of supply data for 2025²⁹⁹ and the Dispensed Price for Maximum Quantity (DPMQ) of each medicine in each month as published in the Schedule of Pharmaceutical Benefits.³⁰⁰ Historical uptake rates for the \$1 allowable discount are drawn from the PBS Expenditure and Prescriptions Report 2022-23.³⁰¹

We have indexed the maximum general co-payment and the upper limit of the discretionary discount mechanism (DDM upper limit) using projected CPI, meaning that they grow by 2.5 per cent per year from their 2026 values.³⁰² The 2026 maximum general co-payment is \$25, and the 2026 DDM upper limit is \$51.10.

299. Department of Health, Disability, and Ageing (2026c).

300. Department of Health, Disability, and Ageing (2026b).

301. The discount was last fully in place in 2023-24, but these data appear to duplicate the 2022-23 figures so have been excluded: Department of Health and Aged Care (2024a) and Department of Health, Disability, and Ageing (2025i, Tables 15a and 15b).

302. Commonwealth of Australia (2026, Table 1.1).

B.2 Net savings

Net savings for a given cap are calculated as the projected patient savings for that discounting cap minus the baseline savings that we expect to see with existing discounting policy. Savings per script from existing policies are limited to the amount of the projected discounting cap (for example, if we estimate a \$3 discount based on existing discounting policies, only \$1 is counted when considering net savings under a \$1 cap).

B.2.1 Baseline savings

For general patients, without policy change, the only allowable discounts on over co-payment scripts in 2029 would be under the discretionary discount mechanism. This discount can be applied to scripts with a DPMQ between the maximum general co-payment and the DDM upper limit.

We have identified scripts as discounted when they are above the maximum general co-payment but receive no government contribution (as this is forgone when discounts are applied), and the amount the patient paid at the pharmacy is less than the amount you would expect them to pay if they paid full price.³⁰³ Using this method, we estimate that the DDM uptake rate in 2025 was 14.2 per cent (that is, 14.2 per cent of scripts in the DPMQ range eligible for discretionary discounting – \$25 to \$51.10 – had a discount applied).

We then calculate the discount per script. We produce three versions of an adjusted discount per script, by adjusting the discounts on scripts with a discount greater than the discount cap (\$1, \$2, or \$5) down, to

303. This is typically the general co-payment, but can also include brand premiums where relevant.

be equal to the discount cap. This adjustment is necessary because the reform reintroduces a \$1 discount while retaining the discretionary discount. This policy only replaces the current savings under the discretionary discount up to the value of the proposed cap, so using the full value of existing discretionary discounts would understate the additional savings attributable to the reform. We then estimate the average discount per discounted script. We use this adjusted discount per script to calculate an average discount per discounted script for each cap.

Baseline savings are calculated as the projected count of scripts eligible for discretionary discounting in 2029, multiplied by the 2025 DDM uptake rate and the 2025 average discount per discounted script.

For concession patients, the existing allowable discount reaches zero in 2029, so the concession baseline saving in 2029 is zero.

B.2.2 Projected additional savings

For the \$1 cap scenario, projected savings are equal to the projected number of general and concession over co-payment scripts in 2029, multiplied by the actual 2022-23 \$1 discount uptake rates of general and concession scripts. The 2022-23 uptake rates for the \$1 discount were 29 per cent for scripts for general patients and 21 per cent for concession scripts. We assume that all discounts are for the full dollar in line with observed behaviour.³⁰⁴

Under a \$2 cap scenario, savings increase by the actual value of discounts between \$1 and \$2, weighted across the share of scripts discounted by more than \$1. For example, a script discounted by \$1.50 contributes an additional 50 cents of savings, while one discounted by

the full \$2 or more contributes an additional \$1 (the cap). At \$5, savings increase further by the actual value of discounts between \$2 and \$5.

The scripts receiving further discounts beyond \$1 are derived from observed pharmacy behaviour under the DDM in 2025. We calculate the proportion of scripts with a DPMQ within \$5 of the maximum general co-payment (\$31.60) that had a discount applied. Under a discount cap where pharmacies are not required to surrender government subsidies when discounting (as the discretionary discount does currently), pharmacy incentives would more closely resemble their current behaviour on these lower-priced scripts. This yields 25.7 per cent of general patient scripts being discounted by \$2 or more and 21.2 per cent by \$5 or more. We scale down this rate for concession scripts based on the ratio of the historical uptake of the \$1 discount on concession versus general scripts (21 per cent versus 29 per cent).

B.3 Volume projections

The eighth Community Pharmacy Agreement (8CPA) appendix reports projected volumes of over co-payment scripts directly through to 2028.³⁰⁵ We extrapolate to 2029 by applying the simple average of the 2026-27 and 2027-28 annual growth rates to 2028 volumes.

Scripts with a 2025 DPMQ between \$25.00 and \$31.60 are reclassified from under co-payment to over co-payment to reflect the 2026 reduction in the maximum general co-payment. This projected share is added to the total 2029 volume estimate because the original 8CPA estimates did not include these medicines that were, at the time of signing in 2024, below the maximum general co-payment.

To calculate the share of these 2029 medicines in each patient category, we use the patient breakdown from 2025: 30 per cent of scripts

304. 98 per cent of discounted prescriptions were discounted by the full \$1: Department of Health, Disability, and Ageing (2025i, Table 15b).

305. Department of Health, Disability, and Ageing and Pharmacy Guild of Australia (2024, p. 34).

were for concession Safety Net patients, 54 per cent for concession non-Safety Net, and 12 per cent were general non-Safety Net patients. The remaining four per cent were for general Safety Net, and RPBS patients.

B.4 Our projections underestimate true savings

Our estimates probably understate patient savings, for two reasons.

First, our methodology does not fully account for additional charges patients may pay, such as Safety Net recording fees, allowable additional patient charges, or brand premiums, which inflate the cost of some medicines. We filter out observations where the amount the patient paid at the pharmacy is more than the amount expected to be paid, but due to aggregation per medicine per month, some of these additional payments will remain obscured in the data. Second, the projections are anchored to DDM behaviour, where pharmacies forgo the government subsidy to offer a discount; observed discounting on the DDM is therefore a lower bound on the discounting that would occur if pharmacies were not penalised.

The data do not allow for modelling of 60-day prescribing: where a patient pays less because they are dispensed a smaller quantity rather than because of a discount. However, as Figure 6.1 on page 43 shows, estimated discounts decline in line with policy settings, suggesting that confounding effects of 60-day prescriptions – which would occur across price levels – do not have a major impact.

The analysis also does not account for the effect that lower prices have on demand for medicines. If more patients purchased medicines at discounted prices due to increased affordability, this would increase the observed level of discounting.

Appendix C: Cost-effectiveness evidence for new pharmacy services

In Chapter 8, we recommend that government fund pharmacist prescribing for urinary tract infections, and that government run large-scale trials of other promising pharmacy services. These services are prescribing for other minor ailments, oral contraceptive prescribing, collaborative chronic disease management, and smoking cessation. These recommendations are based on Grattan's review of literature about the cost-effectiveness of expanded-scope pharmacy services.

Evidence suggests that many service types are safe and accepted by pharmacists and patients.³⁰⁶ But evidence about effectiveness is more mixed, and of those that evidence suggests are effective, even fewer have demonstrated cost-effectiveness. Given the risks to cost-effectiveness in the Australian setting (discussed in Chapter 8), and the importance of achieving value for government spending, we have focused on cost-effectiveness.

We have prioritised systematic reviews, including single studies only where no recent systematic reviews were identified or where they provide high-quality Australian evidence.

We have split pharmacy services by goal, rather than intervention type, into: minor ailments services, chronic disease management, screening, and lifestyle change services.

For each study, we have captured any findings related to cost-effectiveness, either measured in terms of impact on total healthcare costs, or incremental cost-effectiveness (based on a quality-adjusted life years threshold). Given the scarcity of direct cost-effectiveness evidence, we have also captured findings related to underlying drivers of cost-effectiveness:

- **Outcomes** – whether the service improved patients' outcomes, relative to either usual pharmacy care, or an equivalent service in an alternate setting.
- **Unit cost** – how the cost of delivering the service in a pharmacy compared with the cost in alternate settings.
- **Substitution** – whether the service reduced demand for equivalent services in other settings.

C.1 Minor ailments consultations

Minor ailments services involve consulting with a patient, making a diagnosis, and potentially prescribing medication to treat a minor, short-term health issue such as a urinary tract infection (UTI), shingles, or impetigo. Chapter 8 recommends that government fund a national trial of minor ailments services.

Until recently, there was little evidence about the cost-effectiveness of minor ailments services, despite them being mainstream overseas (see Table C.1).³⁰⁷

But recently released results from large trials conducted in NSW and the ACT show that pharmacist care for uncomplicated UTIs is cost-effective.³⁰⁸ This is strong, compelling evidence, because it is based on a very large trial (providing care for 17,219 people),³⁰⁹ included detailed cost-effectiveness and cost distribution modelling, used linked administrative data to account for re-presentations, and found that the

306. See Chapter 8.

307. Lewis and Williams (2023) and Aly et al (2018).

308. Dineen-Griffin et al (2026a).

309. This represents nearly 10 per cent of all women 18-35 experiencing an uncomplicated UTI in NSW and the ACT during the trial period: Dineen-Griffin et al (ibid, p. 169).

service was cost-effective across all modelled scenarios. On the basis of this finding, we deem pharmacist care for uncomplicated UTIs to have a strong enough evidence base to justify government funding.

A similar trial was conducted for oral contraceptive continuation, which also found that the service could result in savings for government.³¹⁰ This result is less strong, however, because it was based on a smaller trial (providing care for 1,946 patients),³¹¹ and conducted cost distribution analysis that did not use the trial results or attempt to assess cost-effectiveness directly. It also didn't include initiation of oral contraceptives and had very restrictive eligibility criteria for continuation, differentiating it from the models being proposed and adopted elsewhere.³¹² For these reasons, we recommend a further, larger trial be undertaken that explicitly assesses cost-effectiveness using real world data.

For other minor ailments, we don't have high quality contemporary Australian evidence. Available evidence suggests they may provide equivalent outcomes to other settings at a lower cost.³¹³ But it is unclear whether they reduce demand for other health services, and it is possible that they do not improve outcomes above and beyond usual, informal pharmacy advice / care.³¹⁴

These gaps mean that the current widespread expansion of minor ailments services is getting ahead of the evidence base.

Based on these findings, in Chapter 8 we recommend that the government fund pharmacists to provide care for uncomplicated UTIs and

trial consultations for other minor ailments, including contraception prescribing. The trial should confirm if the lower unit cost of pharmacy services translates into cost-effectiveness once overall costs are taken into account.

C.2 Chronic disease management

Chronic disease management services include pharmacists monitoring and providing advice to patients about how to manage their chronic disease or diseases. These services might also involve a pharmacist prescribing or adjusting a medicine dosage.

There is more evidence about these services than other service types, but systematic reviews note that the varied targeting, implementation, and independence of these services make it difficult to generalise about their effectiveness or cost-effectiveness.³¹⁵

Services targeting diabetes or hypertension have repeatedly been found to improve outcomes, and have been shown to reduce overall healthcare costs compared to usual care. For other service types there is less evidence, and mixed or negative results in terms of impact on outcomes and overall healthcare costs.

The services that were shown to be effective for diabetes and hypertension were collaborative care models, involving patients' GPs and a combination of education, medicine management, making changes or recommendations about dosages and prescriptions, or monitoring.³¹⁶

Based on these findings, in Chapter 8 we recommend that the government should trial collaborative chronic disease management for diabetes and hypertension. The trial should test whether these services duplicate care patients receive in other settings, given the lack of

310. Dineen-Griffin et al (2026b).

311. This represents just 0.63 per cent of all women using oral contraception in NSW: Dineen-Griffin et al (ibid, p. 103).

312. Ibid (p. 102).

313. Paudyal et al (2013) and Watson et al (2015).

314. Amador-Fernández et al (2022), Dineen-Griffin et al (2020a), and Paudyal et al (2013).

315. Price et al (2023), Sanyal and Husereau (2020), and Sanyal and Husereau (2019).

316. Price et al (2023), Newman et al (2020), and Milosavljevic et al (2018).

evidence about whether these services substitute for other healthcare. It should also test whether these services are more cost-effective than alternatives in the context of Australia's healthcare system, given the local risks identified in Chapter 8.

C.3 Screening

Screening services involve pharmacists opportunistically screening patients for diseases or disease risk factors.

There is little high-quality evidence about the cost-effectiveness of these programs (see Table C.3).³¹⁷ This suggests community pharmacy-based services should not be prioritised for government investment in screening programs, unless new evidence comes to light.

C.4 Lifestyle change

Lifestyle change services involve pharmacists supporting patients to reduce lifestyle-related health risk factors, such as by losing weight or reducing their alcohol consumption.

Smoking cessation services consist of pharmacists providing behaviour change support over multiple sessions, either on its own or in combination with prescribing pharmacotherapy. They have been shown to deliver better outcomes than usual care, at an acceptable additional cost, although this evidence is poor quality.³¹⁸ There is little evidence about weight loss and alcohol-use reduction services, and none

suggesting they provide better value than similar services delivered in alternate settings (see Table C.4).

Based on these findings, in Chapter 8 we recommend that the government should trial smoking cessation services. Given the lack of strong cost-effectiveness evidence, this trial should comprehensively test cost-effectiveness in Australia.

317. Note that the UK government has published modelling suggesting its hypertension case-finding service could result in large cost-savings: UK Government (2023). We have not included these savings in our review because these are based on hypothetical, rather than observed, increases in detection and uptake of care, and subsequently published evidence shows that 80 per cent of patients who were indicated to receive further assessment did not go on to receive it: Tsuyuki et al (2025). There is no peer-reviewed evidence about this service's impact.

318. Carson-Chahhoud et al (2019) and Brown et al (2016).

Table C.1: Summary of evidence on pharmacy minor ailments schemes

Author (Year)	Study design	Service type	Strength of evidence	Relevant findings
Dineen-Griffin et al (2026a)	Mixed-methods cohort study (Australia)	Uncomplicated UTI care	Moderate (single large study, strong methodology)	Cost-effectiveness: Equivalent outcomes for lower system-wide costs, compared to usual care.
Dineen-Griffin et al (2026b)	Mixed-methods cohort study (Australia)	Oral contraceptive continuation	Weak (single small study)	Outcomes: Equivalent to usual care. Unit cost: Cheaper than usual care.
Lewis and Williams (2023)	Literature review	Minor ailments scheme	Weak (not peer-reviewed)	Cost-effectiveness: Inconclusive.
Amador-Fernández et al (2022)	Cluster RCT (Spain)	Minor ailments scheme (without prescribing)	Weak (single small study)	Outcomes: Similar to usual pharmacist care.
Dineen-Griffin et al (2020a) and Dineen-Griffin et al (2020c)	Cluster RCT (Australia)	Minor ailments scheme (without prescribing)	Weak (single small study)	Outcomes: Better than usual <i>pharmacist</i> care. Cost-effectiveness: More expensive than usual <i>pharmacist</i> care, but cost-effective using a quality-adjusted life year threshold.
Watson et al (2015)	Non-randomised trial (UK)	Minor ailments scheme (without prescribing)	Weak (single small study)	Unit cost: Substantially lower costs than ED/GP care. Outcomes: Comparable to GP/ED care.
Paudyal et al (2013)	Systematic review (31 studies)	Minor ailments scheme	Weak	Unit cost: Pharmacy probably cheaper than GP care. Substitution: Unclear whether services substituted for GP care. Outcomes: Comparable to GP care.

Note: For systematic reviews or MSAC reviews, 'strength of evidence' reflects the reviewers' assessment of the collective strength of the evidence base they are assessing, rather than being an assessment of the review itself.

Table C.2: Summary of evidence on pharmacy chronic disease management services

Author (Year)	Study design	Service type	Strength of evidence	Relevant findings
Alsaeed (2025)	Rapid review (3 systematic reviews)	Pharmacy services	Weak	Cost-effectiveness: Inconclusive. Most promising for chronic disease management and medication therapy management.
Farhana et al (2025)	Systematic review (26 studies, 12 relevant)	Medication adherence for chronic disease	Weak	Outcomes: Inconclusive (most studies showed improvement, some showed no improvement).
Price et al (2023)	Systematic review (75 studies, 17 relevant)	Chronic disease management	Moderate	Outcomes: Better than usual care for hypertension, diabetes, and warfarin monitoring. Cost-effectiveness: Either reduced costs or acceptable costs using a quality-adjusted life year threshold, for hypertension, diabetes, and warfarin monitoring. Inconclusive for medicine reviews, adherence interventions, smoking cessation, and other conditions.
Bužančić et al (2022)	Systematic review (24 studies, 6 relevant**)	Deprescribing	Moderate	Outcomes: Reduced prescriptions/dosage, but no influence on falls, quality of life, or mortality. Cost-effectiveness: Greater benefit at lower cost (one study only).
MSAC (2022)	Review of application based on pre-post trial (Australia)	Chronic pain medication review	Weak (single small study)	Outcomes: Inconclusive. Cost-effectiveness: Inconclusive.
MSAC (2021)*	Review of application based on cluster RCT (Australia)	Asthma management	Weak (single small study)	Outcomes: Inconclusive.
Newman et al (2020)	Systematic review (15 studies)	Chronic disease management	Moderate	Cost-effectiveness: Lower overall healthcare costs for diabetes; otherwise inconclusive. Outcomes: Better than usual care for diabetes.
Milosavljevic et al (2018)	Systematic review (22 studies)	Medication adherence interventions	Moderate	Cost-effectiveness: Inconclusive.

Notes: For systematic reviews or MSAC reviews, 'strength of evidence' reflects the reviewers' assessment of the collective strength of the evidence base they are assessing, rather than being an assessment of the review itself. *See Department of Health, Disability, and Ageing (2023b). **'Relevant studies' refers to the number of studies specifically about community pharmacy-based chronic disease management. Excluded studies are typically out-of-scope due to alternative settings (e.g. hospital pharmacy, GP clinic, or in-home care).

Table C.3: Summary of evidence on pharmacy screening services

Author (Year)	Study design	Service type	Strength of evidence	Relevant findings
Ou et al (2024)	Systematic review (26 studies, 21 relevant**)	Mental illness screening	Weak	Outcomes: Inconclusive.
Hayes et al (2024)	Systematic review (27 studies)	Viral hepatitis screening	Moderate	Outcomes: Similar treatment uptake to alternate settings. Cost-effectiveness: Less cost-effective than alternate settings.
MSAC (2023)*	Review of application based on cluster RCT (Australia)	Cardiovascular disease risk factor screening/management	Weak (single small study)	Outcomes: Inconclusive.
MSAC (2021a)	Review of application based on cluster RCT (Australia)	Diabetes screening	Weak (single large study)	Outcomes: Inconclusive (no comparison to usual care). Cost-effectiveness: Inconclusive (no comparison to usual care).
Willis et al (2014)	Systematic review (16 studies)	Diabetes and cardiovascular disease screening	Moderate	Outcomes: Poorer rate of accessing follow-up testing/treatment compared to GP screening.
Ayorinde et al (2013)	Systematic review (50 studies)	Screening	Weak	Outcomes: Inconclusive. Unit cost: Inconclusive. Cost-effectiveness: Inconclusive.

*Notes: For systematic reviews or MSAC reviews, 'strength of evidence' reflects the reviewers' assessment of the collective strength of the evidence base they are assessing, rather than being an assessment of the review itself. *See Department of Health, Disability, and Ageing (2023b). **'Relevant studies' refers to the number of studies specifically about community pharmacy-based screening programs. Excluded studies are typically out-of-scope due to alternative settings (e.g. hospital pharmacy, GP clinic, or in-home care).*

Table C.4: Summary of evidence on pharmacy lifestyle change services

Author (Year)	Study design	Service type	Strength of evidence	Relevant findings
Carson-Chahhoud et al (2019)	Cochrane review (7 studies)	Smoking cessation	Weak	Outcomes: Better than usual <i>pharmacy</i> care. Cost-effectiveness: Better than usual <i>pharmacy</i> care.
Brown et al (2016)	Systematic review (19 studies)	Weight management, alcohol-use reduction, and smoking cessation	Weak	Outcomes: Better than usual care for smoking cessation; similar to alternate setting for weight loss; inconclusive for alcohol-use reduction. Unit cost: Similar to alternate setting for weight management. Cost-effectiveness: Acceptable costs using a quality-adjusted life years threshold for smoking cessation; Inconclusive for alcohol-use reduction.
Gordon et al (2011)	Systematic review (10 studies)	Weight management	Weak	Outcomes: Inconclusive. Unit cost: Inconclusive. Cost-effectiveness: Inconclusive.

Notes: For systematic reviews or MSAC reviews, 'strength of evidence' reflects the reviewers' assessment of the collective strength of the evidence base they are assessing, rather than being an assessment of the review itself. Excluded studies are typically out-of-scope due to alternative settings (e.g. hospital pharmacy, GP clinic, or in-home care).

Appendix D: Costing methodologies

Throughout this report we provide cost estimates for several recommendations. This appendix sets out how we calculated them.

D.1 Independent Health and Aged Care Pricing Authority data collection and analysis

We have recommended that the Independent Health and Aged Care Pricing Authority (IHACPA) be made responsible for determining pharmacy remuneration, including for dispensing and services. We estimate this would cost \$9.8 million per year.³¹⁹

Depending on the method IHACPA decide to use in its calculations, this may require a representative sample of community pharmacies to report data on cost inputs – including labour and infrastructure – as well as the time taken to complete different dispensing tasks and services. We estimate this would cost an additional \$3.3 million a year.

D.1.1 Calculation of fees

When the federal government expanded IHACPA's remit to cover aged care pricing in 2021-22, it allocated \$49.1 million over five years – about \$9.8 million per year.³²⁰ This figure excludes data collection costs, because the Quarterly Financial Report – the aged care data collection tool – is conducted and funded separately.

We consider \$9.8 million per year to be a generous upper bound for what a pharmacy pricing function would cost. Aged care funding requires IHACPA to calculate a baseline price and then separate weightings for dozens of distinct classes reflecting different levels of

patient care need and facility characteristics.³²¹ Pharmacy dispensing fees, by contrast, will probably vary by fewer characteristics, for example whether a medicine is ready-prepared or compounded, and whether it is a dangerous medicine. The classification task for pharmacy is therefore likely to be simpler.

D.1.2 Data collection

To estimate the cost of ongoing data collection, we use the Occasions of Care Explained and ANalysed (OCEAN) study as a proxy. Run by the University of Sydney, OCEAN collects data on the clinical activity of general practice nurses, nurse practitioners, physiotherapists, and Aboriginal and/or Torres Strait Islander Health Workers – analogous to what we are proposing for pharmacy.³²²

The Australian Government funded the OCEAN study at \$8.5 million over three years.³²³ As this excludes the cost of developing the data collection tool itself, we round up to \$10 million as a conservative estimate. This implies an annual cost of approximately \$3.3 million to develop and run a comparable study for the pharmacy sector.

The exact size, scope and method of the proposed data collection for community pharmacies will vary from the OCEAN study, so this estimate should be considered approximate.

319. The estimates in this section are rough approximations only and have not been adjusted for inflation.

320. Department of Health (2021b).

321. Specifically, 15 classes of permanent care residents, four respite classes, and seven base care tariff classes. See IHACPA (2025b, pp. 11-13).

322. University of Sydney (2025).

323. AusTender (2024).

D.2 Quality monitoring scheme

There is no close analogue for the proposed quality and outcomes monitoring scheme, so any cost estimate is necessarily rough. Drawing on the costs of comparable schemes in aged care and general practice, we estimate that the scheme would cost in the order of \$6.4 million to design and set up, and \$1.7 million a year to administer.³²⁴ These figures should be treated as indicative rather than precise.

D.2.1 Set-up costs

Set-up costs would cover the design and testing of indicators, development of any new data collection and reporting systems, and initial training and guidance for pharmacies on the scheme.

Developing eight additional indicators for the National Aged Care Quality Indicator Program cost \$3.2 million.³²⁵ The aged care indicators are more complex to design and require more bespoke data collection than the proposed pharmacy indicators, which can probably draw more heavily on existing administrative data.³²⁶ Working against this, these costs cover only eight indicators, whereas the pharmacy scheme would involve a larger set. Balancing these factors, we use a broad assumption that pharmacy indicator development would cost roughly twice as much at \$6.4 million.

D.2.2 Ongoing administration

The closest comparator for ongoing administration is the Practice Incentives Program Quality Improvement Incentive, which collects quarterly indicator data from about 5,700 general practices. Data are

324. The estimates in this section are rough approximations only and have not been adjusted for inflation.

325. AusTender (2019) and AusTender (2022).

326. AIHW (2026b).

aggregated through Primary Health Networks, with the Australian Institute of Health and Welfare acting as national data custodian.³²⁷

This custodianship function costs \$5.2 million over three years, or roughly \$1.7 million per year.³²⁸ The figure excludes incentive payments to practices, which we do not propose for the pharmacy scheme.

D.3 Pharmacist care for uncomplicated urinary tract infections

In Chapter 8, we recommend that government fund pharmacists to provide care for uncomplicated urinary tract infections. We estimate that this care would cost up to \$2 million per year, should the government choose to cover the cost for all eligible patients. If the government were to cover the cost only for concessional patients, or cover partial costs, some of this cost would be borne by patients and the budgetary cost would be lower.

Each year, about 570,000 Australian women aged 18 to 65 experience an uncomplicated urinary tract infection.³²⁹

The PATH-UTI study estimates that if pharmacist care was available, 13.15 per cent of eligible patients would access it.³³⁰ Using this assumption, we assume that there would be approximately 75,000 instances of care per year.³³¹

327. AIHW (2023).

328. AusTender (2025).

329. Dineen-Griffin et al (2026a) estimates that 185,000 women aged 18 to 65 in NSW and the ACT experience an uncomplicated urinary tract infection each year. We have scaled this up using national, NSW, and ACT population data for women aged 18 to 65 from ABS (2026c).

330. Dineen-Griffin et al (2026a, p. 97).

331. This follows the assumption of Dineen-Griffin et al (ibid) that each patient would only access care once per year. The clinical protocol for the PATH-UTI study required immediate GP referral (rather than pharmacist care) for patients with multiple UTIs within a six-month period. But it is possible that the same patient might access care multiple times, more than six-months apart, and so this number may be an underestimate.

In the PATH-UTI trial, the NSW government paid pharmacists a \$20 consultation fee.³³² For the purpose of our costing, we have assumed that consultation fee would be the same, except for an inflation adjustment; but we recommend that IHACPA review the cost of delivering the service and set the price accordingly, and so this may vary in practice. 75,000 consultations per year, at \$21.52 per consultation, would total \$1.7 million, which we have rounded up to \$2 million to account for the uncertainty of the estimate.

We also recommend that prescriptions for PBS-listed medicines issued by pharmacists are PBS prescriptions, meaning the government subsidy for any antibiotics prescribed would be the same as if the patient had received care and been prescribed from a different care provider. For this reason, we assume that this recommendation would not increase PBS costs. It is possible that having a pharmacy care option would generate new demand for care, among people who would not otherwise have sought medical treatment for their UTI. If this is the case, it is still unlikely there would be a large increase in PBS costs, because standard antibiotics prescribed for UTI are below or only just above the general co-payment, and so most patients would bear all or almost all of the cost of their medicines without government subsidy.³³³

332. Ibid (p. 98).

333. For example, the Victorian protocol for treatment of uncomplicated UTIs by community pharmacists specifies the following medicines: Trimethoprim 300mg, Nitrofurantoin 100mg, or Cefalexin 500mg: Safer Care Victoria (2023). All three have a Dispensed Price for Maximum Quantity (DPMQ) between \$19.18 and \$27.78, meaning that for a general patient, the government would only subsidise up to \$2.78 for each additional prescription for general patients, or up to \$20.08 for each additional prescription for concessional patients: Department of Health, Disability, and Ageing (2026d). Given this service is targeted at working-age patients, concession card holders are probably a small proportion of the overall cohort.

D.4 Integrated pharmacists

In Chapter 8, we recommend that the government provides funding for integrated, non-dispensing pharmacists in GP clinics and Aboriginal Community Controlled Health Services. We estimate that this would cost about \$80 million a year at full scale.

D.4.1 General practice

We recommend that the federal government funds a program of integrated pharmacists working in primary care that would allow one-in-eight GP clinics to employ a non-dispensing pharmacist for two days a week. This would take Australia to approximately half of the rate of GP clinics with integrated pharmacists as England.³³⁴ In population terms, Australia would have a ratio of 1.3 full-time-equivalent integrated pharmacists to every 100,000 people, compared with 3.0 per 100,000 people in England.³³⁵

There are about 7,100 GP clinics in Australia.³³⁶ This means that this would require about 360 full-time-equivalent pharmacists. We have assumed a pharmacist salary of \$102,000 per year, plus 30 per cent to cover salary on-costs.³³⁷ This means that the total salary expenses would come to about \$47.2 million.

GP clinics would require additional funding for care coordination and program reporting. We estimate this would be 10 per cent of salary expenses – \$4.7 million, which is about \$5,000 per participating clinic, per year.

334. In 2022, 22 per cent of GP clinics in England had a non-dispensing pharmacist working in them: Chopra et al (2022).

335. In mid-2024, England had 1,774 FTE pharmacists working in GP clinics: National Health Service England (2026, Bulletin Table 1a), for a population of 59 million people: Office for National Statistics (2025).

336. As of 30 June 2023, there were 7,135 GP clinics: Productivity Commission (2024).

337. Jobs and Skills Australia (2025) and ANU (2015).

Primary Health Networks would require additional funding for their commissioning role, including providing ongoing training and support for integrated pharmacists working in their region. We estimate this would be 10 per cent of total program costs – \$5.2 million.

D.4.2 Aboriginal Community Controlled Health Services

In 2023, the Medical Services Advisory Committee considered an application for funding a program of integrated pharmacists in Aboriginal Community Controlled Health Services.³³⁸ The committee supported a model with an estimated annual cost of \$22.7 million at full scale.

This would fund one pharmacist per 6,000 patients accessing Aboriginal Health Services, providing:

- a pharmacist working at least one day a week for all non-remote Aboriginal Health Services;³³⁹
- a full-time pharmacist for all remote Aboriginal Health Services; and
- 10 pharmacists to work across Aboriginal Health Services run by the Northern Territory government.

This also included funding of \$460,000 per year to provide mentoring and operate a community of practice.

338. MSAC (2023b, p. 27).

339. For the purpose of this program, Aboriginal Health Services include services that are funded by the Department of Health, Disability, and Ageing's First Nations Health Division for the provision of primary healthcare services to First Nations people.

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