



# REWRITING THE SCRIPT

UNLOCKING THE VALUE OF PHARMACIST  
PRESCRIBING IN AUSTRALIA

JUNE 2026

IN THE SPIRIT OF RECONCILIATION THIS REPORT ACKNOWLEDGES THE TRADITIONAL CUSTODIANS OF COUNTRY THROUGHOUT AUSTRALIA AND THEIR CONNECTIONS TO LAND, SEA AND COMMUNITY.

WE VALUE ABORIGINAL AND TORRES STRAIT ISLANDER CULTURES, TRADITIONS, VIEWS AND WAYS OF LIFE AND PAY OUR RESPECTS TO ELDERS PAST AND PRESENT.

## FOREWORD BY HTANALYSTS

HTANALYSTS has been providing boutique value and impact assessment services for over two decades. Originally founded in 2002, our organisation has grown to become a leader in social impact consulting, providing services to the healthcare industry. We exist to make a powerful impact on society by driving human-centric outcomes.

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***Our purpose is to have a powerful impact on the health of society by connecting people with the best treatments in the fastest time.***

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This report, prepared for the Pharmacy Guild of Australia, examines the potential role of pharmacist prescribing as a structural workforce reform, using economic modelling to assess its impact on service utilisation, health system costs and patient outcomes. The findings provide an evidence base to inform policy decisions on nationally consistent implementation of pharmacist prescribing within Australia's primary care system.

## ABBREVIATIONS

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**ABS**

Australian Bureau of Statistics

**AECC**

Australian Emergency Care Classification

**AIHW**

Australian Institute of Health and Welfare

**AR-DRG**

Australian Refined Diagnosis Related Groups

**BEACH**

Bettering the Evaluation and Care of Health

**COPD**

Chronic Obstructive Pulmonary Disease

**CPI**

Consumer Price Index

**CVD**

Cardiovascular Disease

**ED**

Emergency Department

**GORD**

Gastro-Oesophageal Reflux Disease

**GP**

General Practitioner

**IHACPA**

Independent Health and Aged Care Pricing Authority

**MBS**

Medicare Benefits Schedule

**NHCDC**

National Hospital Cost Data Collection

**OCP**

Oral Contraceptive Pill

**PBS**

Pharmaceutical Benefits Scheme

**QALY**

Quality-Adjusted Life Year

**RACGP**

Royal Australian College of General Practitioners

**UTI**

Urinary Tract Infection

**VSLY**

Value of a Statistical Life Year

## CONTENTS

- 3 Foreword by HTANALYSTS**
- 4 Abbreviations**
- 6 Unlocking the value of pharmacist prescribing in Australia**
- 8 Current state of pharmacist prescribing**
- 10 Case studies**
  - 10 Asthma
  - 12 COPD
  - 14 Hormonal contraception
  - 16 Cardiovascular risk reduction
- 18 Recommendations and conclusion**
- 20 References**

# UNLOCKING THE VALUE OF PHARMACIST PRESCRIBING IN AUSTRALIA

Australia's primary care system is under increasing strain. An ageing population, rising rates of chronic disease, and increasing multimorbidity are driving demand beyond current workforce capacity. [1] The supply of General Practitioners (GPs) is not keeping pace, particularly in regional and remote areas. [2, 3] With a projected GP workforce shortfall of 8,600 by 2048, structural reform is required to maintain timely access to care. [2]

Community pharmacy represents one of the most accessible components of the health system. One in four Australians already consults a pharmacist as a trusted source of health advice. [4] Internationally, pharmacist prescribing has been embedded for over a decade in countries such as the United Kingdom (UK), Canada, and New Zealand, where it is delivering safe, effective care and strong patient outcomes. [5]

This report shows how nationally consistent pharmacist autonomous prescribing would expand workforce capacity, improve outcomes, and generate substantial economic value. Case studies in asthma, chronic obstructive pulmonary disease

(COPD), hormonal contraception, and cardiovascular risk reduction demonstrate how pharmacists can complement the GP workforce, shifting millions of routine consultations from general practice to pharmacy annually, freeing GPs to focus on patients with more complex and multimorbid needs.

This redistribution of care would increase effective GP capacity, enabling medical practitioners to focus on more complex patients within the existing workforce while reducing wait times and improving timely access, particularly in rural and remote communities. Economic modelling demonstrates substantial annual value across the case studies, including direct health system savings, productivity gains, and wellbeing benefits. Given the geographic reach, extended hours and walk-in availability of community pharmacies, especially in regional Australia, pharmacist prescribing can further improve access, reduce travel and time burden, support earlier intervention in chronic disease, and strengthen primary care resilience during workforce shortages.



COPD



CVD RISK

Across the four case studies alone, pharmacist prescribing would deliver:

- Over **\$1 billion** in combined direct health system savings annually
- Over **10 million GP appointments** freed for more complex patients each year
- Over **30,000 hospitalisations** prevented annually
- Substantial improvements in quality of life

These quantified impacts likely underestimate the total system benefits. The modelling does not fully capture gains in equity of access, reductions in travel and time burden, particularly in rural and remote areas, or longer-term prevention benefits from earlier intervention in chronic conditions. Realising these benefits requires coordinated national reform. Based on the findings of this report, three priority actions are essential:



### IMPLEMENT NATIONALLY CONSISTENT REGULATORY REFORM

A nationally aligned framework enabling endorsed pharmacists to prescribe autonomously within individual scopes of practice should be established.



### EMBED PRESCRIBING WITHIN DIGITAL INFRASTRUCTURE

Pharmacist prescribing must be supported by shared electronic health records, secure messaging and interoperable prescribing systems to ensure real-time communication with general practice and continuity of care.



### ESTABLISH SUSTAINABLE FUNDING MECHANISMS

Appropriate remuneration for pharmacist consultations, PBS eligibility for medicines prescribed within scope, and funding models that incentivise collaborative care are critical to equitable and scalable implementation.

Australia's primary care pressures are structural and long-term. Reform must explicitly prioritise equity by leveraging the geographic reach and accessibility of community pharmacy to reduce disparities in care for regional, rural and socioeconomically disadvantaged populations. In doing so, pharmacist prescribing can strengthen primary care resilience and ensure those who have historically faced barriers to timely GP care are not left behind.

Given strong international evidence and the scale of projected workforce shortages, Australia should now transition from

fragmented pilot programs to nationally endorsed, permanent implementation. Pharmacist prescribing offers a practical, evidence-based reform that unlocks workforce capacity, improves health outcomes and advances equity while delivering more than \$21 billion in annual economic impact across the modelled case studies, including over \$1 billion in healthcare savings.

The growing body of international evidence supports the effectiveness of pharmacist prescribing. The policy imperative now is to build on this evidence and progress towards nationally consistent implementation.

# CURRENT STATE OF PHARMACIST PRESCRIBING

Australia's ageing population and rising burden of chronic disease have made health workforce planning a critical system priority. While there are approximately 40,000 GPs nationally, capacity is not keeping pace with need, placing sustained pressure on primary care and the broader health system. [2] These pressures are compounded by issues such as geographic distribution and increasing clinical complexity. The Royal Australian College of General Practitioners (RACGP) reports a decline in GPs per capita since 2019, with especially low numbers in outer regional and remote areas. [3] Increasingly complex care needs and multimorbidity represent a significant challenge, as almost 40% of Australians are living with multimorbidity, with higher rates in regional and remote areas. [1, 3] As demand grows more complex and geographically uneven, the gap between service need and workforce capacity continues to widen.



## GP WORKFORCE SHORTAGES

**8,600**

Estimated GP workforce shortage by 2048 [2]

With appropriate training, pharmacists can assess, diagnose and initiate treatment for a range of health conditions, positioning them to complement the GP workforce and improve timely access to care. Globally, pharmacist prescribing is well established. In countries such as the UK, Canada, New Zealand, and parts of the US, trained pharmacists have been authorised to prescribe independently or within defined scopes of practice for over a decade. [5] In contrast, Australia continues to rely largely on pilot programs and limited jurisdictional reforms. This is despite mounting workforce pressures and evidence demonstrating at least equivalent – and in many cases improved – patient outcomes. [6,7]



**1 in 4**

Australians currently consult a pharmacist as one of their go-to sources of health advice [4]

Expanding pharmacist prescribing presents a practical opportunity to improve timely access to care, optimise medication use, and relieve pressure on GPs. The proposed model – autonomous prescribing – allows trained pharmacists to independently prescribe scheduled medicines within their individual scope. [8] This scope is established through completion of accredited training and is exercised within appropriate collaborative relationships with patients and other members of the healthcare team. Areas of practice may include a wide range of acute and chronic health conditions, mental health, women's and sexual health, travel health and other defined domains.



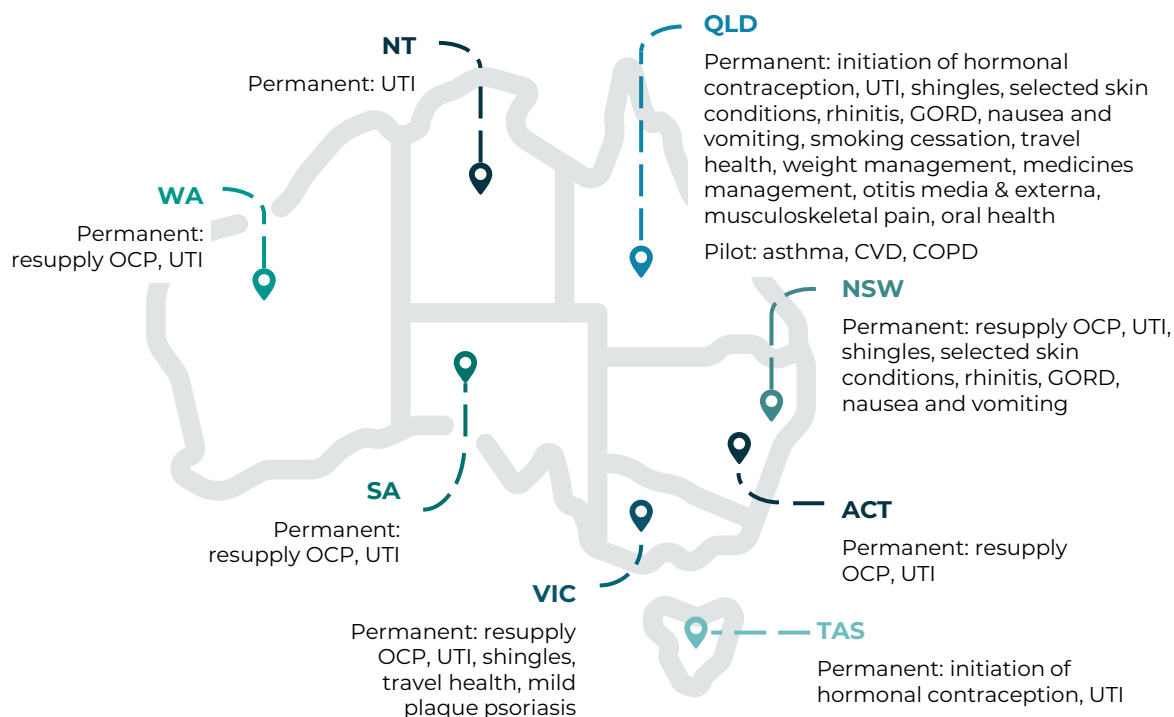
## KEY BENEFITS OF PHARMACIST PRESCRIBING

- Earlier initiation of treatment
- Easier access to medication reviews
- Improved medication adherence
- Reduced burden on GP workforce

This report uses four case studies of the potential benefits of pharmacist prescribing in Australia: asthma, COPD, cardiovascular risk assessment, and hormonal contraception. These case studies were chosen to demonstrate the broad financial benefits associated with the expansion of pharmacist prescribing for a broad range of conditions.

Given the strength of international evidence and the urgency of domestic workforce constraints, it is timely to move beyond pilot activity and progress to nationally consistent implementation of endorsed pharmacist autonomous prescribing.

## Permanent and pilot pharmacist prescribing programs in Australia



## METHODS

Impact models were developed for each of the four case studies to assess the direct and indirect savings resulting from pharmacist prescribing. These models analysed impacts of pharmacist prescribing over a 1-year time horizon for 2025. Costs sourced from the literature were inflated to 2025 dollars using ABS CPI index.

DATA SOURCE	INPUT
MBS online	Cost of Medicare-funded services
IHACPA	Cost and utilisation of hospital and emergency department services
ABS	Employment and income data
AIHW	Population data
Literature	Population-specific estimates of effect

The approach used in this analysis relies on published sources for each of the included costs, prevalence and utilisation, rather than primary data collection and analysis. As such, results are limited by the availability and quality of the underlying data. The modelling also assumed sufficient trained

pharmacist prescriber capacity to meet projected demand. Savings accounted for in the modelling include:

### DIRECT SAVINGS

- Avoided GP visits
- Avoided hospitalisations and ED visits
- Avoided specialist appointments

### INDIRECT SAVINGS

- Productivity benefits from reduced absenteeism

### WELLBEING BENEFITS

- Improved quality of life


## RESULTS

Enabling pharmacist prescribing for cardiovascular risk reduction would shift routine prescription renewals and stable hypertension reviews from general practice to community pharmacy. Pharmacist care is estimated to avoid approximately **6.1 million GP appointments** annually, freeing substantial primary care capacity while maintaining safe, collaborative management.

 The government savings of avoided GP appointments amount to **\$268.8 million.**

 The out-of-pocket savings of avoided GP appointments amount to **\$88.6 million.**

Reducing the number of GP appointments required for prescription renewal and management of stable patients would allow GPs to **dedicate more time to patients with complex disease and multimorbidity**, supporting more efficient use of a constrained primary care workforce. This benefit is valued as the opportunity cost of GP time reallocated for higher-complexity care. However, this likely represents a conservative estimate, as it does not fully capture the additional clinical and economic value generated when GPs focus on complex comorbidities and both clinicians operate at full scope across the primary care system.

 The value associated with increased time for complex cases amounts to **\$8.9 million.**


When pharmacists can prescribe for cardiovascular risk reduction, patients have easier access to timely risk assessment and medication optimisation, leading to reduced cardiovascular events and an estimated reduction of approximately **530 hospitalisations** annually, with associated healthcare cost savings. [38, 41, 42]

 The savings associated with avoided hospitalisations amount to **\$7.6 million.**

Earlier, protocol-driven cardiovascular risk management delivered through community pharmacy can reduce the incidence of cardiac and cerebrovascular events requiring emergency treatment. [38, 41, 42] This approach is estimated to prevent approximately **300 CVD-related ED presentations** annually, generating associated healthcare savings.

 The savings associated with avoided ED presentations amount to **\$0.5 million.**

Shifting routine cardiovascular medication reviews from general practice to community pharmacy reduces the need for patients to take time off work for GP appointments. Fewer consultations translate into meaningful productivity gains and substantial annual savings through reduced workforce absenteeism.

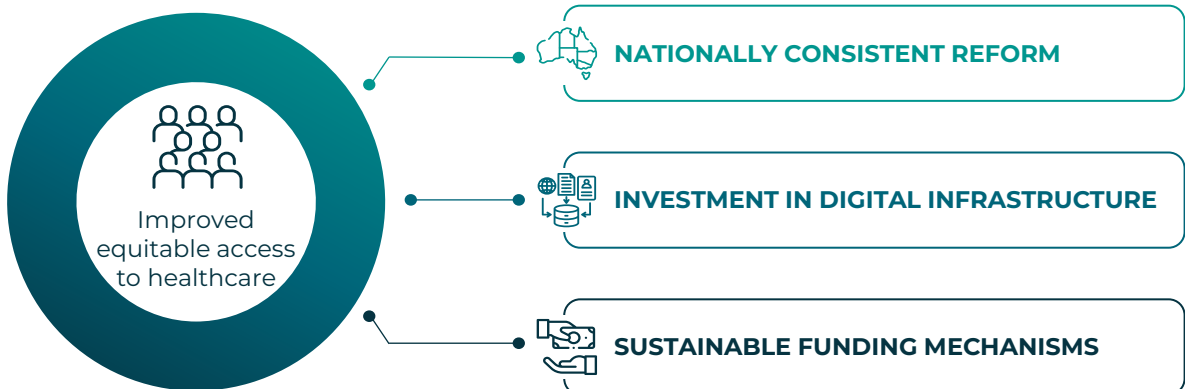
 The savings associated with increased productivity amount to **\$252.8 million.**

Improved cardiovascular risk control through pharmacist prescribing is associated with incremental gains in health-related quality of life, reflecting better blood pressure management, and optimisation of preventive therapy. [44] When applied across the eligible CVD population and valued using standard QALY thresholds, these improvements translate into substantial societal wellbeing benefits.

 The savings associated with increased wellbeing amount to **\$1.50 billion.**

## RECOMMENDATIONS

Pharmacist prescribing represents a significant opportunity to unlock additional capacity within Australia's primary care system, improve timely access to care and deliver substantial health and economic benefits. Based on the findings of this report, a nationally consistent implementation of pharmacist prescribing within a 'self defined' scope of practice should be prioritised. Realising this will require coordinated leadership and consensus across governments, health system stakeholders, and the pharmacy and medical professions.



### Recommendation 1: Implement nationally consistent regulatory reform

Commonwealth, State and Territory governments should implement regulatory changes enabling autonomous prescribing by endorsed pharmacists within 'self defined' scopes of practice. A coordinated framework would reduce jurisdictional fragmentation, provide regulatory clarity and transition Australia beyond pilot programs toward sustainable system reform. International experience provides a clear paradigm. The UK's independent non-medical prescribing framework demonstrates the value of a universal competency standard, with the Prescribing Competency Framework guiding regulators and education providers. [45] To enable genuine autonomy, reform should also include amendments to medicines and controlled drug legislation. Similarly to the UK, permitting pharmacists to prescribe Schedule 2-8 medicines, supported by real-time monitoring for Schedule 8 within their competence reduces care bottlenecks and supports comprehensive treatment within a single consultation. [46, 47] A nationally aligned, competency-based, legislatively enabled model would embed pharmacist prescribing as a collaborative component of Australia's primary care system. This should

be underpinned by investment in accredited prescribing education and workforce development to build capability at scale.

### Recommendation 2: Embed prescribing within collaborative digital infrastructure

Effective pharmacist prescribing requires dynamic digital systems that enable real-time communication with GPs and broader collaborative healthcare. Investment in shared electronic health records, secure messaging and integrated prescribing software is essential to support continuity of care, medication safety and transparent clinical documentation. The Queensland pharmacist prescribing pilot requires prescribers to access and interpret relevant patient records before issuing a prescription, demonstrating an operational model for national implementation. [48]

To avoid information silos, digital systems should support sharing of clinical notes and prescribing decisions, include decision-support tools, provide access to national formularies and funding schedules, and maintain privacy safeguards. Consultation records should also be uploaded as My Health Record event summaries to support continuity of care. [48]

### Recommendation 3: Establish sustainable funding mechanisms

Funding reform is essential to enable pharmacist consultation services and is critical to achieving system-wide access to medicines. Targeted changes to funding settings would align incentives to support high-value, collaborative models of care:

- **Establish remuneration for pharmacist prescribing consultations:** Nurse practitioners are able to bill dedicated MBS attendance items and can hold a Medicare provider number, demonstrating an established funding mechanism for non-medical prescriber consultations in primary care. [49] Extending a comparable mechanism through the Pharmacy Programs Administrator to authorised pharmacist prescribers would embed sustainability and equity of access.
- **Secure PBS funding for medicines prescribed within scope:** Under the PBS,

authorised nurse practitioners and endorsed midwives may prescribe subsidised medicines, with prescribing limited by scope of practice and state/territory prescribing rights. A comparable framework could be applied to authorised pharmacist prescribers. [50] This would, for example, mean that women could access contraceptive at a price of \$25 compared to paying up to \$107 privately.

- **Align funding incentives to support collaborative healthcare:** Existing PBS and MBS arrangements already recognise non-medical prescribers working in shared-care models (for example, PBS criteria that permit nurse practitioners or optometrists to share care of a patient with a medical practitioner for some medicines), illustrating how funding rules can encourage collaborative rather than fragmented care. [50]

## CONCLUSION

Together, nationally aligned regulatory reform, integrated digital infrastructure, and sustainable funding models provide the foundation for embedding pharmacist prescribing within Australia's primary care system. Continuing education and capacity building for pharmacists is essential to realising the projected benefits. Implemented cohesively, these reforms would relieve pressure on general practice and deliver important equity gains.

Expansion of pharmacist prescribing has significant implications for geographic and socioeconomic access. Pharmacies are more geographically accessible than GP services across all of Australia, with 92% of Australians living within 2.5km (urban) or 5km (regional) of a pharmacy, compared with 87% for GP services. A similar gap is experienced in regional areas (83% versus 81%). [51] Given the higher burden of chronic disease in lower socioeconomic and regional communities, pharmacist prescribing offers a practical mechanism to reduce

underservicing due to long waitlists, geographic barriers, improve timely access to care, and lessen travel burden in areas where healthcare access is more limited. [52]

International evidence demonstrates that pharmacist prescribing delivers at least equivalent and often improved clinical outcomes across a range of conditions. [47, 53-55] In the context of ongoing GP workforce pressures, [2] Australia is well-positioned to build on existing evidence and progress toward implementation. A coordinated reform agenda encompassing regulation, digital integration and funding will allow Australia to fully realise the health, economic, and wellbeing benefits of pharmacist prescribing while ensuring that GPs remain central to the coordination and oversight of patient care. Pharmacists are well placed to play a complementary role in improving access and efficiency within a clearly defined and collaborative model of care.

## REFERENCES

- AIHW. Multimorbidity in Australia. 2025.
- Australian Government Department of Health and Aged Care. Supply and Demand Study: General Practitioners in Australia Canberra, Australia; 2024 August 2024.
- RACGP. General Practice Health of the Nation. 2025.
- Australian Healthcare Index. Australian Healthcare Index September 2025, Patients Australia; September 2025 September 2025.
- Mesbahi Z, Piquer-Martinez C, Benrimoj SI, Martinez-Martinez F, Amador-Fernandez N, Zarzuelo MJ, et al. Pharmacists as independent prescribers in community pharmacy: A scoping review. *Research in Social and Administrative Pharmacy*. 2025;21(3):142–53.
- Brennan B, Strawbridge J, Stewart D, Cadogan C, Eustace-Cook J, Lowrey M, et al. An umbrella review of pharmacist prescribing: stakeholders' views and impact on patient outcomes. *International Journal of Pharmacy Practice*. 2024;32(Supplement\_1):i7–i1.
- Australian Government Department of Health and Aged Care. Getting your asthma under control using the skills of the community pharmacist – Final report. Canberra, Australia: Australian Government Department of Health and Aged Care; 2021.
- Joint Pharmacy Organisations. Joint Pharmacy Organisations' Paper for Endorsed Pharmacist Prescribers. 2025 October, 2025.
- AIHW. Chronic respiratory conditions: Asthma. Canberra, Australia: Australian Institute of Health and Welfare; 2025 20/02/2026.
- RACGP. Australian Asthma Handbook: National Asthma Council Australia.; 2025 [Available from: <https://www.racgp.org.au/clinical-resources/clinical-guidelines/guidelines-by-topic/view-all-guidelines-by-topic/chronic-disease/australian-asthma-handbook?>
- Queensland Health. Asthma prescribing protocol: Community pharmacy scope of practice. Brisbane, Australia; 2025.
- Davis SR, Ampon RD, Poulos LM, Lee T, Marks GB, Toelle BG, et al. Prevalence and burden of difficult-to-treat and severe asthma in Australia: A national population survey. *Respirology*. 2024;29(8):685–93.
- ABS. Income and work: Census 2021 Canberra, Australia: ABS; 2022 [Available from: <https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/income-and-work-census/latest-release>.
- ABS. Employee earnings Canberra, Australia: ABS; 2025 [Available from: <https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/employee-earnings/aug-2025>.
- Office of Impact Analysis. Value of a statistical life – Guidance note. Canberra, Australia; 2024.
- Bollmeier SG, Prosser TR. Community pharmacy-based asthma services: current perspectives and future directions. *Integrated Pharmacy Research and Practice*. 2014;49–70.
- Haywood P. Self-management education and regular practitioner review for adults with asthma. 2002.
- AIHW. Chronic obstructive pulmonary disease. AIHW, Australian Government; 2026.
- Queensland Health. COPD prescribing protocol: Community pharmacy scope of practice. 2025.
- Tommelein E, Mehuys E, Van Hees T, Adriaens E, Van Bortel L, Christiaens T, et al. Effectiveness of pharmaceutical care for patients with chronic obstructive pulmonary disease (PHARMACOP): a randomized controlled trial. *British Journal of Clinical Pharmacology*. 2014;77(5):756–66.
- Pharmaceutical Benefits Scheme. Background and terms of reference: COPD review. Canberra, Australia; 2017.
- Khan AJ, Gumber A, Richardson M, Nolan CMM, Man WD, Singh S, et al. Cost-effectiveness of a self-management maintenance programme following pulmonary rehabilitation: a UK randomised controlled trial for patients with chronic obstructive pulmonary disease. *BMJ Open Respir Res*. 2025;12(1).
- Soler-Cataluña JJ, Huerta A, Almagro P, González-Segura D, Cosío BG. Lack of clinical control in COPD patients depending on the target and the therapeutic option. *International Journal of Chronic Obstructive Pulmonary Disease*. 2023;1367–76.
- Bourbeau J, Julien M, Maltais F, Rouleau M, Beupré A, Bégin R, et al. Reduction of hospital utilization in patients with chronic obstructive pulmonary disease: a disease-specific self-management intervention. *Archives of internal medicine*. 2003;163(5):585–91.
- Stevenson TB, Rumbold A, Callander E, Buckingham P, Assifi A, Mazza D, et al. Online platforms for prescription and supply of hormonal contraception in Australia: a mapping review. *Sexual Health*. 2023;20(4):273–81.
- ABS. National, state and territory population — June 2025. Canberra, Australia; 2025.
- Organon Australia. Report on women's health, contraception and access in Australia. 2022.
- Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990&#x2013;2019. *The Lancet Global Health*. 2020;8(9):e1152–e61.
- Mazza D, Harrison C, Taft A, Brijnath B, Britt H, Hobbs M, et al. Current contraceptive management in Australian general practice: an analysis of BEACH data. *Med J Aust*. 2012;197(2):110–4.
- Australian Government Department of Health and Aged Care. Medicare Statistics: MBS item statistics - GP attendances (Item 23) by calendar year: Services Australia; 2025 [Available from: [https://medicarestatistics.humanservices.gov.au/SASStoredProcess/guest?\\_PROGRAM=SBIP%3A%2F%2FMETASE\\_RVER%2FShared+Data%2Fsasdata%2Fprod%2FVEA0032%2FSAS.StoredProcess%2Fstatistics%2Fmbs\\_item\\_stand\\_ard\\_report&DRILL=ag&group=23&VAR=services&STAT=count&RPT\\_FMT=by+state&PTYPE=calyear&START\\_DT=202501&END\\_DT=202512](https://medicarestatistics.humanservices.gov.au/SASStoredProcess/guest?_PROGRAM=SBIP%3A%2F%2FMETASE_RVER%2FShared+Data%2Fsasdata%2Fprod%2FVEA0032%2FSAS.StoredProcess%2Fstatistics%2Fmbs_item_stand_ard_report&DRILL=ag&group=23&VAR=services&STAT=count&RPT_FMT=by+state&PTYPE=calyear&START_DT=202501&END_DT=202512).
- Queensland Health. Hormonal contraception guideline: Community pharmacy scope of practice. 2025.
- Loxton D, Tooth L, Barnes I, Byrnes E, Cavenagh D, Chung H-F, et al. Reproductive health: contraception, conception and change of life-findings from the Australian Longitudinal Study on Women's Health. 2021.
- Rodriguez MI, Hersh A, Anderson LB, Hartung DM, Edelman AB. Association of Pharmacist Prescription of Hormonal Contraception With Unintended Pregnancies and Medicaid Costs. *Obstetrics & Gynecology*. 2019;133(6):1238–46.

34. Jean Hailes for Women's Health. Australian women's pregnancy intentions. Melbourne, Australia; 2026.
35. Goller JL, Bittleston H, Kong FYS, Bouchier L, Williams H, Malta S, et al. Sexual behaviour during COVID-19: a repeated cross-sectional survey in Victoria, Australia. *Sexual Health*. 2022;19(2):92–100.
36. ABS. National Health Survey 2022 Canberra, Australia: ABS; 2023 [Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/2022#cite-window1>].
37. Queensland Health. Cardiovascular risk reduction and hypertension prescribing protocol: Community pharmacy scope of practice. 2025.
38. Tsuyuki RT, Rader F. Pharmacist's Role in the Success of Blood Pressure Control Interventions: Evidence Isn't the Barrier.... *Circulation: Cardiovascular Quality and Outcomes*. 2024;17(8):e011175.
39. Gastens V, Tancredi S, Kiszio B, Del Giovane C, Tsuyuki RT, Paradis G, et al. Pharmacists delivering hypertension care services: a systematic review and meta-analysis of randomized controlled trials. *Front Cardiovasc Med*. 2025;12:1477729.
40. RACGP. 'Your lack of organisation doesn't constitute our emergency' – repeat prescription management in general practice. *Australian Journal of General Practice*. 2014;43:404–8.
41. Banks E, Crouch SR, Korda RJ, Stavreski B, Page K, Thurber KA, et al. Absolute risk of cardiovascular disease events, and blood pressure-and lipid-lowering therapy in Australia. *Medical Journal of Australia*. 2016;204(8):320–.
42. D'Agostino RB, Vasan RS, Pencina MJ, Wolf PA, Cobain M, Massaro JM, et al. General Cardiovascular Risk Profile for Use in Primary Care. *Circulation*. 2008;117(6):743–53.
43. AIHW. Heart, stroke and vascular disease: Australian facts. AIHW, Australian Government; 2025.
44. Tam-Tham H, Clement F, Hemmelgarn BR, Manns BJ, Klarenbach SW, Tonelli M, et al. A Cost Analysis and Cost-Utility Analysis of a Community Pharmacist-Led Intervention on Reducing Cardiovascular Risk: The Alberta Vascular Risk Reduction Community Pharmacy Project (REACH). *Value in Health*. 2019;22(10):1128–36.
45. Royal Pharmaceutical Society. A competency framework for all prescribers 2016 [Available from: <https://www.rpharms.com/resources/frameworks/prescribers-competency-framework>].
46. GOV.UK. Nurse and pharmacist independent prescribing: Mixing of medicines, possession authorities under patient group directions and personal exemption provisions for Schedule 4 Part II drugs (Circular 009/2012). In: Crime jal, editor.: GOV.UK; 2012.
47. Graham-Clarke E, Rushton A, Noblet T, Marriott J. Non-medical prescribing in the United Kingdom National Health Service: A systematic policy review. *PLoS One*. 2019;14(7):e0214630.
48. Queensland Health. Prescribing in community pharmacy: quality and safety management. Brisbane, Australia: Queensland Government; 2025.
49. Australian Government Department of Health and Aged Care. Medicare access for nurse practitioners: Australian Government; 2025 [Available from: <https://www.health.gov.au/topics/medicare/access-practitioners-industry/nurse-practitioners>].
50. Pharmaceutical Benefits Scheme. Review of PBS items for prescribing by nurse practitioners and endorsed midwives: Australian Government Department of Health, Disability and Ageing; 2026 [Available from: <https://www.pbs.gov.au/info/reviews/review-pbs-items-prescribing-nurse-practitioners-endorsed-midwives>].
51. Pharmacy Guild of Australia. Accessibility at Grade 1b Level. 2026.
52. Victoria University. Australia's health tracker: Chronic conditions by socioeconomic status. Melbourne, Australia: Institute for Health & Sport; 2024.
53. Royal Pharmaceutical Society. Pharmacist Independent Prescribers 2021 [Available from: <https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/pharmacist-independent-prescribers>].
54. Bhatia S, Simpson SH, Bungard T. Provincial Comparison of Pharmacist Prescribing in Canada Using Alberta's Model as the Reference Point. *Can J Hosp Pharm*. 2017;70(5):349–57.
55. Pharmacy Council of New Zealand. Pharmacist prescribing competency framework. 2021.



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