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Sector Analysis Report 2025

Quantifying the Economic & Social Value of Community Pharmacy

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The primary sources of information and data in this publication include responses from WPC member organisations to the WPC Sector Analysis Survey conducted in September and October 2025. Other references are cited.

NOTE: Unless otherwise stated, opinions and positions (direct or implied) expressed in this report are those of the editor and/or WPC, not of individual member organisations.

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The mission of the World Pharmacy Council is to promote international recognition of community pharmacy's role and value, securing its position as a fundamental pillar of person-centred, sustainable and resilient health systems.

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WPC member organisations have access to an extended, members-only version of this report.

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ABOUT THIS REPORT

This is the eighth annual World Pharmacy Council Sector Analysis Report. The report provides an overview of community pharmacy practice, regulation, trends, opportunities, research and statistics focused primarily on the twelve WPC member countries as at September 2025 – Australia, Belgium, Canada, Denmark, Germany, Ireland, Israel, New Zealand, Portugal, Spain, United Kingdom and United States of America. References to other OECD countries are also included.

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Currency conversion

Where figures in this report are converted to US Dollars, the conversion uses the average exchange rate for the 365 days ending 30 June 2025. The exchange rates used are listed in the table below. For reference and comparison, the exchange rates used in last year's report are also included in the table.

Country	Exchange rate to USD (as used for this report)	*Exchange rate to USD 2024 Sector Analysis Report*
Australia (AUD)	0.648	*0.656*
Belgium (EUR)	1.089	*1.082*
Canada (CAD)	0.717	*0.738*
Denmark (DKK)	0.146	*0.145*
Germany (EUR)	1.089	*1.082*
Ireland (EUR)	1.089	*1.082*
Israel (ILS)	0.274	*0.268*
New Zealand (NZD)	0.591	*0.607*
Portugal (EUR)	1.089	*1.082*
Spain (EUR)	1.089	*1.082*
United Kingdom (GBP)	1.294	*1.259*
United States of America (USD)	1.000	*1.000*

CHIEF ECONOMIST'S INTRODUCTION

Welcome to the World Pharmacy Council's **2025 Sector Analysis Report**. This report brings together data, research and updates relevant to community pharmacy's essential role in person-centred health systems around the world. It includes expanded datasets relating to community pharmacy operations in each WPC member country, as well as integrating OECD data from across all WPC-eligible countries - countries that share a similar level of economic development but often vary significantly their approaches to healthcare and community pharmacy.

This year's report continues to emphasise the importance of core funding and dispensing, which was the main theme of the **2024 Sector Analysis Report** and the subject of a new WPC position statement in 2025. Importantly, the OECD has recognised, in a landmark report, that "sustainability" - a word so often linked to lowering government spending and used as justification for policies that lead to funding cuts or stagnation - must also be applied to the funding of healthcare providers.

The feature section of this 2025 edition relates to the Economic & Social Value of Community Pharmacy. By quantifying the effect community pharmacies and community pharmacy services have on overall health system costs, health outcomes and economic productivity, the community pharmacy sector can ensure it is viewed not as as a cost centre but as critical healthcare infrastructure to secure and expand. The feature section highlights evidence generated through major studies in countries such as Portugal, Finland, the United Kingdom and Australia - each demonstrating, in monetary terms, the substantial positive effect that community pharmacies have (and can have) on health systems, budgets and the economy.

Economic value is only one part of the value picture. Documentation of **social value**, including through qualitative analysis, is equally critical for making the case for the importance of funding models that sustain a thriving community pharmacy network, and for illustrating the importance to patients of expanding pharmacy's role. Qualitative evidence captures pharmacies' unique accessibility, including in underserved areas, and their impact on health equity, their importance to local communities, and the public's trust, satisfaction and confidence in their services. This proves pharmacies' role as vital community hubs and complements the economic evidence for enabling, expanding and funding services like pharmacy-based vaccination, pharmacist prescribing, "Pharmacy First" schemes, point-of-care testing and more.

Viable, growing core funding - recognising the clinical importance of dispensing - forms the foundation for patient accessibility to medicines and effective pharmaceutical care through community pharmacies. With that secure base, further enablement and funding of a broad range of community pharmacy services and scope of practice - already reported in many countries - will ensure community pharmacy and pharmacists deliver their full potential value to economies and societies worldwide.

SECTION 1
Community Pharmacy Operation & Regulation

This section provides a very brief overview of community pharmacy in each WPC member country, to provide further context for the information and data in this report.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Australia

Pharmacist ownership

Large unregulated pricing segment

5-year national funding agreements

State-based scope of practice

Community pharmacies in Australia must be 100% owned by registered pharmacists. Almost all community pharmacies are approved through the federal government to dispense medicines subsidised under the national Pharmaceutical Benefits Scheme (PBS). Items dispensed under this scheme account for almost 90% of dispensing, although about one-third of the items dispensed are paid for entirely by the patient as the drug price is less than the applicable maximum co-payment, which results in a lower proportion of medicine subsidisation than for all WPC member countries except the USA and Canada.

There are two levels of co-payment for PBS prescriptions. The lower co-payment applies for people aged over 65, people with a disability, the unemployed, and war veterans. A higher co-payment applies for the rest of the population - this reduced for the first time from $42.50 to $30.00 in 2023 and is legislated to reduce to $25.00 in 2026. Many items are priced below this co-payment and their price is unregulated for this portion of the population.

In addition to prescription only medicines and controlled drugs, there are two other pharmacy medicines schedules limited to pharmacy-only sale: pharmacist-only medicines and pharmacy-only medicines.

Since 1990 there has been a series of five-year Community Pharmacy Agreements negotiated between the Australian Government and The Pharmacy Guild of Australia. These agreements include the rates of remuneration for dispensing PBS prescriptions. The most recent agreements, including the new **8th Community Pharmacy Agreement** (8CPA) that commenced on 1 July 2024, have provided funding for specific programs delivered through pharmacies. Some of these programs are specific to rural and remote pharmacies and indigenous populations.

Pharmacies also provide a range of other services outside of the 8CPA. Pharmacist scope of practice is determined and legislated at a state and territory level and **authorisation has been expanding strongly in many areas**. Pharmacists with additional training can now assess, manage and treat (prescribe) for a range of acute and common conditions, although there remains considerable variability in authorised scope across the states and territories.

Recently, pharmacies have been included as a **provider of funded vaccinations under the national scheme**, allowing eligible patients to access free National Immunisation Program (NIP) vaccines in a community pharmacy, with no out-of-pocket costs.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Belgium

Regulated system with compulsory health insurance

Moratorium on new pharmacies

Progress toward expanded roles and sustainability

Belgium's health-care system is built around a compulsory **public health-insurance** scheme that guarantees universal coverage for all residents. Under this scheme the majority of health-care costs, including the cost of medicines, are settled by the insurer on a third-party basis; patients are required only to pay a modest co-payment at the point of dispense. This financing model is complemented by strict controls on the distribution of pharmaceuticals: medicines for human use may be dispensed exclusively by licensed community pharmacies.

Belgium has a legally regulated system for pharmacy distribution. A **moratorium** is in place that freezes the number of pharmacies that can be opened, ensuring controlled growth. The law sets a maximum number of pharmacies per municipality based on population size. The current ratio is approximately 1 pharmacy per 2,500 inhabitants, with a gradual evolution toward the European average of 1 per 4,000 inhabitants.

An estimated 500,000 patients enter a pharmacy each day, out of a population of 11.7 million.

Priorities for the Association of Pharmacists Belgium (APB) include progressively **"rethinking and reworking" the remuneration model** for community pharmacies to ensure it is future-proof, sustainable, and aligned with evolving healthcare demands. This shift aims to better reflect the expanding role of pharmacists while securing the economic viability of their practices.

Another key focus is anchoring and expanding vaccination services, empowering pharmacists to administer a broader range of vaccines - such as HPV, tetanus, travel vaccinations, RSV, and shingles - to improve public health access and convenience. Additionally, the APB is committed to establishing high-value patient services, including early detection of chronic diseases and point-of-care testing, which not only enhance care but also strengthen the financial sustainability of community pharmacies. These initiatives highlight the APB's dedication to innovation, patient-centered care, and the profession's long-term resilience.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Canada

Mix of public and private plans

Move to national pharmacare

Broad scope of practice, but variable by province

Canada's healthcare system, known as Medicare, ensures universal access to medically necessary services, funded federally but administered by provinces. Prescription drug coverage is not universally included, resulting in a mix of public and private drug plans. However the Canadian government has committed to providing Canadians with **national Pharmacare**, which has begun to be rolled out, with the first phase limited to diabetes medication and contraception.

Canada's 12,000 pharmacies serve as vital community health hubs in virtually every community across the country. Community pharmacies play a vital role in the Canadian healthcare landscape, with pharmacists providing not only medication dispensing but increasingly offering clinical services. Patients trust pharmacists when it comes to health and wellness needs and there is overwhelming public support for community pharmacy services.

Provinces govern pharmacy practice, expanding pharmacists' scope to include administering vaccines, conducting medication reviews, and managing minor ailments. Many provinces have granted pharmacists the authority to prescribe and administer certain medications. However, the scope of these activities and their funding arrangements vary significantly across the country.

The Neighbourhood Pharmacies Association of Canada, in partnership with other stakeholders, continues to prioritize the positioning of pharmacies as destinations for primary care and public health – by advocating for increased scope; reducing regulatory red tape to enable professionals to work to full scope; advancing pharmacy role in immunization, chronic disease management, and minor ailment treatment.

Across Canada, 2025 has been a major year for advancing pharmacist scope of practice. Details are provided in the Pharmacy Services & Scope of Practice section of this report.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Denmark

Pharmacist ownership

Regulated location, prices & profit

Highly qualified technicians

Significant current structural and economic reforms

The Danish Medicines Agency has the overall responsibility for the legislation that pharmacies must comply with, and their economic framework. Pharmacies in Denmark are owned and operated by pharmacists granted a licence by the Danish Medicines Agency to run a pharmacy at a specific location. Pharmacies in Denmark have exclusive right to sell prescription-only medicines to consumers, and in addition there are many over-the-counter (OTC) drugs that only pharmacies are allowed to sell. Separately there is a non-pharmacy only OTC medicines category, which is also sold in retail outlets authorised by the Danish Medicines Agency.

Pharmacies must annually report their pharmacy financial accounts to the Danish Medicines Agency. Pharmacies in Denmark must pay a number of fees to the agency. In return, the pharmacies are compensated for the services they offer. Special rules apply to pharmacies' profit margins on the sale of medicines in order to make sure the same prices are charged at the customer's pharmacy of choice. These rules apply a dispensing fee and mark-up on the purchase price. The purchase price from manufacturers is set every two weeks via a tender system. Reimbursement for patients is only for the cheapest of interchangeable medicines, and all patients are offered a generic if available.

Regulations which took effect in July 2015 liberalised how close pharmacies can be located to one another. This has led to an increase of more than 50% in the number of pharmacies in Denmark. Prescription medicines can be delivered by carrier or mail order by all pharmacies. The population to pharmacy ratio in Denmark remains relatively high, at about 11,000 people per pharmacy, including branches. Pharmacies on average have about 13 employees (pharmacists and technicians).

Qualified pharmacy technicians in Denmark have undertaken a three-year tertiary degree, compared with the five-year tertiary degree completed by pharmacists. They can dispense and work as pharmacy managers but cannot own a pharmacy.

There is currently a major reform underway in the Danish healthcare system, where the regions will play a more central role. A key objective for the Denmark association in this reform is to position Danish pharmacies centrally within the future Danish healthcare sector.

In addition to the aforementioned healthcare reform, which encompasses the entire healthcare sector, a reform of the pharmacies' economic system has been implemented. This reform presents several challenges for pharmacies: not only is the sector as a whole underfunded due to the many new pharmacy units established over the past decade - without adequate funding to support them - but the reform also involves significant internal redistribution, which disadvantages smaller pharmacies.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Germany

Statutory health insurance

Pharmacist ownership with strict limits, numbers falling

Prescription drugs same price in every pharmacy

Almost 90 percent of the German population is insured in a statutory health insurance (SHI) fund, with membership compulsory for most workers.

The owner of a community pharmacy in Germany must be a pharmacist. A pharmacist may own one main pharmacy and up to three subsidiaries. Three requirements apply to the establishment of subsidiaries: (1) the pharmacist owner manages the main pharmacy; (2) the pharmacist owner employs a responsible pharmacist in each of the subsidiaries; and (3) all subsidiaries must be located within the same or a neighbouring district. At the end of 2024 there were 12,530 pharmacy owners in charge of 17,041 business locations.

The number of pharmacies in Germany has decreased each year from 2009 to 2024. In 2024 there were 578 closures and only 48 openings.

Several instruments of consumer protection are applied in Germany. All prescription drugs have the same price in every pharmacy across the country. Germany's Drug Price Regulation defines the price components of all prescription drugs – from the manufacturer via the wholesaler to the pharmacy. The main purpose is that a prescription drug is dispensed at the same price in every pharmacy in Germany to ensure that people have easy access to pharmacy-services wherever they live, day and night.

Generics substitution is mandatory, and Germany introduced biosimilar pharmacy substitution starting March 15, 2024, making it one of the first countries to implement such a policy. It currently applies to only a small set of parenteral biosimilars - primarily low-molecular-weight heparins such as enoxaparin.

Over-the-counter (OTC) drugs may only be sold by a licensed pharmacy. Mail-order sales of prescription and non-prescription medications have been permitted in Germany since 2004. The market share of the mail-order trade is around 22% for non-prescription medicines, but is much lower for prescription drugs covered by SHI funds. Since 2020, mail order pharmacies have been prohibited from offering discounts on prescription drugs to SHI-insured patients

Since 2022, new pharmaceutical services have enabled pharmacies to offer patients free, comprehensive, personalised consultations – independent of individual prescriptions. At present, community pharmacies can provide their patients with five different low-threshold services aimed at promoting health.

In October 2025, a **draft bill of reforms to the pharmacy law** has been released in Germany. While there is an intention to increase the breadth of pharmacy services, **it does not address crucial concerns around stagnation of dispensing remuneration**.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Ireland

Landmark new Community Pharmacy Agreement 2025

Multitude of national public drug schemes

Large range of unfunded services

The Community Pharmacy Agreement 2025 was agreed between the Irish Pharmacy Union, Department of Health and the Health Service Executive and published on 18 September 2025. It introduces a **structured framework for integrating pharmacies more deeply into national health priorities, including by expanding services, reducing administrative burden and implementing digitalisation**. A key focus for the Irish Pharmacy Union over the next year will be to implement this agreement.

Although pharmacies in Ireland received their **first increase in dispensing fees in 17 years** as part of the Community Pharmacy Agreement, further increases are required to achieve sustainable remuneration for pharmacies.

Key enhancements from the Community Pharmacy Agreement 2025 include:

- the rollout of a Common Conditions Service, enabling pharmacists to treat and prescribe for conditions such as thrush, impetigo and shingles
- expanded roles in vaccination programmes
- the ability of pharmacists to extend prescriptions for hormonal contraception
- patient registration as part of the BowelScreen screening programme.

The Irish government operates several different schemes related to medicines. Under the Medical Card Scheme, there is a Prescription Levy of €1.50 (USD $1.74) per item on medicines, with a cap of €15.00 (USD $17.40) per month. The Drugs Payment Scheme (DPS) allows individuals and families who do not hold medical cards to limit the amount they have to spend on prescribed drugs. Under the DPS, no individual or family has to pay more than €80 (USD $93) in any calendar month for approved prescribed drugs, medicines and appliances.

There are also several other schemes for certain drugs of population sub-groups – including an income-tested Over 70s Scheme, a High-Tech Scheme and a Long Term Illness (LTI) Scheme. The multitude of schemes creates considerable complexity for pharmacy operations.

The Irish State has saved more than €7 billion ($8.1b USD) from reduced medicine reimbursements and pharmacy fee remuneration since 2009, including over €1 billion directly from cuts to community pharmacists' fees and markups.

Pharmacy ownership is not regulated in Ireland. 75% of pharmacies are pharmacist-owned.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Israel

Hybrid public-private pharmacy system

Structural challenges

National health insurance

Clinical services emerging

Israel's community pharmacy sector comprised 2,120 establishments. These are categorized into 650 privately owned pharmacies (90% of which are pharmacist-owned), 560 pharmacy chains, and 910 pharmacies owned and operated by the four national health maintenance organizations (HMOs).

The National Health Law obliges every health-service provider (the four HMOs) to guarantee that each insured individual can reach a pharmacy at a “reasonable distance.” However, structural challenges have resulted in an oversupply of pharmacies in certain areas, as health service providers are prohibited from serving individuals who are not insured through their organization. The private sector and pharmacy chains do not have these restrictions but are subject to agreements with the HMOs.

Patient interaction varies by pharmacy type. At HMO-affiliated pharmacies, insured patients present electronic prescriptions for seamless processing, direct billing, and automatic co-payment calculation. Private or chain pharmacies offer greater flexibility in location and hours, serving patients from other HMOs or the uninsured; these patients may pay out-of-pocket initially and seek later reimbursement.

Funding operates through Israel’s universal National Health Insurance (NHI) system. Most medicines involve modest co-payments (flat fees or percentages), though clinical services often waive these when HMO-covered. Out-of-network pharmacy use may be reimbursed via supplementary private insurance or direct patient claims.

While the full integration of clinical pharmacy services is still emerging, several key areas are developing:

- Pharmacist prescribing and prescription extensions under safety protocols.
- Point-of-care testing for conditions like glucose and cholesterol.
- Structured medication reviews with physician referrals.
- Pharmacist-administered vaccinations (e.g., for flu and COVID-19).

Although legal authorization exists, full implementation in the field of prescribing is expected to take several years. Pharmacists who have been certified through a dedicated course are authorized to perform two actions: (1) renew expired chronic prescriptions, subject to reviewing the patient’s medical file, and (2) dispense prescription medications from a closed list of formulations.

The regulation enabling these actions was approved only in February 2025. Moreover, private pharmacies have not yet been granted access to patients’ medical records due to various barriers, including privacy protection concerns and the need to develop a dedicated system for this purpose.

Community Pharmacy Operation and Regulation

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New Zealand

Majority pharmacist ownership required

Evergreen national contract, reviewed annually

Medicine co-payment reinstated in 2024, but still free for many

Pharmacies in New Zealand must be majority owned by a pharmacist or pharmacists. This pharmacist or these pharmacists must always have effective control of the company. Ownership is limited to five pharmacies for any individual pharmacist. The government has recently proposed removing all restrictions on ownership of community pharmacies as part of introducing a new Medical Products Bill.

Each of New Zealand's community pharmacies has entered into a contract for the provision of pharmacy services. Until June 2022 these contracts were with one of 20 District Health Boards however these have been disbanded and replaced by Te Whatu Ora – Health New Zealand.

The standard **Integrated Community Pharmacy Services Agreement** (ICPSA) came into effect on 1 October 2018 . The ICPSA is an evergreen contract. It covers service and quality requirements as well as payment and claiming terms. The ICPSA is an evergreen agreement, updated each year, and includes the remuneration for dispensing and professional advisory services, including a Long Term Conditions service focused on medication adherence as well as nationally consistent services, including the opioid substitution treatment service, aseptic service, sterile manufacturing, clozapine service, and influenza immunisation services.

Over the past 12 months there has been a clear trend toward pharmacist-led preventive care, vaccination, and condition management, backed by national standing orders and digital tools, and by decisions from the Medicine Classification Committee (MCC) that deliberately place more therapy initiation in community pharmacy. These changes are detailed in the section on **Pharmacy Services & Scope of Practice**.

NZ's $5.00 (USD $3.00) prescription medicines co-payment was abolished in 2023 by the previous government for all patients, however this charge has been reinstated following the election of a new government in 2024. Medicines are however still free for under 14s, over 65s and Community Service Card holders. The co-payment is however being waived entirely by some discount pharmacies. Pharmacies may charge for extra services such as delivering medicines or compliance packaging.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

Portugal

Regulated ownership and location

Range of mostly unfunded services

Advanced, centralised pharmacy systems

Progress in access to hospital medicines

Portugal has a mostly centralised system for both healthcare regulation and reimbursement, with the exception of the Azores and Madeira. Serviço Nacional de Saúde (SNS): This is the national health system, which provides universal coverage

In Portugal, all community pharmacies are privately owned and hold the exclusivity of supply for prescription medicines, however since 2005 the sale of other medicines has been allowed outside of community pharmacies. Prescriptions are electronic or QR-coded.

Approval is required to open a new pharmacy, based on criteria including a minimum local population (3,500 people) and distance to the nearest alternative pharmacy (500 metres). There are also mobile pharmaceutical posts, which can be approved when there is no pharmacy within 2 kilometers of the proposed location. Each pharmacy is allowed up to four mobile pharmaceutical posts.

Since 2007, the range of pharmaceutical services provided has been widened with the introduction of immunisation services, disease management campaigns, and home care support. Pharmacies provide programs for medication adherence, medicines reconciliation and dose administration aid, as well as education programmes on appropriate use of medical devices, and point of care testing.

While most of these services remain unfunded (requiring full payment by patients), the SNS now funds seasonal influenza, COVID-19 vaccination and the syringe exchange program.

Infarmed is the primary regulatory body for pharmacies in Portugal. It has a wide range of responsibilities, including: medication and medical device approval, licensing and inspection of pharmacies, distributors, and manufacturers.

The ANF administers the national pharmacy-claims platform and maintains a centralised stock-availability database. If a pharmacy is out of stock of a medication, a patient can call or go online to find a pharmacy that has it available.

In 2024 the Portuguese government completed the regulation of the new scheme for the dispensing of hospital medicines in community pharmacies, which benefits around 150,000 patients who currently make frequent trips to hospitals to collect medication. The new arrangements include remuneration for pharmacies.

Community Pharmacy Operation and Regulation

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Spain

New medicines regulation framework is pending

National scheme via autonomous regions

Pharmacist ownership

Regulated pricing

During 2025 Spain has been working towards an updated regulatory framework through the **Draft Bill on Medicines and Medical Devices**. The pharmacy sector is increasingly committed to public health and social cohesion, and a digitisation process that guarantees patients safe, equitable, and quality access to medicines and the provision of new pharmaceutical services that respond to patients needs.

All residents in Spain have access to the public Spanish healthcare system, although there is also the option of having private health insurance. There is a wide range of reimbursed medicines (in 2020 there were 21,703 medicines on the reimbursement list, inclusive of all forms and dosages), with a patient co-payment which is a percentage of the cost of prescription medicines. The percentage depends on income and whether the person is of working age or a state pensioner, and is also capped at 10% for chronic disease medicines. For pensioners there is a monthly cap on total co-payments. Schemes are handled by each of the 17 Spanish autonomous regions.

Spain has a relatively broad range of medicines available without a prescription, so pharmacies are a regular destination for minor ailments. The dispensing of prescription and non-prescription medicine is restricted to pharmacies only (OTC medicines cannot be sold in any other outlet).

Only individual pharmacists can own and run community pharmacies. Community pharmacies must be in possession of an authorisation granted by the appropriate authority in the autonomous region where the pharmacy is located, which is issued according to a quota system based on geographic location and population among other factors. Direct mailing, distance and online selling is prohibited for prescription-only medicines.

Many pharmacies offer certain health checks to patients, including cholesterol and blood pressure, as part of a set of services related to prevention and promotion of health.

Medicine prices are regulated. Discounts or any other offer on prescription only medicines or on medicines that can be advertised to the public are not allowed. Advertising to consumers is only allowed for medicines that (a) are not included in the public reimbursement system, (b) are not subject to medical prescription and (c) do not contain narcotic or psychotropic substances.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

United Kingdom

Separate funding frameworks under NHS in each country

Decreasing number of pharmacies

Pharmacy First services for common conditions

Community pharmacy is one of the four primary care contractor groups under the National Health Service (NHS) in England. Whilst the core role remains dispensing medicines, community pharmacies also provide other national services such as a New Medicine Service, hypertension case-finding, influenza vaccination, Pharmacy Contraception Service and the Pharmacy First service. Others that may be commissioned at local level include screening and prevention services.

NHS England commissions community pharmacy owners to provide NHS pharmaceutical services through a **Community Pharmacy Contractual Framework** (CPCF). The CPCF consists of nationally commissioned Essential Services (services that all pharmacies must provide), Advanced Services (national services that can be provided by all pharmacies once accreditation requirements are met) and Enhanced Services (commissioned locally by Integrated Care Boards or nationally by NHS England) to meet certain identified needs.

There are two regulated and registered professions:

- Pharmacists, who train for 4 years at Masters Degree level plus a 1 year foundation year;
- Pharmacy Technicians, who train for 2 years for a Level 3 Diploma.

Pharmacists are able to prescribe certain medicines if they undertake suitable postgraduate training. By 2026, all newly registered pharmacists will be independent prescribers.

Community pharmacy contractors to the NHS who own six or more pharmacies are known as ‘multiple contractors’ (also known as pharmacy chains). Those who own five or fewer pharmacies are known as ‘independents’. Some major supermarket chains in the UK operate pharmacy chains, although supermarket pharmacy numbers have reduced in number particularly with the closure of 237 branches within one supermarket chain.

Separate funding frameworks are in place in **Scotland**, **Wales** and **Northern Ireland**. As well as funding core services, a major component of the Scottish framework is the Pharmacy First Scotland service. This is designed to encourage everyone to visit their community pharmacy as the first port of call for all minor illnesses and specific common clinical conditions.

A new Pharmacy First service started in England in early 2024 following a commitment of additional funding for up to 12 million consultations per year across seven common health conditions.

Community Pharmacy Operation and Regulation

This section provides a very brief overview of community pharmacy in each country, to provide further context for the information and data in this report.

United States or America

50/50 government and private insurance

PBMs administer health plans and own pharmacies

Broad scope but varies between states.

About half of prescriptions dispensed in the USA are covered by one of two Government programs. Medicare Part D is for over 65s and younger people with disabilities, who do not have access to drug coverage through their employment-related benefits. Enrolment in Medicare Part D totals around 54 million people. The Medicaid program is funded through the states and provides coverage for low-income residents.

Most of the remaining prescriptions are covered by Prescription Drug Benefit insurance provided by the person's employer or union.

Pharmaceutical Benefit Managers (or PBMs) are third-party intermediary administrators of prescription drug programs for health plans, including employee health plans and Medicare Part D plans. The three largest PBMs are CVS Caremark, Express Scripts, and OptumRx, which cover more than half of all prescriptions filled in the USA annually. PBMs create many issues for pharmacies, consumers, and from a drug cost perspective. **There is growing recognition of, and action on, some of these issues.**

Authorisation of scope of practice for pharmacists is governed at a state level. There is broad commonality among states regarding a pharmacist's ability to deliver preventive services. The vast majority of states authorise pharmacists to perform preventive services, which include diabetes, cholesterol and blood pressure screening, smoking cessation, diet and obesity counselling and a range of immunizations.

As an example of the differences between states, many require a collaborative agreement with a physician, or a prescription, in order to allow a pharmacist to administer a vaccine, although many large states – such as California – allow pharmacists to independently prescribe and administer all vaccines, including for most children.

Physicians and certain non-physician health care professionals are reimbursed under Medicare Part B for providing necessary health care services. With only a few exceptions pharmacists' services are not reimbursed in this fashion, which limits their uptake.

Since the COVID-19 pandemic, **pharmacies have become the number one provider of immunization services in the USA**.

With the exception of North Dakota (majority pharmacist ownership) and Michigan (25% minimum pharmacist ownership), there are no pharmacy ownership restrictions in the USA. Overall, about 35% of pharmacies are independently pharmacist-owned.

CRITICAL ISSUE ANALYSIS

International implications of USA drug pricing & Most Favoured Nation policy

President Trump's Most Favoured Nation (MFN) policy aims to align the USA's costs with lower prices paid in other developed nations, and secure more onshore manufacturing. This initiative has the potential to severely disrupt international pharmaceutical pricing and affect policies and budgets globally.

What has been said and done so far?

The core of the MFN policy is to ensure that the USA does not pay more for prescription drugs than other economically comparable countries, arguing that historically, the USA has subsidised healthcare costs for foreign nations. Late in Trump's first term, an attempt to implement MFN pricing was blocked by courts. The current administration has revived and expanded its approach. The situation remains fluid,

- **Voluntary Agreements and "TrumpRx":** The administration is primarily advancing the MFN policy through voluntary agreements with major pharmaceutical manufacturers (using pressure of more adverse outcomes). These deals aim to lower drug prices, particularly for Medicaid patients, and facilitate sales through a new direct-to-consumer (DTC) platform, "TrumpRx.gov". This platform is slated for launch in early 2026. Pharmacies may act as partners to enable dispensing.
- **Tariffs as a Negotiation Tool:** A 100% tariff on branded and patented drugs came into effect on October 1, 2025, for companies not establishing USA manufacturing facilities. However, the White House immediately announced a temporary pause on this tariff to allow for negotiations with pharmaceutical companies and to finalize implementing documents. The threat of imposing tariffs on foreign-manufactured drugs has been a significant bargaining chip to encourage pharmaceutical companies to agree to MFN pricing and/or establish manufacturing operations within the USA. Companies including Eli Lilly, Novo Nordisk, Pfizer, and EMD Serono, have entered into voluntary MFN agreements with the administration. Companies that have signed MFN agreements have received multi-year exemptions from tariffs on their products. The threat of tariffs has also been used as leverage to push for higher prices for US-manufactured drugs in international markets.

International implications

Additionally to the measures referred in the adjoining section, an investigation under the USA's Trade Act is being prepared to scrutinize other nations' drug pricing practices, potentially leading to further tariffs and other forms of international pressure to achieve the goals of the MFN policy.

The Trump administration's actions, and the responses of the governments of other countries and multi-national pharmaceutical companies, are likely to increase spending on pharmaceuticals outside of the USA, as drug pricing and reimbursement policies are reevaluated. Pharmaceutical executives have indicated that the focus on "rebalancing and equalization of the cost and the risk" of medicines across developed countries. The broader impact on international pricing strategies and the financial burden on other countries' healthcare systems remains a significant concern at a time when new, high-priced drugs are dominating the growth trajectory for national and regional budgets.

Separation of drug budgets from pharmacy service budgets

Reductions to pharmacy service budgets, including funding for medicine dispensing, must not be considered a viable means of achieving budgetary equilibrium in the context of more expensive drug costs. In terms of budgetary decision making, drug costs should be considered separate from budgets for the pharmacy services that ensure the safe and effective use of those medicines (independent of price), including core funding for dispensing. Failure to do so would result in an erosion of the pharmacy infrastructure, diminishing patient access to medicines and other services, lowering health system resilience, and leading to suboptimal health outcomes. Through shifting costs to other primary care settings, and through increasing use of hospital emergency rooms, it would ultimately incur greater costs for patients and to health budgets.

SECTION 4
FEATURE SECTION
The Economic and Social Value of Community Pharmacy

The indispensable role of community pharmacy in strengthening health systems is increasingly evident. In recent years healthcare systems worldwide have grappled with a major pandemic, rising costs, workforce shortages, and widening health inequities. Through it all, community pharmacies have delivered uniquely accessible, cost-effective interventions and services that relieve pressure on hospitals, primary care, and public budgets. The challenges have not stopped with the passing of the COVID-19 pandemic. The pandemic years may have laid bare the fragilities of health systems, but the triple threat of increasing prevalence of chronic disease, ageing populations and large fiscal deficits create a new urgency to find sustainable, effective, long-term solutions.

By quantifying the effect community pharmacies and community pharmacy services have on overall health system costs, on health outcomes and on economic productivity, the community pharmacy sector can ensure it is viewed not as as a cost centre but as a solution to problems - a critical component of healthcare infrastructure, vital to secure and expand. **This feature section highlights evidence generated through major value studies in countries such as Finland, the United Kingdom and Portugal. Each have demonstrated, in monetary terms, the substantial positive effect that community pharmacies have (and can have) on health systems, budgets and the economy.**

Economic value is only one part of the value picture. Documentation of **social value**, including through qualitative analysis, is equally critical for making the case for the importance of funding models that sustain a thriving community pharmacy network, and for illustrating the importance to patients of expanding pharmacy's role. Qualitative evidence captures pharmacies' unique accessibility, including in underserved areas, and their impact on health equity, their importance to local communities, and the public's trust, satisfaction and confidence in their services.

In combination, quantitative and qualitative evidence proves pharmacies' role as vital community hubs and makes the case for enabling and funding services like pharmacy-based vaccination, pharmacist prescribing, "Pharmacy First" schemes, point-of-care testing and more.

SOCIO-ECONOMIC VALUE HIGHLIGHT

Literature Review, PICOSTEPS & counterfactual-based avoided cost model

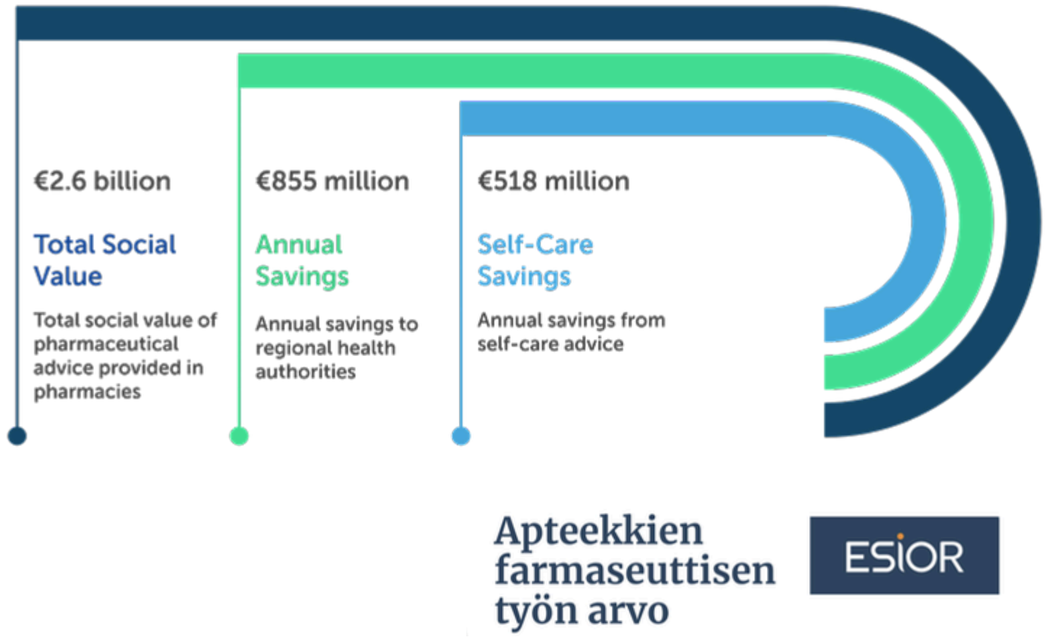
The value of pharmaceutical services in Finland

A 2024 study carried out by ESiOR in Finland found that the work of pharmacies reduces the use of Finnish public health services, saving well-being regions (health authorities) an estimated €855 million annually.

The economic value expanded to **€2.6 billion annually** when health benefits and work absence impacts were added, based on conservative valuations.

As shown on the previous page, this Finnish study applied the **PICOSTEPS framework**. The researchers employed a model that integrated multiple data sources including literature review, public and unpublished reports, and a spring 2024 physician survey.

The analysis focused on four pillars of pharmaceutical services: self-care advice, prescription medicine counseling, prescription error checking, and drug interaction screening. For each service area, the model calculated avoided healthcare resource utilization by comparing current practice against a counterfactual scenario where these pharmaceutical services wouldn't exist, using physician estimates of increased healthcare demand without pharmacy interventions. The researchers valued avoided public healthcare services from societal, wellbeing region, and customer perspectives. While the main analysis conservatively focused only on avoided public healthcare costs and basic health benefits, the researchers explicitly noted exclusions, such as travel costs, customer expenses, private healthcare impacts, and full valuation of health benefits from a patient perspective.



SOCIO-ECONOMIC VALUE HIGHLIGHT

Literature Review, PICO & Cost-Utility Analysis

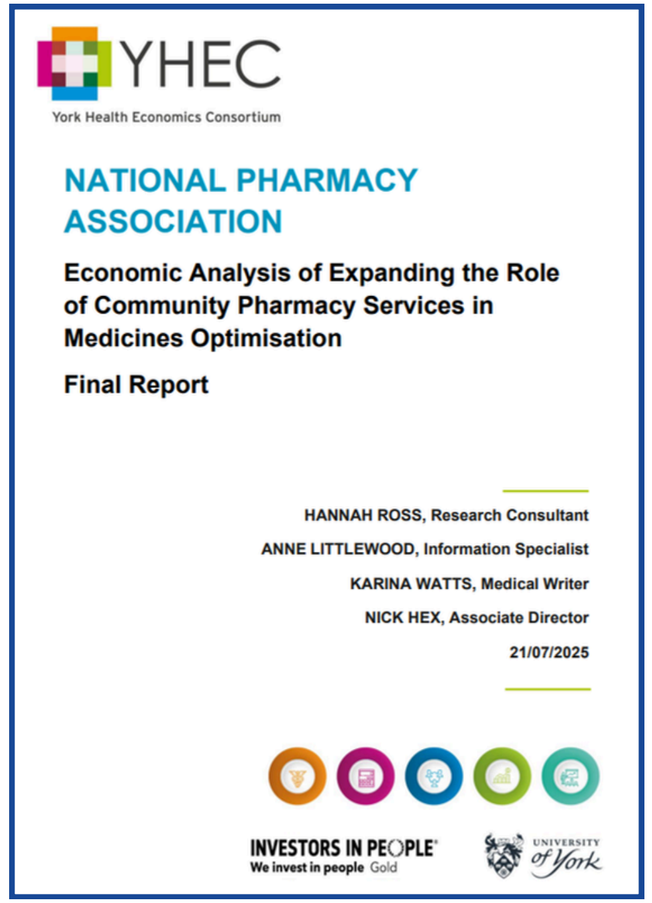
Economic benefits of expanded role in medicines optimisation

In a research report prepared for the National Pharmacy Association, the York Health Economics Consortium modelled a **potential £1.2 billion of savings and other benefits from expanding community pharmacies role in medicines optimisation – driving a further £2.7 billion in health outcomes for the NHS**.

Existing, funded interventions related to medicines optimisation in England are the **New Medicine Service** (NMS) and the **Discharge Medicines Service** (DMS). The report found substantial economic benefits could be achieved through expansion of both programs.

The researchers also examined and quantified the potential benefits of new initiatives including **personalised polypharmacy clinics** (£619 million net cost savings), **personalised asthma action plans** (up to £71.6 million cost savings) and **chronic obstructive pulmonary disease (COPD) education and advice** (£100 million cost savings and £146 million gains through Quality Adjusted Life Years).

Methods Used	Purpose & approach
Rapid, pragmatic literature review	To locate UK-based studies that reported cost, resource-use, or QALY data for pharmacy-led medicines-optimisation interventions.
Cost-Utility Analysis (CUA)	Combines the extracted cost and outcome parameters with national population data, unit cost sources, and inflation adjustments.
Incremental cost-effectiveness calculations	ΔCost, ΔQALY, ICER) for each existing and proposed service.
Scenario/sensitivity analyses	To explore the impact of alternative cost and effectiveness assumptions.


YHEC
York Health Economics Consortium

NATIONAL PHARMACY ASSOCIATION

Economic Analysis of Expanding the Role of Community Pharmacy Services in Medicines Optimisation

Final Report

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NICK HEX, Associate Director
21/07/2025

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SOCIO-ECONOMIC VALUE HIGHLIGHT

Literature review, effectiveness data, quality of life and health resource consumption

Social and economic value of Portuguese community pharmacies in health care

A 2017 published study estimated that current community pharmacies services in Portugal provide **a gain in Quality of Life (QoL) of 8.3% and an economic value of €879.6 million**, including €352.1 million in non-remunerated pharmaceutical services and €448.1 million in avoided expense with health resource consumption. Additionally, the researchers found that potential future community pharmacies services may provide an additional increase of 6.9% in QoL and be associated with an economic value of €144.8 million.

The social and economic value of community pharmacies services was estimated through a decision analytic model. Model inputs included effectiveness data, quality of life (QoL) and health resource consumption, obtained though literature review and adapted to Portuguese reality by an expert panel. The estimated economic value was the result of non-remunerated pharmaceutical services plus health resource consumption potentially avoided. Social and economic value of community pharmacies services derives from the comparison of two scenarios: "with service" versus "without service".

The model was designed to consider micro outcomes to evaluate the effectiveness of each service and macro outcomes, such as quality-adjusted life years (QALYs) and health resource consumption, to allow the assessment of the aggregated social and economic value of all the services.

Category	With Service	Without Service	Difference
Population Covered (n)	4,180,190	4,180,190	0
Estimated Pharmaceutical Services (n)	120,675,438	0	120,675,438
Time Spent in Services (hours)	11,087,135	0	11,087,135
Quality of Life	0.813	0.751	+0.062 (+8.3%)
Quality Adjusted Life Years	3,399,191	3,138,946	260,245
Health Resource Utilisation (n)	20,818,175	26,853,745	-6,035,571
Physician Visits (n)	17,881,598	23,872,706	-5,991,108
Economic Value: Total Cost (€)	**1,192.2 M€**	**2,071.9 M€**	**-879.6 M€**
Community Pharmacist Service (€)	-352.1 M€	0.0 €	-352.1 M€
Cost of Physician Visits (€)	1,198.4 M€	1,599.9 M€	-401.5 M€
Cost of Hospitalisations (€)	134.4 M€	179.4 M€	-45.0 M€
Medicines Waste Management (€)	14.9 M€	85.0 M€	-70.1 M€
Syringe Exchange (€)	-6.3 M€	-0.3 M€	-6.0 M€

Source: Félix et al. "Social and economic value of Portuguese community pharmacies in health care", BMC Health Services Research (2017) 17:606 DOI 10.1186/s12913-017-2525-4

SOCIO-ECONOMIC VALUE HIGHLIGHT

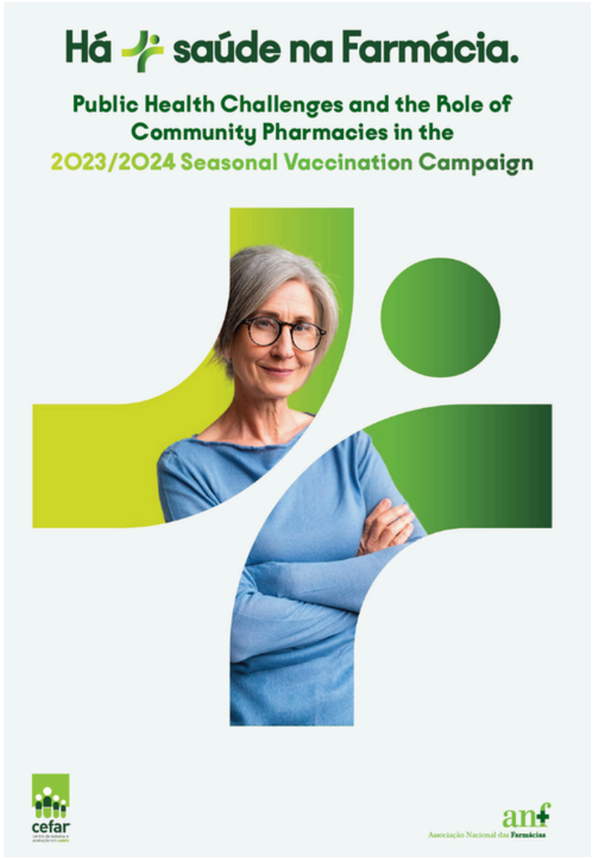
Patient survey with geospatial & economic analysis

Pharmacy-based vaccination saves money, time and medical resources

A study by Portugal's Center for Health Studies and Evaluation (CEFAR) for the National Association of Pharmacies (ANF) assessed the impact of the participation of community pharmacies in the 2023/24 seasonal vaccination campaign under the country's National Health Service. The extension of the 2023/24 seasonal vaccination campaign to community pharmacies increased the physical availability of vaccination points by over **400%** compared to 2022/23.

Key findings included:

- an estimated direct savings for users of around **€2.4 million in travel alone**, including public transport, cars and cabs, as the average distance to the nearest vaccination site reduced by half, to just 1.2km.
- a much higher percentage of people (around 55%) walked to the community pharmacy to get vaccinated this season compared to only 20% who walked in the 2022/2023 vaccination season.
- there were users who were eligible for flu vaccination who found it more difficult to travel to the health center due to its distance or opening hours, and who chose to go to the pharmacy, paying for the non-participated part of the vaccine and the vaccine administration service.
- pharmacies have **freed up around 310,000 working hours of human resources** in the National Health Service.



Methods Used	Purpose & approach
Telephone survey (CATI methodology)	Random sample of Portuguese population aged 60+. Two waves with same sample.
Geocoding & distance calculation	Calculation was based on geographic information sources relating to population density in Europe and the geographical delimitation of the territory at the municipality level for mainland Portugal.
Cost & resource saving calculations	Based on self-reported travel costs (part of survey) and average administration/co-administration time for vaccines: 10 minutes/12 minutes.

Qualitative data - public perceptions, patient satisfaction, stakeholder opinions & more

Quantitative economic analysis alone cannot reflect the full societal contribution of pharmacies, which includes patient trust, satisfaction, and the empowerment of person-centred care. Qualitative-focused surveys and participatory approaches (such as focus groups and semi-structured interviews) add depth, reveal mechanisms of effect, and give voice to key stakeholder groups to highlight the importance and potential of community pharmacies and the services they provide.

Satisfaction and confidence

Satisfaction rates typically exceed 90% in surveys across WPC countries, driven primarily by convenience, accessibility, and pharmacist professionalism. Community pharmacies are recognised as crucial for improving healthcare access, particularly in deprived areas, with public trust in pharmacists - and in their expertise - a central theme.

A 2023 **Ipsos survey** conducted for NHS England **highlighted positive public perceptions of community pharmacies, with high confidence and satisfaction levels among users**. Pharmacy users reported highly positive experiences, including being treated with respect (90%), successfully obtaining needed items (87%), and timely service (78%). A **YouGov survey in England**, published in May 2025, provided further validation, finding that community pharmacies were perceived as the most easily accessible healthcare service during winter 2024, compared to general practice, dentists, and hospital services..

Convenience & Access

A primary driver for the public's selection and use of community pharmacy services is often convenience. This focus on ease of access is so powerful that, in some cases (e.g., a **2014 UK study**), consumers who were eligible for a free influenza vaccine through their GPs demonstrated a willingness to pay for the pharmacy service due to its inherent convenience and ease of access.

In New Zealand (2023), 65.4% of vaccination service users cited convenience as their reason for choosing community pharmacy and over 90% of immunisation service respondents indicated they would like to see pharmacists administering other vaccines. In Canada (2024), 94.1% of respondents who received influenza vaccinations at pharmacies were satisfied, citing convenience, accessibility, and availability as key factors and in Northern Ireland over 95% of participants in a study were satisfied with the quality of service, professionalism of the pharmacist vaccinator, and caring nature of the pharmacy team.

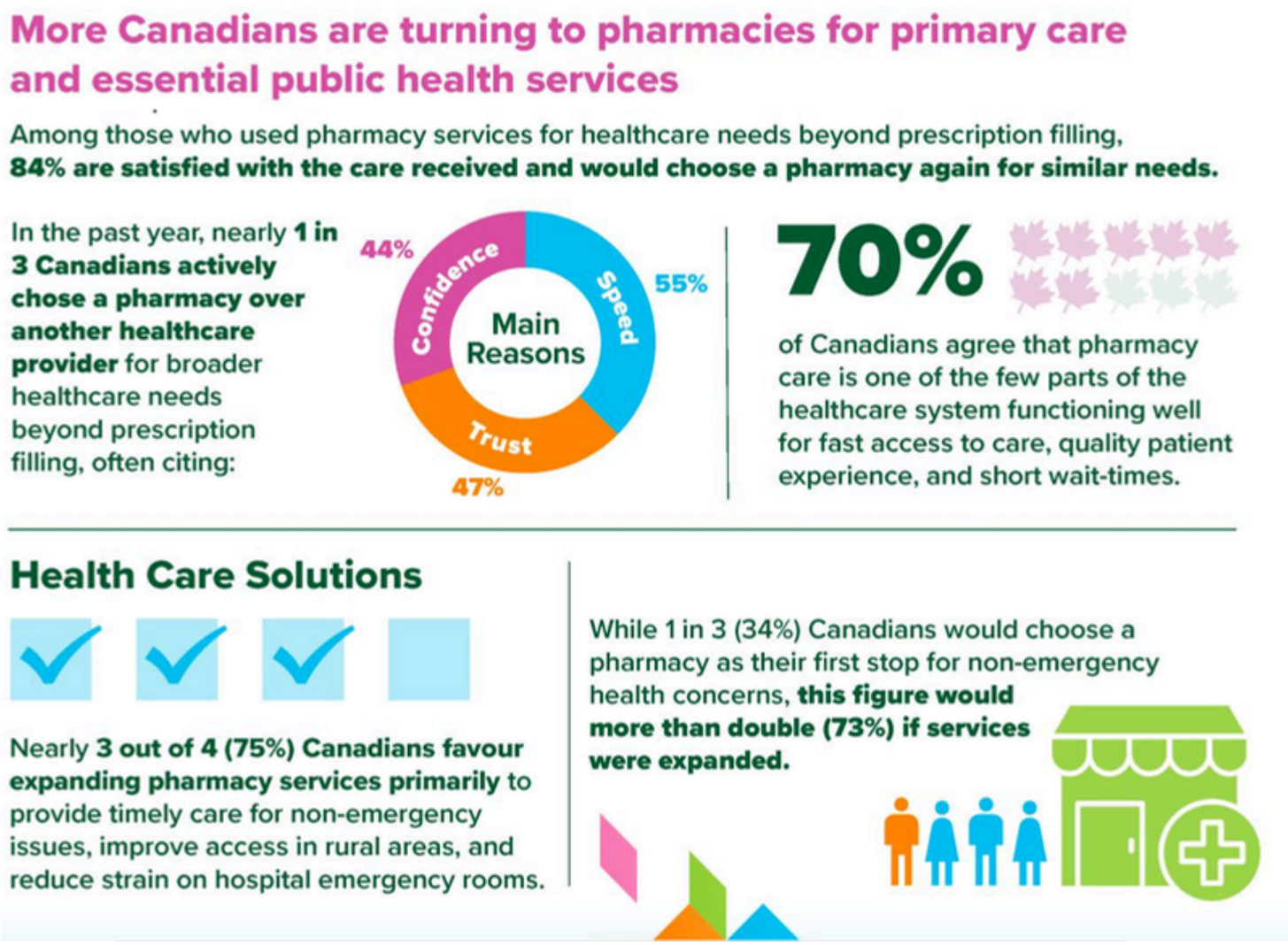
WPC MEMBER HIGHLIGHT

Overwhelming public support for community pharmacy services

In November 2025, national polling was published from the Neighbourhood Pharmacies Association of Canada and Abacus Data showing overwhelming support for an expanded role for pharmacies in primary care and public health. With long wait times, difficulty accessing providers, and growing pressure on the health system, Canadians see pharmacies as trusted, accessible health hubs ready to do more.

The national survey of 4,500 Canadians found:

- 60% of Canadians cite long wait times as a top health-care challenge
- Nearly 1 in 4 do not have a primary care provider
- 84% were satisfied with pharmacy care beyond prescriptions and would choose it again
- 75% support expanding pharmacy services to improve access and reduce ER strain



CRITICAL ISSUE ANALYSIS

Unpaid services & consultations

Community pharmacies are under constant pressure to deliver valuable services without compensation, posing challenges to their financial sustainability and contributing to workforce strain. Research in multiple WPC-member countries has shown very similar results despite different methods: each community pharmacy is providing large numbers of walk-in, informal services that fill gaps in primary care access but are largely unrecognised in formal funding models. The establishment of models such as Pharmacy First Scotland and Nova Scotia's pharmacy primary care clinics are beginning to change this in some locations, but much more needs to be done.

Community Pharmacy England's Pharmacy Advice Audit 2024

CPE conducts a recurring Pharmacy Advice Audit, to capture data about the number of times pharmacies provide ad hoc or informal consultations to patients on a range of health issues, without formal referral from any other part of the NHS, and without any direct remuneration. Based on a survey of almost 4,000 pharmacies, the **2024 report** found:

- More than **1.3 million unfunded consultations a week – 69 million a year** – are taking place in England's community pharmacies.
- Every week, pharmacies help over **922,000** patients who are presenting at the pharmacy for **clinical advice about symptoms** and about **260,000** patients who have questions about an **existing medical condition**.
- The average pharmacy completes **21.7 unpaid consultations per day**.
- **Nearly a quarter of a million** consultations are carried out in community pharmacy every week because patients are unable to access their preferred part of the healthcare system.
- **55%** of patients reported that if they did not have easy access to a pharmacy, they would have visited their GP. As such, CPE estimated that **pharmacy advice will save an incredible 38 million GP appointments over the course of the year**.
- **Over half a million** consultations a week occur in each community pharmacy for clinical advice alone, where no sale of a medicine is made.

Source: Community Pharmacy England
https://cpe.org.uk/quality-and-regulations/clinical-governance/clinical-audit/pharmacy-advice-audit/

New Zealand observation study: two unfunded services per hour

Research published in January 2023 by Yasmin H. Abdul Aziz, et al (University of Otago, New Zealand) investigating the provision, nature and associated costs of unfunded pharmacy services, found that a total of 660 observations of unfunded services were recorded across the 51 pharmacies where 360 observation hours were carried out - almost **two per hour**, which would extrapolate to a similar number to that recorded in the English survey, at **more than 100 per week per pharmacy**. Twenty-three types of unfunded services were identified, where **minor ailments** accounted for **over half** of the total observations.

Source: Investigating the provision, nature and associated costs of unfunded pharmacy services: A nationwide study

Portugal national data shows 96% of cases managed without referral

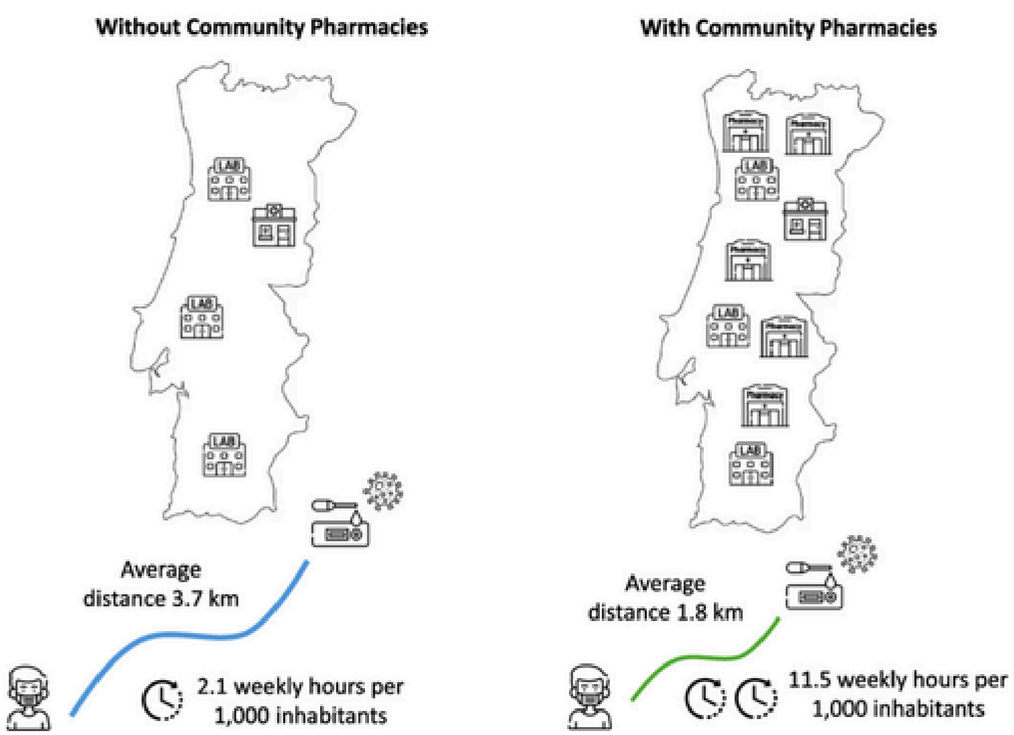
Community pharmacies in Portugal frequently provide unpaid advice and interventions related to assessment, counselling, and triage for common self-limiting conditions such as cold, cough, sore throat, musculoskeletal pain, and mild skin problems. A national data collection tool developed by the National Association of Pharmacies (ANF) recorded over **174,000 pharmacy interventions in 2024, across more than 1,700 pharmacies, with 96% of cases managed without referral to medical consultation**. These were performed free of charge, contributed to improved access to primary care and reduced pressure on health services.

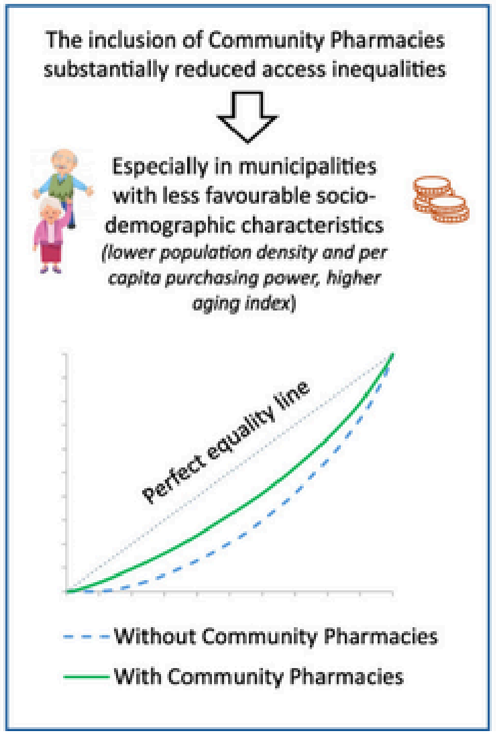
RESEARCH HIGHLIGHT

Community pharmacies greatly improves access to rapid antigen testing

Research published in 2025 demonstrates the significant positive impact of integrating community pharmacies into the Portuguese testing strategy for SARS-CoV-2. The inclusion of community pharmacies substantially increased testing capacity and accessibility while improving equity in testing access across different demographic groups. Notably, it led to a considerable reduction in the average distance to testing sites and a significant increase in weekly testing hours available per 1000 inhabitants. These findings underscore the importance of leveraging community pharmacies to enhance the efficiency, accessibility, and equity of national point-of-care testing services.

Evaluate the increase in the capacity of SARS-CoV-2 professional rapid antigen detection tests offered by the integration of Community Pharmacies into the Portuguese National Health Service and to compare the equity level in access to testing (by distance and available hours)





SECTION 5
Core Funding & Dispensing

Dispensing of prescription medicines is the core community pharmacy service and a vital pathway to a wider range of health services, contributing to comprehensive, personalized care and prevention. Dispensing is the cornerstone of pharmaceutical care, ensuring the safe and effective use of prescription medicines. It is not a simple transactional task but a complex, professional healthcare service integral to patient safety and health outcomes.

Through dispensing, pharmacists provide the public with access to a range of health interventions that improve health outcomes and health system efficiency. Each occasion of dispensing provides a trusted, professional opportunity to refer a patient to, or deliver, additional health services, enabling early interventions, disease detection, and the prevention of adverse health outcomes.

A robust, well-resourced, and well-distributed community pharmacy network is a strategic health asset. As demonstrated during the COVID-19 pandemic, pharmacies provide essential capacity, resilience, and accessibility. Investment in core pharmacy roles, starting with dispensing, is a direct investment in strengthening the entire healthcare infrastructure.

In many countries, core funding (including remuneration for dispensing) has not kept pace with rising operational costs, threatening the viability of pharmacies. Pharmacy closures, reduced opening hours, and discontinuation of services are harming access to essential healthcare, including in rural and underserved communities, thereby exacerbating health inequities. Pharmacists frequently provide the only accessible healthcare services in their communities, whether due to geographic isolation or extended operating hours. Sustainable funding is therefore critical not only to manage immediate challenges like medicine shortages but also to preserve this essential healthcare safety net for local communities.

WPC's Position Statement: Dispensing & Core Funding

The World Pharmacy Council this year published a new position statement on Dispensing & Core Funding.

Dispensing is a critical clinical service that ensures the safe, effective, and rational use of medicines in the community. Pharmacists play a vital professional role in patient engagement and clinical review, identifying medication-related issues and initiating interventions. Underfunding this core service compromises patient care, threatens the viability of local community pharmacies, and increases pressure on the entire healthcare system.

A robust, well-resourced, and well-distributed community pharmacy network is a strategic health asset. As demonstrated during the COVID-19 pandemic, pharmacies provide essential capacity, resilience, and accessibility. Investment in core pharmacy roles, starting with dispensing, is a direct investment in strengthening the entire healthcare infrastructure.

The economic and health consequences of underfunding are borne most heavily by those who can least afford them. The loss of accessible pharmacy services exacerbates health inequities for certain groups, including but not limited to:

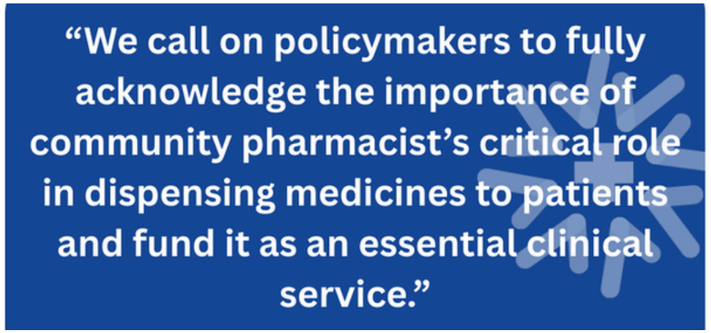
- *Rural and remote communities*: these areas are often the first to lose their only local pharmacy, forcing patients to travel long distances for care.
- *The elderly and mobility-impaired*: for these patients, a local pharmacy closure can mean the difference between maintaining independence and requiring more intensive care.
- *Lower socioeconomic populations*: research confirms that pharmacy closures are more likely in low-income communities, compounding existing health disparities (*Adepoju et al., PLoS One, 2023*).
- *Patients with chronic and complex conditions*: these individuals rely on the ongoing support and expertise of their pharmacist to manage their conditions effectively.

Read the Position Statement

Call to Action

Through the position statement the World Pharmacy Council calls on policymakers to:

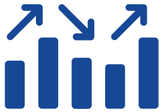
- Recognise prescription dispensing as a crucial clinical service.
- Invest in community pharmacy as a strategic public health asset to build more accessible, efficient, and resilient healthcare systems.
- Secure the future of patient care by ensuring community pharmacy funding models incorporate essential elements of viability, responsiveness, equity, separation, and efficiency (see next page).



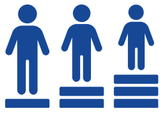
Essential elements of a core funding model

To ensure a viable and accessible community pharmacy network, core funding structures must include the following essential elements:

VIABILITY
Funding must recognize the physical infrastructure and clinical resourcing requirements of operating a pharmacy business - including fixed costs, professional time, and specialized expertise - as well as the need for a sustainable return on investment.



RESPONSIVENESS
Funding models must include automatic indexation for inflation, with safeguards to prevent erosion as a result of drug pricing mechanisms.



EQUITY
Funding structures must actively promote equitable patient access to pharmacies, regardless of geographic location or socioeconomic status, through mechanisms that support services in rural and underserved communities.

SEPARATION
Funding for dispensing must be distinct from other service funding, so that investment in new services is incentivized and all services are individually viable. Additionally, in budgetary decision making and reporting, drug costs should be disconnected from budgets for the services that ensure the safe and effective use of those medicines.

EFFICIENCY
Reimbursement and claiming systems must minimize administrative burden while maintaining accountability.

Funding models that fail to include one or more of these essential elements will inevitably undermine the patient care, threatening essential points of access to medicines, advice, counselling, personalised treatment information, and public health measures.

CRITICAL ISSUE ANALYSIS

Pharmacy closures are reducing patient access

When a local pharmacy closes, its patients are forced to find an alternative one that meets their health needs. Often, the first pharmacies to close are in the most deprived areas, which have greater need and fewer alternatives.

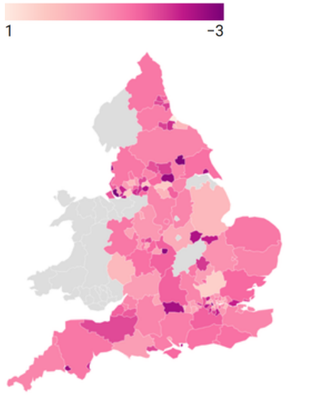
The number of community pharmacies in England has decreased for the seventh consecutive year. As of 30 September 2025 there were 10,402 pharmacies, 756 less than four years earlier.

Previous analysis in 2022 found that 41% of those permanent closures had taken place in the 20% most deprived parts of England, and new October 2025 analysis by the National Pharmacy Association (NPA) has shown that this worrying trend has continued.

Cllr Dr Wendy Taylor, Chair of the Local Government Association's Health and Wellbeing Committee, said: "These new findings are concerning and highlight a deepening challenge in access to vital healthcare services in the communities that need them the most. The disproportionate impact of pharmacy closures on more deprived areas risks widening already stark health inequalities."

Henry Gregg, chief executive of the NPA, added: "Those that have managed to keep their doors open have done so by going to extraordinary lengths and this is simply not sustainable. Community pharmacy is key to the success of the government's 10 Year Plan but it risks failing before it has even begun unless we see urgent uplifts to funding.

Change in pharmacy numbers per 100,000 population since October 2022



"We want to work with the government to deliver new clinical services to patients and take pressure away from the rest of the health system, but we cannot be expected to do this for free."

NPA release **BBC report**

Pharmacy closures in the USA have gained media attention due to large scale exits by large chains such as CVS, Walgreens and Rite Aid, which has now closed all of its stores having at one time had over 5,000 locations. However, research has shown that independent pharmacies were more at risk for closure than chain pharmacies in all neighborhoods and across market characteristics.

The same research found that the first neighbourhoods to lose their pharmacies have tended to be predominantly Black, Latinx and low-income. "According to our estimates, about one in four neighbourhoods are pharmacy deserts. **These closures are disproportionately affecting communities that need pharmacies most**", according to Dima Qato, an associate professor at the University of Southern California (USC) who studies pharmacy access and health equity. Studies have found **associations between pharmacy closures and reductions in patient utilization of prescription drugs** in the immediate period after a closure, for cardiovascular medications and anticonvulsants.

The NCPA, USC School of Pharmacy, and Leonard D. Schaeffer Center for Health Policy and Economics have established the Pharmacy Access Initiative. It will generate real-time information for national, state, and local policy officials, health care academics, industry leaders, and others to identify communities lacking in pharmacy access.

The number of pharmacies in Germany has declined every year since 2008. In 2024 there were 578 closures and only 48 openings. This net loss of 530 is the largest on record, sadly surpassing the previous worst of 497 set in the previous year.

President of the Federal Union of German Associations of Pharmacists (ABDA), Thomas Preis, commented in October 2025: "Pharmacy fees have been frozen for 13 years, and the decline in the number of pharmacies continues unabated – for years, pharmacies have been struggling financially." Speaking in response to the release of draft bills for a reform to the German pharmacy law, Mr Preis also said: "People could even benefit from the proposals contained in the draft for greater integration of pharmacies into primary care. However, these plans will also be rendered absurd if pharmacies are crippled by budget cuts. Only economically stable pharmacies and a comprehensive pharmacy network can adequately handle these additional tasks."

OECD: Fiscal Sustainability of Health Systems (2024)

THE OECD REPORT'S KEY MESSAGES FOR FINANCERS OF HEALTH

MORE FUNDING, AS WELL AS REDESIGN, IS NEEDED TO MAKE HEALTH SYSTEMS MORE EFFECTIVE AND LESS FRAGILE	"Funding more resilient health systems requires finance and health authorities to find common solutions that combine raising additional funds with efforts to free up current resources… Strengthening health system resilience protects economies from destabilising health shocks, as well as protecting people from ill health and premature death."
GREATER USE OF PHARMACY IS PART OF THE SOLUTION	"laws and regulations that extend the scope of practice for non-physicians (such as nurses and pharmacists) can produce cost savings with no adverse effects on quality of care"
INFLATION & THE BAUMOL EFFECT MEAN HIGHER INPUT COSTS	"While inflation is down from its 2022 peak, it remains higher than historical levels, adding to the input costs of healthcare providers." "the Baumol variable captures excess (to economy-wide) health price inflation."
THE PRINCIPLE OF SUSTAINABILITY MUST BE APPLIED TO PROVIDERS, NOT ONLY TO GOVERNMENTS	"Financial sustainability is the ability of an organisation to have sufficient revenues to cover financial obligations in the long term…Applying this term to the health sector, it can refer to private as well as public organisations [including] households (a household's income and assets need to be sufficient to cover out-of-pocket health expenses), private purchasers such as health insurance firms (a firm's insurance premiums need to be sufficient to cover its reimbursement obligations), **private health providers (revenues need to be sufficient to cover its costs)**, as well as government."

WPC Chief Economist's commentary: WHAT ARE THE IMPLICATIONS FOR PHARMACY CORE FUNDING?

Baumol's Cost Disease was discussed in depth in the *2024 Sector Analysis Report*. It is the observed phenomenon whereby inflation has a worse impact on service-based sectors of the economy than for other sectors. It applies for much of the health system, is now well-accepted and was included in OECD's projection model for health costs: a "Baumol variable" was used to capture "excess (to economy-wide) health price inflation". If the OECD accepts that per-unit health costs typically grow faster than inflation, why is this principle not being applied to funding levels for community pharmacy in every country? Are the real risks of health system failure are being ignored, in favor of short-term budget fixes? The COVID-19 pandemic - the largest economic shock since the GFC, and the largest health shock in a century - showed that health systems have inadequate resiliency and are in dire need of corrective action. That has yet to be adequately addressed (system resilience continues to be OECD Health's number one priority). The acceleration in inflation that has followed the pandemic only worsened system resilience, and harmed sectors where funding is not, at a minimum, indexed to inflation. National governments must urgently change their approach to pharmacy core funding if health systems are to be made more resilient and effective into the future.

CRITICAL ISSUE SUMMARY

Medicine Shortages

Medicine shortages are a major global healthcare problem. Some of the main **causes of shortages** include raw material shortages, manufacturing problems, surges in demand, regulatory issues, labour shortages, transportation bottlenecks, political instability, economic factors and market dynamics.

Shortages result in patients being deprived of essential medications and healthcare professionals facing difficulties in identifying and procuring substitute treatments. The efforts made by pharmacy staff to minimise the impact of shortages on patients are labour-intensive tasks that happen quietly in the background, unpaid and often unnoticed, but essential to keeping the system running.

Drug shortages are worsening. The 2025 Pharmacy Pressures Survey conducted by Community Pharmacy England found that 87% of pharmacies are dealing with medicine supply issues at least daily (including 61% multiple times daily). In 2022, just over half (51%) of pharmacy teams said patients were negatively affected by supply chain issues on a daily basis. In 2025, this concern has grown significantly, with 73% reporting risks to patient health caused by delays in accessing medicines.

A 2024 survey by Australia's medicines regulator found that most patients (88.1%) reported finding out about shortages from a pharmacist. 20% of the Australian patients surveyed said that they rationed their own medicine to make it last longer, while 17% received a new prescription from their GP.

At least 11 staff hours every week in every pharmacy is dedicated to managing medicine shortage issues for patients.

Pharmacy workload impact

Mitigating the impact on patients, to ensure continuity of treatment, is the number one priority of community pharmacists when dealing with shortages.

- In Germany, most pharmacists indicate that they spend more than 10% of their working time in finding solutions for medicine shortages. In a recent survey there, in most pharmacies the amount of time that pharmacy staff spend in managing medicine shortages was 20-30 hours per week (average: 23.7 hours).
- According to the Pharmaceutical Group of the European Union (PGEU), every pharmacy across the EU spent on average close to 11 hours per week dealing with medicine shortages, and that this time has tripled over the last 10 years, with 2024 the worst year on record. This places a great burden on staff and resources, almost always with no compensation.
- In Australia, a survey by the Therapeutic Goods Administration released in November 2024 found that 28% of pharmacists spent 4-7 hours per week managing drug shortages while 47% spent 1-3 hours per week.
- The unique single-supplier tendering arrangements in New Zealand limit the options of finding an alternative brand available there, and it has been left to prescribers and pharmacies to communicate this to frustrated patients.

CRITICAL ISSUE

Medicine shortages - actions in response

What is being done?

Some of the strategies recently implemented in WPC member countries to reduce the frequency and impact of medicine shortages include:

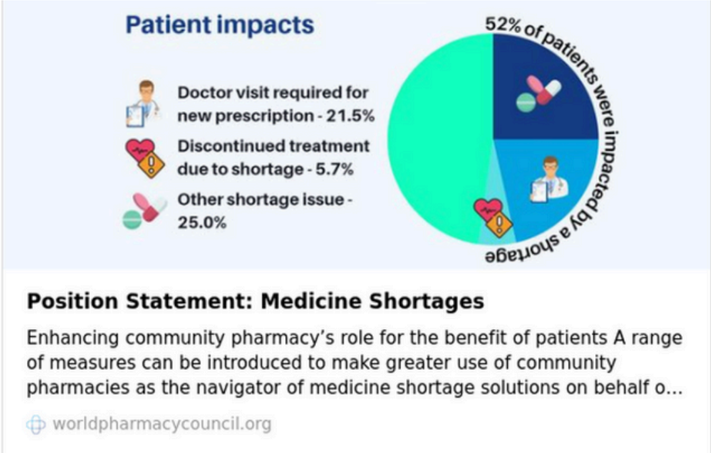
- Improved monitoring and reporting of drug supplies, including innovative data-driven approaches such as the Medicines Supply Information Centre (CISMED), a system developed by Spain's Consejo General de Colegios Oficiales de Farmacéuticos.
- Market intervention approaches, such as the Australian government's implementation of a Supply Security Guarantee under which it set a floor price for subsidised medicines in exchange for a requirement on manufacturers to maintain sufficient stocks within Australia.
- More flexible regulatory requirements to accelerate approvals for new indications for existing drugs, or to bring new drugs into the local market.
- Temporarily reducing the quantity that can be supplied to each patient, to ensure that limited supplies can be made available to the largest number of people.
- Allowing community pharmacists to substitute therapeutically when a severe shortage is declared, such as the UK's Serious Shortage Protocols or Australia's Serious Scarcity Substitution Instruments.
- In several provinces of Canada pharmacists have the authority to perform therapeutic substitution when a prescribed medication is unavailable because of a shortage, provided the substitution is clinically appropriate and the pharmacist documents the change. However, in other provinces pharmacists are not permitted to substitute an equivalent medication without contacting the original prescriber, even when clinically appropriate options are available.

Further action is needed to reduce disruptions to patient care

These are important steps. However, more can and should be done by authorising pharmacists to perform at their full scope of practice so that they can more efficiently and effectively respond to shortage situations before they are declared "severe", which often occurs far too late (or not at all) even with recent improvements in shortage reporting requirements. **In doing, regulators can ensure the best possible continuity of care for patients. Compensation should also be introduced for pharmacies in relation to the increased workload incurred in managing shortages.**

WORLD PHARMACY COUNCIL

WPC Position Statement: Medicine Shortages



"Drug shortages are no longer exceptional disruptions but a common occurrence. To meet this challenge, Canada must update its regulatory and financial frameworks to fully mobilize pharmacists to empower their ability to respond"

Zhang PC, Tadrous M. Empowering pharmacists in Canada's drug shortage response. Canadian Pharmacists Journal / Revue des Pharmaciens du Canada. 2025;0(0). doi:10.1177/17151635251365666

SECTION 6
Pharmacy Services & Scope of Practice

The COVID-19 pandemic changed attitudes toward community pharmacy of many stakeholders, funders and regulators, as they discovered what those within the sector have known all along – pharmacies and their staff are highly accessible, highly skilled, and have capacity to reduce pressure on others in healthcare systems. They can add flexibility, agility and responsiveness to these systems, creating greater resilience to external shocks and surges in demand. Authorisation of additional roles for pharmacists, within a collaborative and technology-enabled environment, can also assist other medical professionals to have more time to focus on complex care.

These changing attitudes have not automatically converted into large scale, permanent change in policies or funding arrangements. Barriers remain and progress varies between countries, and often within each country. However, progress continues to be made in many countries and jurisdictions, as described in this section, which outlines recent developments regarding the implementation of pharmacist scope of practice in each country. Successful services in one jurisdiction can often be used as examples to enable that service in others.

Based primarily on responses to this year's Sector Analysis questionnaire, this report presents the WPC's updated comparison table of authorised scope of practice across member countries. The table has been based on the Canadian Pharmacists Association's table that compares scope across Canadian provinces. Across WPC countries, the comparison table shows that authorised scope is broadest in Canada, the UK and the USA, with New Zealand and Australia following. On the basis of a comparison between the WPC's new table and the Canadian provincial table, all ten Canadian provinces continue to have an authorised scope of practice broader than each of the other WPC member countries.

Scope of Practice International Comparison Table

		AUS	BEL	CAN	DEN	GER	IRE	ISR	NZL	POR	ESP	UK	USA
INITIATING TREATMENT 	Independently prescribe	Limited, pilot	✗	Alberta only	✗	✗	✗	Limited	Limited	✗	✗	Limited	24 states
	Prescribe in a collaborative setting/arrangement	✗	✗	✓ Most provinces	✗	✗	✗	✗	✓	✗	✗	Limited	✓
	Initiate treatment for minor ailments/conditions (formal program)	✓ State-variable	✗	✓	✗	✗	Launching soon	✗	Limited, pilot	✗	✓	✓	Most states
	Initiate treatment for minor ailments/conditions (informal – no program)	✓ State-variable	✗	✓	✗	OTC meds	OTC meds	✗	Limited	OTC meds	✓	✓	✓
	For smoking cessation	OTC meds	OTC meds	✓	OTC meds	✗	✓	✗	✓	OTC meds	OTC meds	✓	18 states
	For hormonal contraception	State-variable	Emergency only	✓	✗	Emergency only	Emergency only	✗	✓	✗	Emergency only	✓	37 states
	In an emergency	✗	Limited	✓	✗	✗	✓	✓	✓	✓	✗	✓	✓
	Vaccines (provide without prescription)	✓	✓ Flu, COVID	✓	Delegated	Limited	✓	✓	✓	✓ Flu, COVID	✗	✓	✓

Scope of Practice International Comparison Table

		AUS	BEL	CAN	DEN	GER	IRE	ISR	NZL	POR	ESP	UK	USA
ADAPT/ MANAGE SCRIPTS	Therapeutic substitution (broad authority)	1 state	✗	✓ Most provinces	✗	✗	✗	✗	✓	✗	✗	✗	24 states
	Therapeutic substitution (declared shortage only)	✗	✗	✗	✗	✓	✗	✗	✓	Limited	✓	✓	✗
	Change drug dosage, formulation, regimen, etc.	Limited	✗	✓	✗	✓	Limited	Limited	✗	✓	✗	✗	✓
	Renew prescription for continuity of care	Limited	✗	✓	Limited	✗	Limited	✓	✗	✓	✗	✗	✗
	Short-term extension of prescription for continuity of care	✓	✗	✓	Limited	✗	✓	✓	✗	✗	Andalusia only	✗	✓
	Deprescribe	✗	Limited	✓	✗	✗	✗	✗	✗	Pilot only	✗	Limited	✗
INJECTION AUTHORITY	Inject drugs	Limited, some states	✗	✓	✗	✗	✓	✗	✓	✓	✗	✓	✓

Scope of Practice International Comparison Table

		AUS	BEL	CAN	DEN	GER	IRE	ISR	NZL	POR	ESP	UK	USA
INJECTION AUTHORITY	Influenza vaccine	✓	✓	✓	✓ Script for some patients	✓	✓	✓	✓	✓	✗	✓	✓
	COVID-19 vaccine	✓	✓	✓	✓ Script for some patients	✓	✓	✗	✓	✓	✗	✓	✓
	Other vaccines	✓	✗	✓	⇔ Requires prescription	✗	✓	✗	✓	⇔ Requires prescription	✗	✓	✓
LAB TESTS	Order and interpret lab tests	⇔ Limited	✗	⇔ Some provinces	✗	✗	✗	✗	✗	✗	⇔ Special qualification	✓ No legal barrier	✓ 37 states
TECHS	Regulated pharmacy technicians	✗	✓	✓	✓	✓	✗	✓	⇔ Education, not registration	⇔ Education, not registration	✓	✓ Exc. Northern Ireland	✓
	Techs can administer vaccines	✗	✗	✓	⇔ On delegation from doctor	✗	✗	✗	⇔ Additional qualification	✗	✗	⇔ Limited	✓ 46 states

Recent progress in scope of practice in WPC member countries

This section is not an exhaustive description of what has been authorised and/or implemented in each country, however it provides references to recent advancements, with a particular focus on pharmacists' ability to prescribe (or otherwise initiate therapy), alter prescriptions, extend prescriptions and administer vaccinations or other injections.

Australia

Scope of practice in Australia is regulated at a state and territory level. Significant variance exists between states, however there has been recent progress across most jurisdictions. Some of the most significant examples in three states are outlined below. The Guild provides status updates through a dedicated web page.

Queensland
Queensland's Community Pharmacy Scope-of-Practice Pilot, launched on 24 April 2024, was made permanent on 1 July 2025. Trained pharmacists now routinely provide medication-management, autonomous prescribing for a list of acute conditions (e.g., gastro-oesophageal reflux, impetigo, otitis media, mild musculoskeletal pain) and structured prescribing for chronic-disease programs such as cardiovascular-risk reduction, asthma and COPD monitoring. The separate Hormonal Contraception Pilot – also permanent from 1 July 2025 – lets pharmacists prescribe oral, injectable and vaginal-ring contraceptives to people ≥ 16 years.

More than 50 % of Queenslanders live outside Greater Brisbane, and the permanent services are expected to reduce emergency-department presentations by an estimated 10-15 % in regional areas.

New South Wales
Building on the successful trials for uncomplicated Urinary Tract Infections (UTIs) and oral contraceptive pill (OCP) resupply, which are now permanent services, NSW has made significant strides towards full scope of practice. Appropriately trained pharmacists will be able to treat a range of acute conditions, mirroring the Queensland trial. These services are expected to commence in 2026.

The conditions include:

- Gastro-oesophageal reflux
- Acute nausea and vomiting
- Allergic and nonallergic rhinitis
- Mild to moderate acne
- Acute wound management
- Acute otitis externa and media
- Mild musculoskeletal pain
- Travel health

Additionally, a trial for pharmacist-led management of several chronic conditions - including asthma, COPD, and cardiovascular disease risk reduction - is set to begin in regional NSW.

South Australia
Following the success of its UTI and OCP resupply services, which led to a 21% reduction in related emergency department visits in metropolitan areas, South Australia is moving forward with a significant expansion of pharmacist scope. The state government has finalised plans for pharmacists who complete postgraduate training to treat a broad range of conditions starting from 2026.

The newly included services will cover acute conditions such as shingles, impetigo, ear infections, nausea and vomiting, gastro-oesophageal reflux, and musculoskeletal pain, as well as aanagement of mild to moderate acne and atopic dermatitis, and acute minor wound management. It also includes services for hormonal contraception, obesity management, smoking cessation, and travel health. The government is offering subsidies of up to $8,500 for over 120 pharmacists to undertake the required training.

Recent progress in scope of practice in WPC member countries

Belgium

In November 2025, the Belgian federal parliament passed a bill granting pharmacists the permanent right to administer the flu vaccine in pharmacies, overcoming the previous temporary provisions. More than 2 million Belgians can thus easily obtain their vaccine at low cost in a pharmacy.

Earlier, April 2024 saw the introduction of the new medicines service for COPD patients.

Looking ahead, a new regulatory requirement - unit-dose dispensing of antibiotics - is expected by April 2026. This aims to support antimicrobial resistance (AMR) reduction, though its effectiveness is uncertain. While this obligation will increase workload and operational costs for pharmacies, APB are actively engaging with policymakers to ensure its implementation is practical, efficient, and financially sustainable. This includes advocating for fair remuneration for the additional work involved in dose dispensing.

Belgium's evolution of services since 2013

Denmark

Major amendments in May 2024 to the pharmacy law in Denmark provide better opportunities for pharmacies to play a larger role in the healthcare sector.

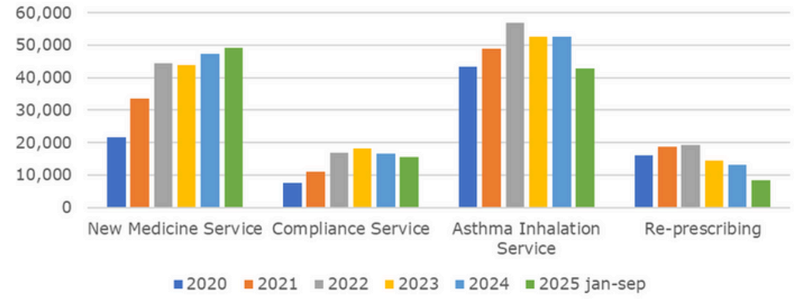
As part of recent reforms, the Medicine Compliance Service went from one target group (which was changed) to five target groups:

1. Non-compliant patients after 6 months of medication usage and
2. Patients at risk of non-compliance for the following reasons:
   - the patient has recently been discharged (following a hospital stay) with changes to their treatment.
   - the patient has recently started dosage dispensing.
   - the patient has begun tapering off medication as per a doctor's agreement.
   - the patient is receiving treatment with injectable medications

Changes have also been made to the New Medicine Service to allow specially trained pharmacy technicians to perform the service. It is important to note that pharmacy technicians in Denmark have a three-year tertiary qualification.

Denmark - Number of services since 2020

Note: Data for 2025 is a part year (to September)



WPC MEMBER HIGHLIGHT

A significant year of change across Canada

Across Canada, 2025 has been a major year for advancing pharmacist scope of practice:

- **Alberta (AB)** – Implemented new Standards of Practice (Feb 2025) expanding what pharmacists can do, including allowing injections for children ages 2-4, clarifying consent and supervision rules, and modernizing pharmacist prescribing authority.
- **New Brunswick (NB)** – Regulations expanded (May 2025) to allow virtual assessments for common-ailment prescribing and launched Pharmacist Care Clinics where pharmacists can assess and prescribe for chronic diseases like asthma and diabetes.
- **Nova Scotia (NS)** – Fully migrated to the Regulated Health Professions Act with a clearly defined pharmacist scope under new Pharmacy Regulations (June 2025).
- **Saskatchewan (SK)** – Expanded therapeutic substitution authority (August 2025), allowing pharmacists to safely substitute medications (e.g., during shortages) after completing new government-approved training.
- **Ontario (ON)** – Announced (Sept 2025) plans to expand pharmacist prescribing for 14 new minor ailments, authorize more publicly funded vaccines, and add point-of-care testing for conditions like strep throat (regulations pending).
- **Quebec (QC)** – Draft regulation (June 2025) under Bill 67 proposes pharmacist prescribing for common and chronic conditions, expanded substitution authority, and advanced collaborative agreements with physicians and nurse practitioners (pending final approval).
- **Manitoba (MB)** – Announced plans to authorize pharmacists to prescribe birth control and HIV medications (expected late 2025).

Positive changes to service fees were also implemented in several provinces:

- Yukon (YK) standardized all publicly funded vaccines at $15).
- Some provinces expanded minor ailment or antiviral prescribing fees (e.g., Ontario and Prince Edward Island (PEI) added COVID-19 and influenza treatment prescribing; Saskatchewan increased coverage for C19 referral fees).
- Follow-up care and biosimilar transition fees increased across several provinces (including Alberta, British Columbia and Ontario).

Alberta ceases funding for pharmacy COVID-19 vaccination

Disappointingly, Alberta decided to stop providing public funding for COVID-19 vaccinations for the majority of the general population in the middle of 2025. In Alberta, community pharmacies have administered more than 4.5 million COVID-19 vaccine doses since the start of the pandemic, delivering care safely, efficiently, and with extended hours and broad community reach. The policy change limits pharmacies' involvement in ongoing COVID-19 immunization efforts and decreases convenience for Albertans - a step backward for public health access. Earlier, in 2024, the Alberta government lowered the fees it pays for initial comprehensive care-plan assessments by pharmacists from $100 to $70 and limited reimbursable follow-up appointments from twelve per year to four. These adjustments were introduced to address a projected budget shortfall in the province's pharmacy-services program.

Recent progress in scope of practice in WPC member countries

Germany

Since June 2022 three pharmacy services can be billed against statutory health insurance: medication reviews, BP control in hypertension and inhaler technique - in addition to two specialised medication services for smaller populations (taking oral anti-cancer drugs or immunosuppresants post-transplantation).

Under the proposed reforms to pharmacy law released in October 2025 pharmacists would be authorized to dispense certain prescription-only medications without a prior doctor's consultation in specific scenarios, such as emergency supplies for long-term treatments documented in a patient's electronic health record, or for minor acute conditions like mild urinary tract infections. They would also be empowered to administer more vaccines, including tetanus and tick-borne encephalitis (FSME), in addition to flu and COVID-19 jabs. However, as discussed under Member Priorities, the proposed reforms do not take the required steps for financial stabilisation of pharmacies through increases in core funding, and the package of measures is opposed by the sector. The ABDA President Thomas Priess has stated that “pharmacies are ready, but economic strengthening is essential”.

Since 2020, pharmacists have been allowed to administer vaccines under severe professional, spatial and organisational constraints. The number of influenza vaccinations administered in pharmacies increased from 67,300 in 2022/23 to 97,200 in 2023/24.

Israel

While the full integration of clinical pharmacy services is still emerging in Israel, several key areas are developing:

- Pharmacist prescribing and prescription extensions under safety protocols: changes to pharmacy prescribing policy allow pharmacists (after completing a Ministry-of-Health-approved training program) to prescribe medications, primarily for extensions, to patients who have a previous prescription from a physician.
- Point-of-care testing for conditions like glucose and cholesterol: Pharmacies in Israel are increasingly becoming hubs for point-of-care testing, offering rapid diagnostics for conditions such as glucose and cholesterol levels, among others, enhancing accessibility and quicker health insights for patients.
- Structured medication reviews with physician referrals: pharmacists produce a documented action plan that is sent to the patient’s physician.
- Pharmacist-administered vaccinations (e.g., for flu and COVID-19): Community pharmacists in Israel have been granted the authority to deliver immunization services, including the administration of influenza vaccines to adults, with formal training in vaccine administration being mandatory for pharmacy students.

Recent progress in scope of practice in WPC member countries

Ireland

Ireland's new Community Pharmacy Agreement 2025 includes enhancements to empower pharmacists to deliver more accessible, timely, and patient-centred care, easing pressure on other parts of the health system and modernising the delivery of primary healthcare in Ireland.

Key enhancements from the agreement include:

- the rollout of a Common Conditions Service, enabling pharmacists to treat and prescribe for conditions such as thrush, impetigo and shingles
- expanded roles in vaccination programmes
- the ability of pharmacists to extend prescriptions for hormonal contraception
- patient registration as part of the BowelScreen screening programme
- the safe disposal of unused medicines

In 2023 the Minister for Health, Stephen Donnelly, established the Expert Taskforce to Support the Expansion of the Role of Pharmacy. The Expert Taskforce comprised of 13 experts with experience in pharmacy education and practice, healthcare policy and delivery, and other related disciplines.

As a result of a recommendation in an initial report, starting from 1 September 2024 pharmacists received the authority to extend prescription validity from the current six months up to a maximum of 12 months, if deemed safe and appropriate for the patient. The final report presents a pathway for implementing pharmacist prescribing in Ireland, focusing initially on a Common Conditions Service (CCS) and eventually progressing to full prescribing authority for pharmacists.

IPU's 2024 White Paper outlines a bold vision for community pharmacists to practice to their full scope, aligning with national policy objectives and bringing Ireland closer to integrated, patient-led care.

Key recommendations of the final Expert Taskforce report include:

- Pharmacists prescribing, by way of a Common Conditions Service, for common clinical conditions including:
  - Allergic rhinitis;
  - Cold sores;
  - Conjunctivitis;
  - Impetigo;
  - Oral thrush;
  - Shingles;
  - Uncomplicated urinary tract infections (UTIs); and
  - Vulvovaginal thrush.
- Full independent pharmacist prescribing within scope of practice.
- The appointment of a Chief Pharmaceutical Officer
- A system of Continuous Professional Development training
- Optimising interprofessional communication.

Recent progress in scope of practice in WPC member countries

New Zealand

Over the past 12 months, there has been a clear and deliberate trend toward expanding pharmacist-led preventive care, vaccination, and condition management.

- **Early Care Vaccinator Standing Order:** This national order empowers trained pharmacists, interns, and nurses to administer a wide range of National Immunisation Schedule, COVID-19, and non-funded vaccines without an individual prescription.
  - *Broad Scope:* It explicitly moves pharmacies beyond the old "flu-plus" model to cover infant series, HPV, meningococcal (including MenB), pneumococcal, MMR, and shingles.
  - *Formalised Pathway:* It provides a formal, auditable pathway for pharmacist-led immunisation across a patient's life-course.

- **Digital Tools & Outcome Measurement (Conporto HSI):** The Conporto Health Status Index (HSI) and associated digital service tiles provide the means to record and share outcomes from pharmacy-led care.

There have been several **medicine reclassifications** that significantly expand pharmacists' ability to initiate and supply treatments under clear protocols:

- **Gout Management (Allopurinol):** Pharmacists can now initiate allopurinol for gout prophylaxis in eligible patients, improving access and continuity of care, particularly for Māori and Pacific men.
- **HIV Prevention (PrEP):** Trained pharmacists can supply tenofovir/emtricitabine for HIV PrEP, establishing a high-trust, protocol-driven service that moves pharmacy firmly into sexual health prevention.
- **Expanded Adult Immunisation (RSV & Shingles):** The scope for pharmacists to vaccinate against RSV and shingles has been widened to include more age groups and at-risk populations (e.g., RSV for adults 60+ and at-risk 50-59; Shingrix for 50+). This solidifies pharmacy as the most convenient hub for adult immunisation.
- **Smoking Cessation (Cytisine):** Cytisine was reclassified to "pharmacist-only," formally recognising the pharmacist's role in delivering cessation counselling alongside supply.
- **Supportive Medicines for Vaccination:** The MCC endorsed pharmacists using standing orders to administer supportive medicines, such as liquid paracetamol for infants after a Bexsero vaccination, enabling a complete "immunise and manage" service in one visit.

Overall, these changes represent a fundamental shift in the role and potential of community pharmacy in New Zealand.

1. *From Task to Program*: The model has evolved from simply being able to "give an injection" to running a comprehensive immunisation service end-to-end—including consultation, vaccination, supportive care (via standing orders), and digital recording.
2. *New Authority in Long-Term Conditions*: The ability to initiate gout and HIV PrEP therapies marks a genuine expansion of clinical authority, allowing pharmacies to actively manage chronic conditions and improve health equity.
3. *A Repeatable Model for Future Growth*: The MCC has established a clear template for future service expansion.

While the clinical and regulatory frameworks are advancing, the full potential of these services will only be realised once funding and local commissioning within the community pharmacy contract catch up to these policy changes.

Recent progress in scope of practice in WPC member countries

Portugal

There have been two key regulatory advancements recently, enhancing access to specialized therapies and reinforcing pharmacists' role in integrated care.

1. Proximity Dispensing of Hospital Medicines
A new framework (Decree-Law No. 138/2023 and Ordinance No. 106/2024) allows community pharmacies to dispense hospital-prescribed medicines for outpatient care, improving equity and therapeutic continuity. Eligible patients - those clinically stable and adherent to long-term treatments (>6 months) - can access therapies closer to home, reducing hospital dependency. Community pharmacies must register with INFARMED, complete specialized training, and collaborate with hospital pharmacists via shared electronic health records. Dispensing is reimbursed at €11.96 per episode (€6.38 to pharmacies), with distribution managed by SUCH (central warehouse) and licensed wholesalers. Pilot projects are underway, targeting ~150,000 patients nationwide. The new framework strengthens pharmacist-led care coordination, reduces hospital burdens, and enhances access to high-cost medicines (e.g., biologics).
[Sources: Portaria 104/2024, Despacho 10110/2024]

2. Community Pharmacy Dispensing of Insulin Pumps and CGM Systems
From 31 January 2025, community pharmacies will dispense insulin pumps (CSII), continuous glucose monitors (CGM), and consumables under the National Diabetes Programme (Ordinance No. 18/2025). This shift from hospital-based distribution recognises automated insulin delivery (AID) as standard care for type 1 diabetes (T1D). The new arrangement expands access to advanced diabetes technologies, reduces hospital loads, and leverages pharmacies' proximity for continuous patient support. Features:

- 100% NHS reimbursement for eligible patients.
- Prescriptions: electronic only, limited to endocrinology/internal medicine/paediatrics specialists.
- Pricing: reference pricing for devices; pharmacies receive a 2.54% margin + €3.90 per unit.
- Annual limits: defined by the Directorate-General of Health (DGS), with clinical exceptions.

[Sources: Portaria 18/2025, INFARMED]

These reforms reflect Portugal's commitment to integrated, patient-centred care, empowering pharmacists as key healthcare providers. By shifting dispensing responsibilities from hospitals to communities, the changes:

- Improve accessibility (especially in rural areas).
- Enhance therapeutic adherence through local pharmacist follow-up.
- Optimize NHS resource allocation via efficient reimbursement models.

Future steps may include scaling pilots and expanding eligible therapies, further solidifying pharmacists' role in chronic disease management.

Recent progress in scope of practice in WPC member countries

Spain

Pharmacists currently do not have any rights with regard to prescribing, or adaption or extension of a prescription in Spain. Over the past 12 months, no **national** legislative or funding advances have expanded community pharmacists' scope of practice in Spain. Most services remain patient-funded, except for regionally agreed programs (often targeting specific patient groups. Importantly, In November 2024, the first **Map of Pharmaceutical Services** in Spain was developed after intensive collaboration with the provincial associations of pharmacists and the respective regional councils of pharmacists' associations. Recent key regional developments include:

- *Basque Country:* A therapeutic adherence program for asthma and COPD patients, funded by the regional government, was launched in community pharmacies.
- *Sentinel Pharmacy Networks:* Expanded to Galicia and the Basque Country, joining five existing regions. These pharmacies - trained in drug safety - actively report adverse drug reactions, medication errors, and issues with medicines (including herbal remedies and cosmetics). Some also participate in regional studies on medicine use.
- *Rural Pharmacy Pilot (La Rioja):* A pilot will soon begin in seven rural pharmacies, delivering remunerated socio-health services under a new agreement with three ministries and the CGCOF.

United Kingdom

The UK has recently broadened pharmacists' and pharmacy technicians' roles, improving healthcare access and reducing inequalities.

In England, the **Pharmacy Contraception Service** now includes oral emergency contraception, ensuring consistent NHS-funded access nationwide - replacing patchy local provision. From October 2025, pharmacy technicians will also offer this service if competent.

Vaccination services have been expanded in England, with pharmacy technicians now permitted to independently administer flu and COVID-19 vaccines under a Patient Group Direction (PGD), with pharmacist oversight but full clinical decision-making authority. A pilot for childhood flu jabs (ages 2-3) is testing pharmacy-led delivery, while 150 pharmacies now provide **RSV and pertussis vaccines** in areas with low GP coverage. In Liverpool, two pharmacists have begun inserting and removing contraceptive implants, marking a shift into minor surgical procedures. Although this is expected to remain a specialist, niche service, it reflects another advancement for the profession

In Scotland, **Pharmacy First Plus** - allowing pharmacists to prescribe for minor ailments - now covers over 40% of community pharmacies, with plans for full rollout by 2030.

Recent progress in scope of practice in WPC member countries

United States of America

The number of states that allow pharmacists to **prescribe under a collaborative agreement** has increased from 46 states to 49. There has also been an increase in the number of states allowing pharmacists to interpret and order labs.

Summary of State Scope of Practice Legislation updates

In Kentucky, HB 274 allows pharmacists to administer vaccines to individuals three years and older. Florida passed HB 159, enabling pharmacists to screen adults for HIV and prescribe HIV prevention drugs under collaborative practice agreements. Maryland enacted HB 76, expanding pharmacists' authority to order and administer vaccines for certain age groups. Tennessee's SB 869 broadens the definition of pharmacy practice to include the prescription of specific medications and the administration of vaccines.

Additionally, Iowa's legislation allows pharmacists to order and administer epinephrine auto-injectors under statewide protocols. In Washington, D.C., recent laws revise health occupation regulations to enhance pharmacists' roles. New York has passed bills enabling pharmacists to initiate treatment for COVID-19 and influenza, while Hawaii's legislation authorizes pharmacists to perform certain CLIA-waived tests. North Carolina's bill expands pharmacists' authority to administer vaccines without practitioner orders. Montana has revised laws to broaden pharmacists' immunization authority.

These legislative actions across multiple states reflect a growing trend to enhance pharmacists' roles in healthcare, particularly in areas like vaccination and HIV prevention, enabling them to provide critical services directly to patients.

More detail on recent legislation updates is available here.

RESEARCH HIGHLIGHT

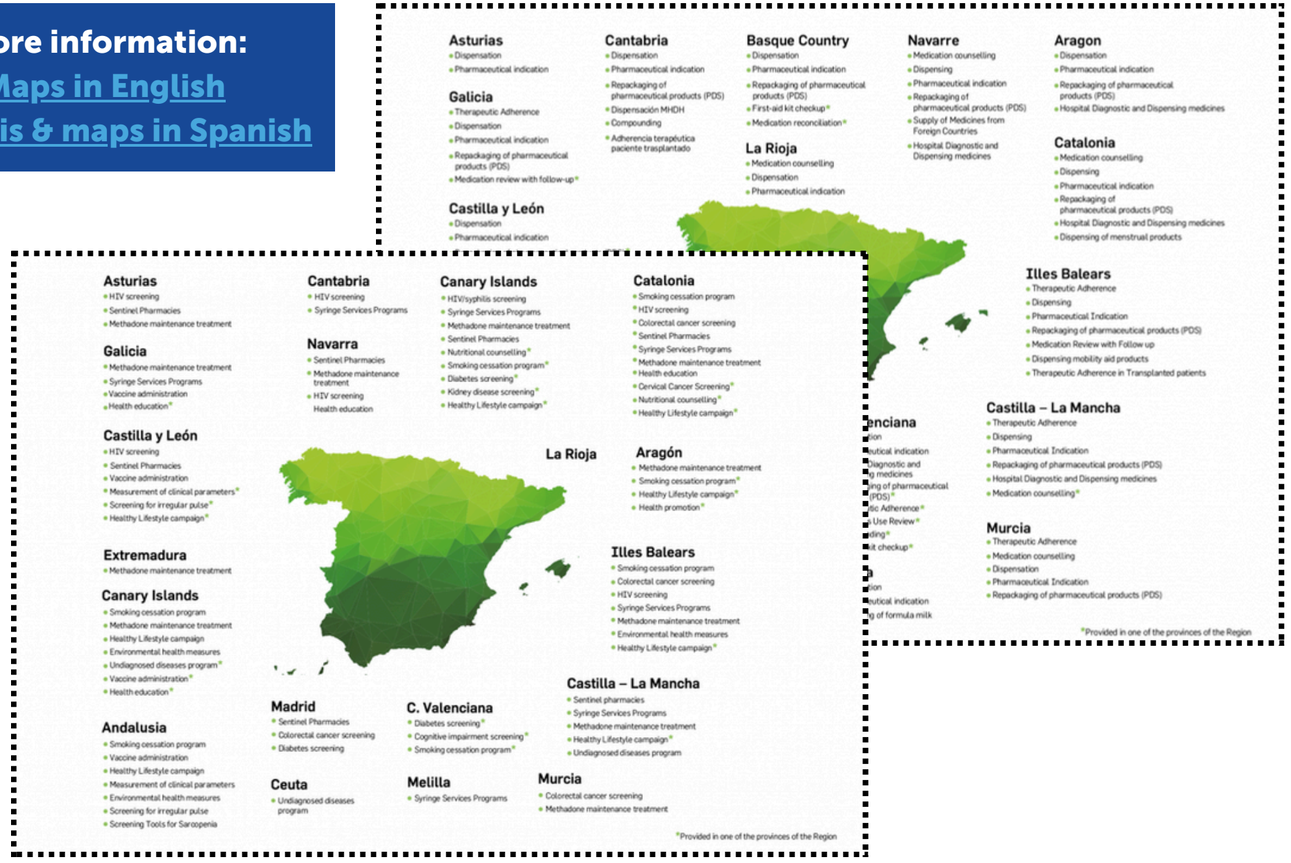
Spain’s new map of pharmaceutical services highlights regional disparity

General Council of Pharmacists, together with the Platform of Patient Organizations, has presented the first Maps of Pharmaceutical Services in Spain, covering the country’s 17 autonomous communities and 2 autonomous cities. Upon its release in October 2024, the president of the General Council of Pharmacists, Jesús Aguilar, highlighted that “**the provision and agreement of services in pharmacies has been expanding, but at an uneven pace and with an unequal portfolio among the autonomous communities, which are the ones that have the capacity to decide which services to finance.**”

In the field of **public health** (95 initiatives) the most widespread services provided by community pharmacies are disease screening services (11 autonomous communities), harm prevention through methadone programs (11 autonomous communities), healthy habits campaigns (8 autonomous communities) and smoking cessation services (7 autonomous communities).

The most widespread services in the healthcare field directly **linked to medicines** (apart from dispensing and advice) are led by the medicine repackaging service using Personalized Dosing Systems (SPD) (16 autonomous communities), collaborative dispensing between hospital pharmacy and community pharmacy (8 autonomous communities) and therapeutic adherence programs (7 autonomous communities).

More information:
Maps in English
Analysis & maps in Spanish



RESEARCH HIGHLIGHT

MULTI-COUNTRY

Building the evidence for pharmacy-based vaccination

In March 2025, *Human Vaccines & Immunotherapeutics* published a **systematic literature review** (SLR) identifying studies that evaluated vaccination by complementary providers and/or at expanded sites, outside of the United States (a country which was already considered to be well studied). The SLR included evidence from multiple countries and vaccine types, including influenza, HPV, pneumococcal, herpes zoster, and pertussis-containing vaccines.

The study builds on the strong evidence supporting pharmacy-based vaccination as a vital addition to vaccine rollout strategies. For example, the researchers cited the following research from Canada as part of concluding that adding community pharmacists as vaccinators results in increasing vaccine accessibility and uptake:

1. Isenor et al. (Nova Scotia) found **5.9% influenza vaccine coverage rate (VCR) increase** ($p < .001$).
2. Buchan et al. (Canada) reported **2.2% higher VCR in pharmacist-allowing provinces**.
3. Marra et al. (BC) found **older adults had higher vaccination rates with pharmacists**.
4. O'Reilly et al. (Ontario) reported **17% increase in influenza vaccines post-policy**.
5. Isenor et al. (Nova Scotia) reported **6.0% VCR rise overall, 9.8% for people aged 65 and over**.

Study authors included current employees of Merck Sharp & Dohme LLC (known as MSD in international markets). MSD is an affiliate member of the World Pharmacy Council.

> *While vaccination at pharmacies is not a new phenomenon, many countries around the world still do not offer pharmacy vaccination, or impose substantial limitations. However, momentum from the successful use of pharmacies to deliver COVID-19 vaccinations in many countries has accelerated interest in these strategies. Legislation has since been passed in many jurisdictions to expand the authority of pharmacists to administer other vaccinations. There is therefore a timely opportunity to leverage pandemic-related policies, including the expansion of complementary vaccination delivery systems at pharmacies, to reach VCR targets for other communicable diseases.*

Larson, A., Shanmugam, P., Mitrovich, R., Vohra, D., Lansdale, A. J., & Eiden, A. L. (2025). Expanding vaccination provider types and administration sites can increase vaccination uptake: A systematic literature review of the evidence in non-United States geographies. Human Vaccines & Immunotherapeutics, 21(1). https://doi.org/10.1080/21645515.2025.2463732

SECTION 7
OECD Health Data
Trends and comparisons across WPC countries

All data used in this section is sourced from the OECD Health Statistics Database

The data covers 24 OECD-member countries that meet WPC-defined thresholds of Gross Domestic Product and Human Development Index. They represent a pool of comparable countries consistent with the WPC's focus.

Some charts cover less than 24 countries due to data availability from the OECD datasets.

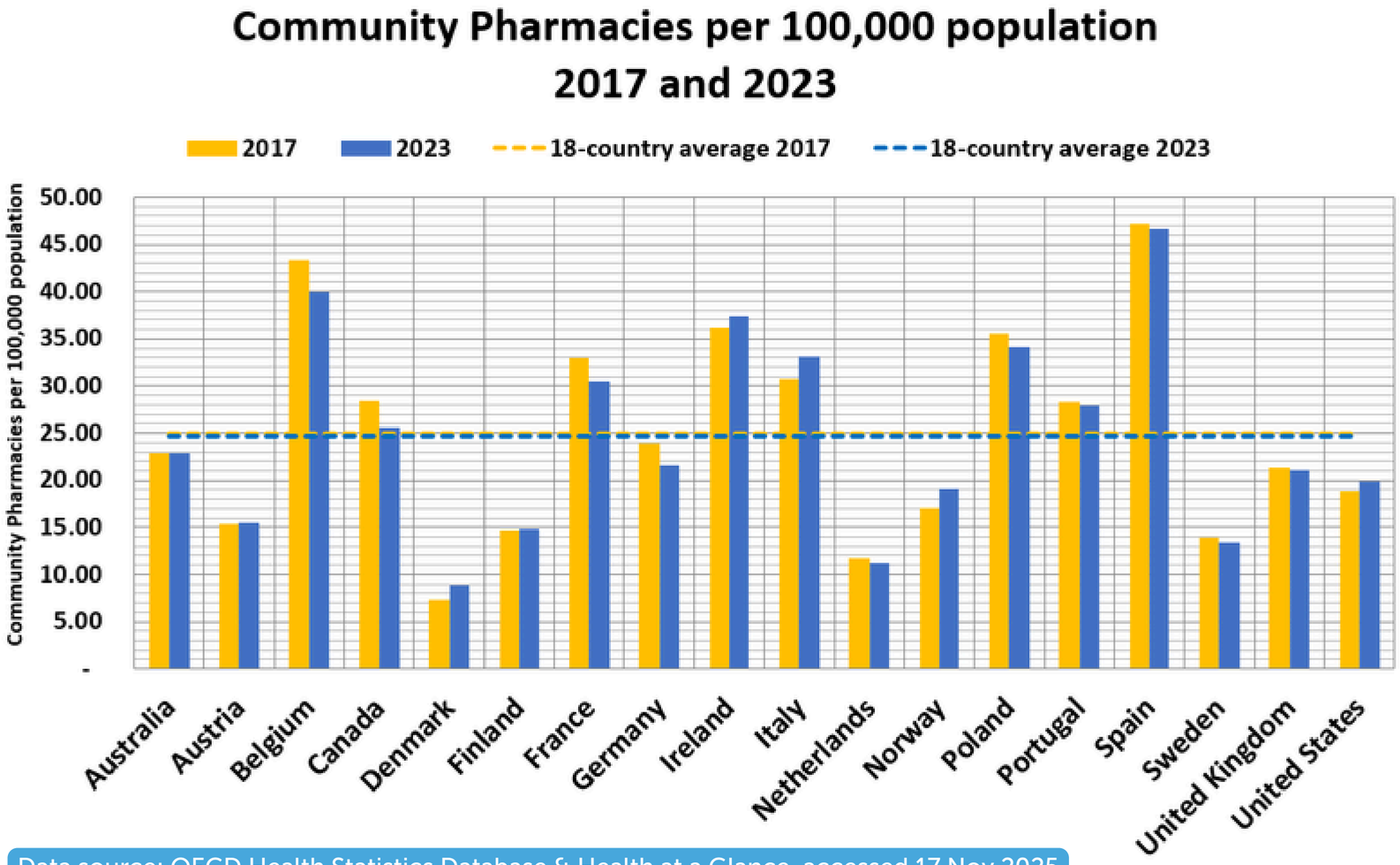
Averages shown are simple, unweighted means across the available countries.

NOTE: Comments presented in this section are the views of the WPC Chief Economist, not of the OECD.

Community Pharmacies per 10,000 population, 2017 and 2023

CHIEF ECONOMIST COMMENT

The average number of community pharmacies per 10,000 people has increased slightly from 2.09 to 2.15 over the five years of data. However, density has fallen in 10 out of 19 countries. Germany has had the largest reduction (6%) compared to population growth (see the **Pharmacy Closures** page) while Belgium (with a 5% reduction) has introduced new rules for the distribution of pharmacies. Denmark's numbers have increased since the 2015 change in regulations.

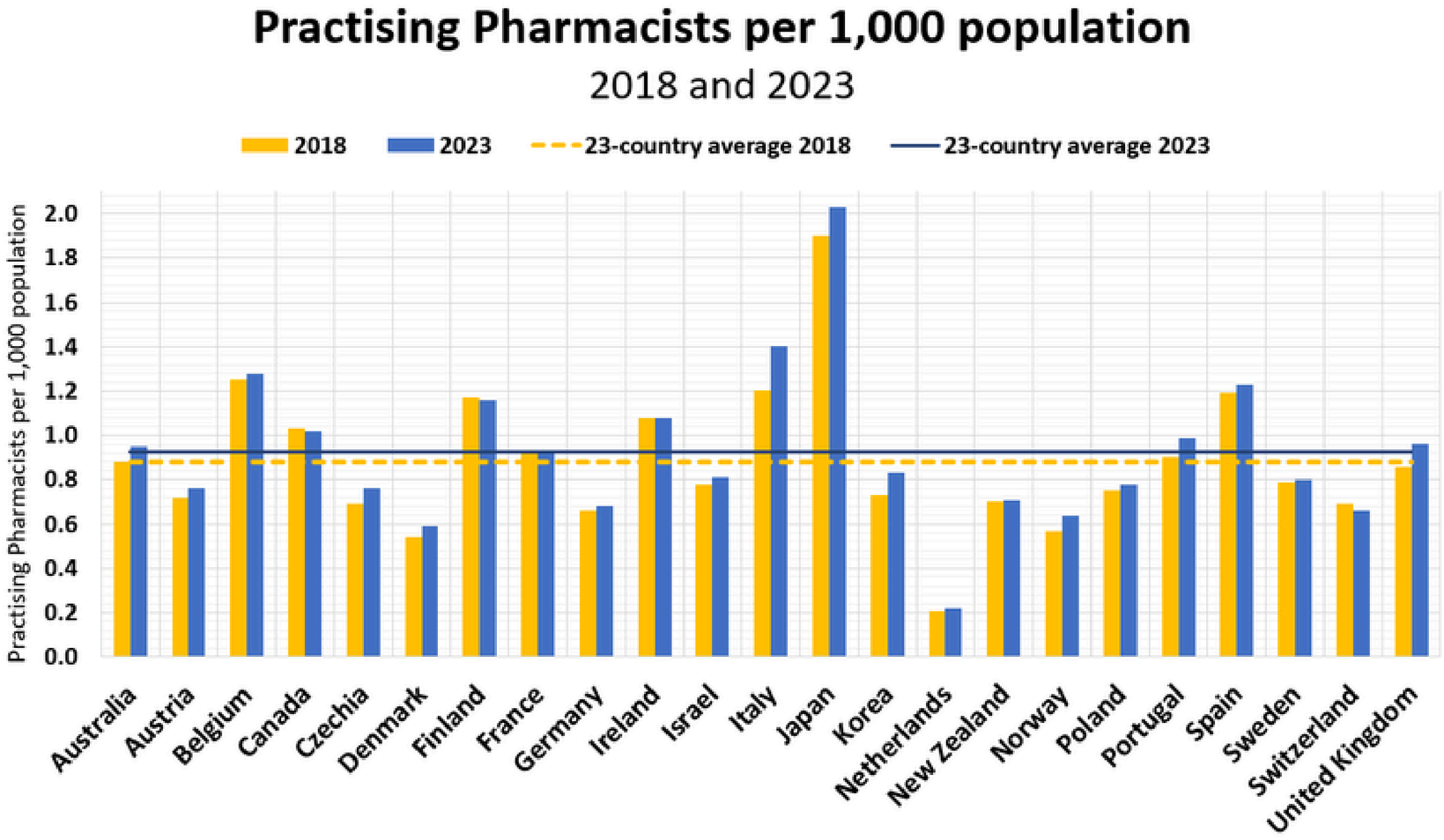


Data source: OECD Health Statistics Database & Health at a Glance, accessed 17 Nov 2025

Pharmacists per 1,000 population, 2018 and 2023

CHIEF ECONOMIST COMMENT

It is encouraging that the pharmacist workforce is growing faster than the population in 20 out of 23 measured countries, and it is important that this trend continues. Density varies widely. Japan is notable for having no pharmacy technicians (so a high number of pharmacists), while Denmark and the Netherlands, at the other end of the scale, has a highly qualified technician workforce (3 years of study) and a registered pharmacist must have a masters qualification (5-6 years of study). Of other WPC member countries, New Zealand has the lowest pharmacist density, and the workforce crisis in that country has been noted as a priority issue there.



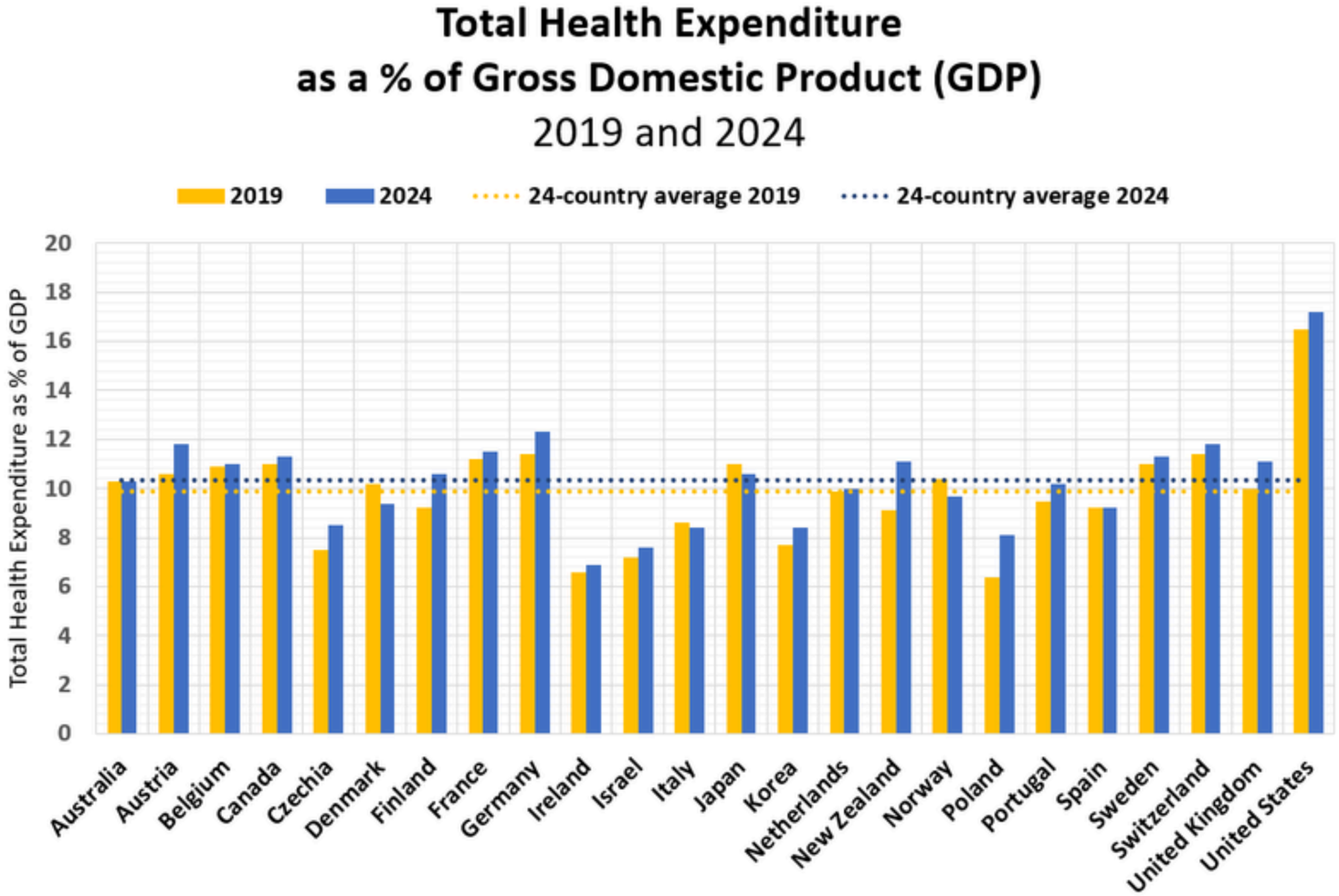
Data source: OECD Health Statistics Database, accessed 24 Sep 2025

Total Health Expenditure as % of GDP, 2019 and 2024

CHIEF ECONOMIST COMMENT

Total health expenditure (all sources) is growing faster than the economy in most WPC countries, with the 24-country average growing from 9.9% to 10.3% between 2019 and 2024. The most significant increases were seen in Austria, Germany, New Zealand and the United Kingdom.

As you will see from following pages, the growth is driven mainly by factors outside of pharmacy and pharmaceuticals - particularly hospital-related expenditures. The USA continues to have significantly higher health expenditures than any other country.

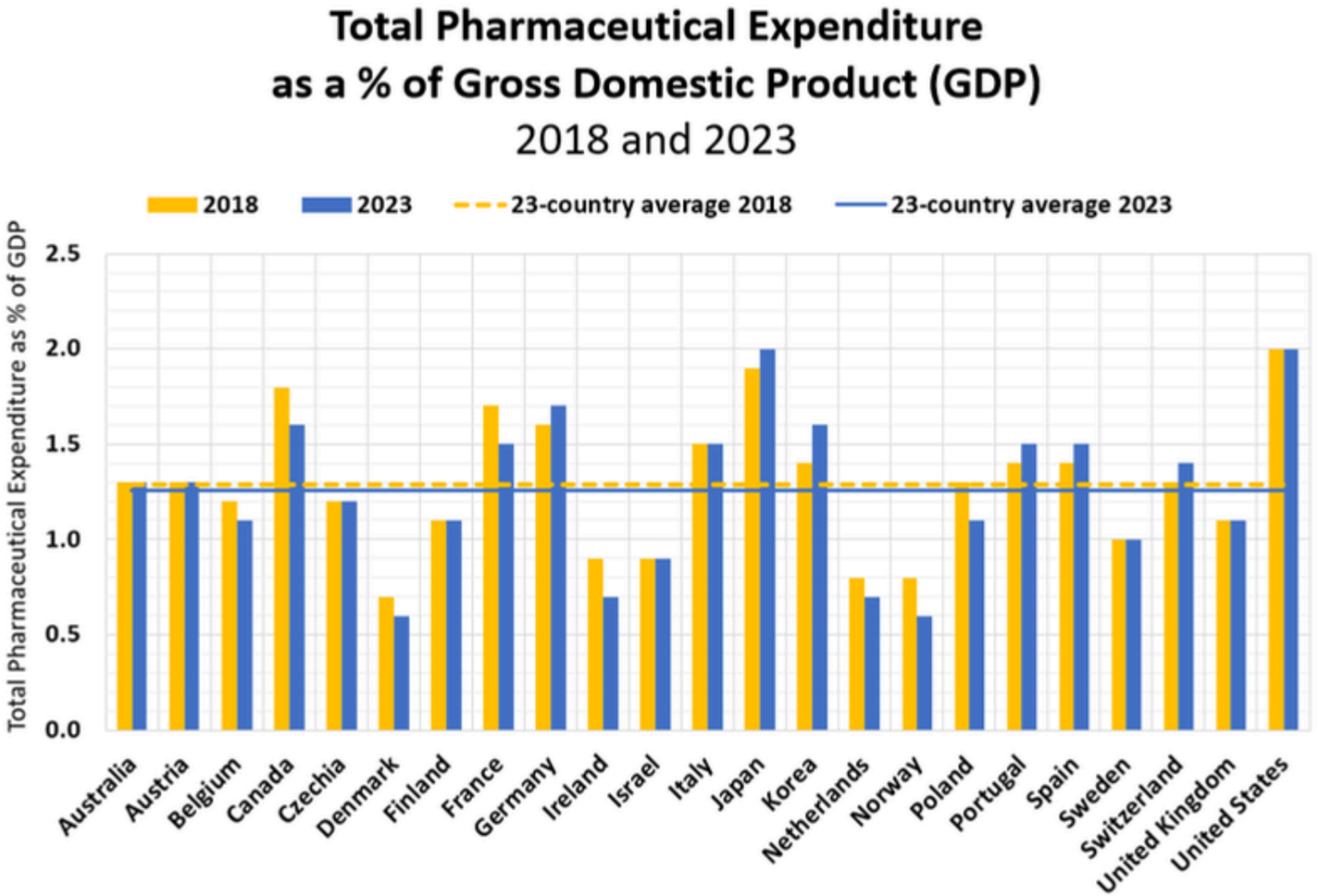


Data source: OECD Health Statistics Database, accessed 24 Sep 2025

Total Pharmaceutical Expenditure as % of GDP, 2018 and 2023

CHIEF ECONOMIST COMMENT

Unlike total health expenditure, total pharmaceutical expenditure (all payers, including patient) actually decreased slightly from 1.29% to 1.26% across the 23 WPC countries for which OECD publishes data. Only 6 countries have showed an increase. While there are more very expensive medicines each year, they tend to be for small populations, and their expenditures are counterbalanced by continued downward price pressure on prices for older (but still highly-effective) high-volume generic medicines, and price reductions as more biosimilars become available in the large molecule space.

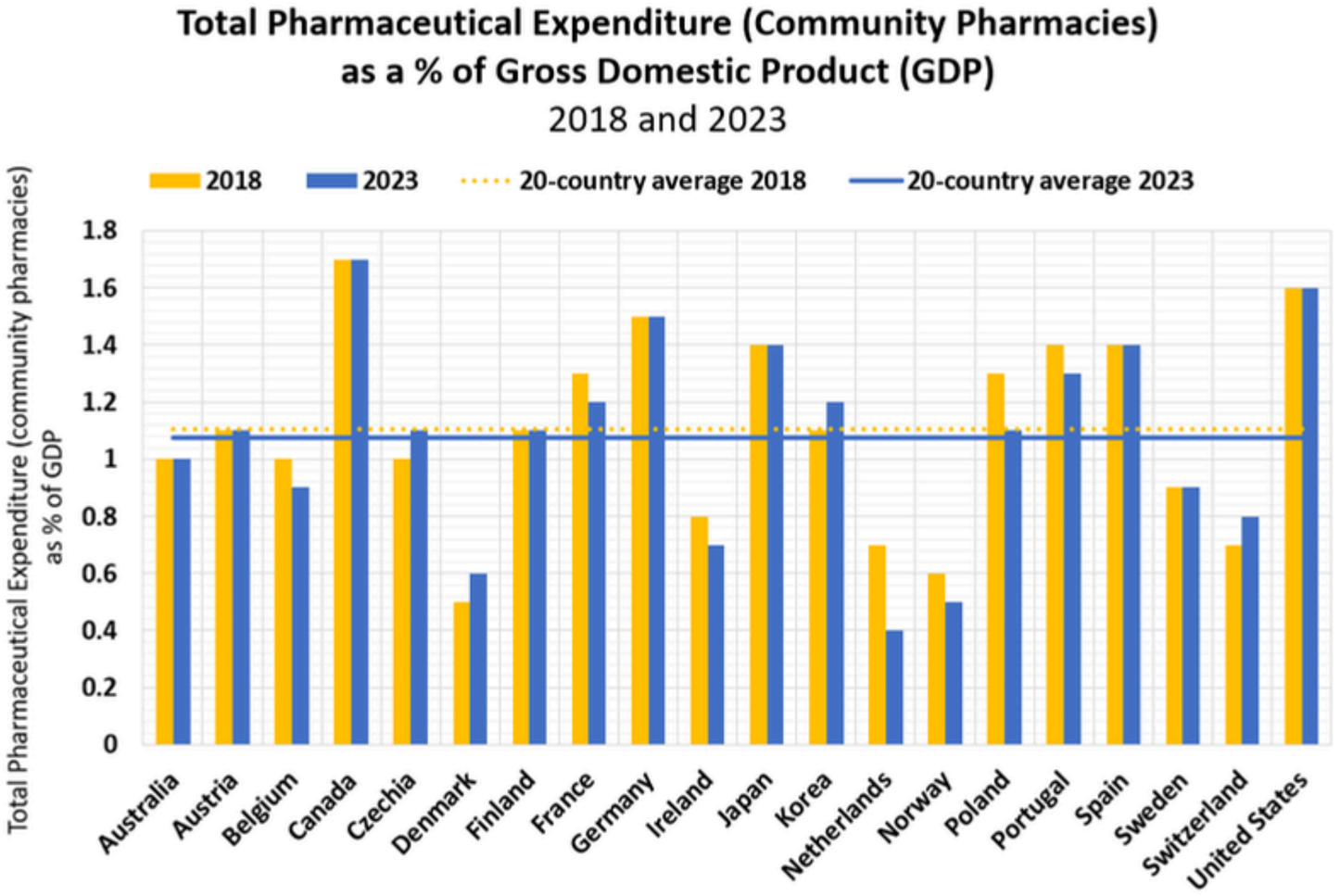


Data source: OECD Health Statistics Database, accessed 24 Sep 2025

Total Pharmaceutical Expenditure through Community Pharmacies as % of GDP, 2018 and 2023

CHIEF ECONOMIST COMMENT

The OECD also publishes pharmaceutical expenditure data through community pharmacies only. This data shows that the decline of 0.03% in GDP contribution of pharmaceuticals (previous page) has been entirely through community pharmacy (and not other sectors, such as hospital). WPC's Sector Analysis data - not produced by the OECD - shows that prescription volumes continue to grow year-on-year in most countries, so this relative decrease in expenditure (representing income for community pharmacies) is not an indication of less workload or value-delivery.



Data source: OECD Health Statistics Database, accessed 24 Sep 2025