Position Statement: **Dispensing & Core Funding**

Introduction

As a clinical service, dispensing is central to ensuring the safe, effective, and rational use of medicines in the community. Dispensing is comprehensive and highly regulated, and requires expert clinical judgment. The pharmacist is entrusted with a duty of care as the final checkpoint before a patient uses a prescription medicine. As they dispense, pharmacists apply their expertise to perform crucial patient engagement and clinical review, identifying medication-related issues and initiating interventions. Dispensing is the core community pharmacy service and a vital pathway to a wider range of health services, contributing to comprehensive, personalized care and prevention.

Underfunding of this core service compromises continuity of care, patient safety, and timely, equitable access to treatment. It also threatens the viability of local community pharmacies and the sustainability of the community pharmacy network and, as a result, increases pressure on other areas of the healthcare system. Sustainable core funding is imperative. Funding arrangements must reflect the full clinical, economic, and public health value of community pharmacy, incorporating mechanisms for inflation and ensuring equity of access for all patients, and securing future capability and capacity.

Community pharmacies are the most frequently visited healthcare provider in most developed countries, and this access is driven primarily by dispensing:

- In Germany, there are more than 1 billion patient interactions per year in pharmacies, about 13 per person, and 64% of all adults use their local pharmacy at least once each month (ABDA, 2024; ABDA, 2025).
- In Portugal, pharmacies see around 570,000 people daily, representing 5% of the population, with most interactions linked to dispensing (ANF, 2025).
- 55% of Canadians visit a community pharmacy at least once a week, and see a community pharmacist up to ten times more frequently than their family physician (Raiche et al.,2021)
- Over 1.1 billion prescription items are dispensed annually in England, which is approximately 19 per person (NHSBSA, 2025).

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.

WPC Policy Positions

1. Dispensing is a clinical service

Dispensing is a highly regulated, evidence-based clinical service requiring professional expertise. It 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. Dispensing ensures patients receive medicines appropriate to their clinical needs, in correct doses according to their individual requirements, for the appropriate duration, and with the information necessary for correct use. This trusted, professional service reflects the pharmacist's duty of care and clinical expertise, delivered within established regulatory frameworks.

- *Appendix A* provides a general description of the elements involved in dispensing.
- *Appendix B* outlines key evidence of the clinical value of dispensing-related interventions.
- *Appendix C* demonstrates the community pharmacist's critical role in enhancing medication adherence, including through dispensing.

2. Dispensing is a pathway to wider health services

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.

- *Appendix D* includes examples of services often initiated through dispensing.

3. Community pharmacies are essential public-private health infrastructure

A properly funded community pharmacy network is a strategic health asset. It was demonstrated without doubt during the COVID-19 pandemic that pharmacies function as essential local health hubs, as agents of public health and social cohesion, and as a pillar of health system resilience. To fulfill and expand upon these vital roles, sustainable and responsive core funding is essential, as it gives pharmacy owners the confidence to make the necessary capital investments in new services and technologies that improve personalised patient care.

Implementing these service enhancements requires significant upfront and ongoing investment in physical space reconfiguration, specialized equipment, robust staff training, and continuous professional development. Pharmacy owners can only commit to these vital improvements with the financial stability and assurance provided by

dependable funding arrangements. Underfunding, therefore, not only threatens current services but also actively diminishes the healthcare system's future capacity and capability.

- *Appendix E* elaborates on the role of new technologies in augmenting clinical practice.
- Also refer to the WPC's *Position Statement: Community Pharmacy is key to more resilient healthcare systems*

4. Sustainable core funding is essential for viability and access

In many countries, funding 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.

- *Appendix F* details the negative economic consequences of underfunding community pharmacy's core activity.

5. 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.
- **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 community pharmacy model, threatening essential points of access to medicines, advice, counselling, personalised treatment information, public health measures, and patient care.

Call to Action

Healthcare systems worldwide face mounting pressures from demographic shifts, chronic disease prevalence, and capacity constraints. Investing in a well-funded community pharmacy network, anchored by sustainable dispensing services, is a direct and proven strategy to build more resilient, equitable, and cost-effective healthcare.

The World Pharmacy Council calls on policymakers to:

1. Formally recognize prescription dispensing, overseen by a licensed pharmacist, as a crucial clinical service that is essential for patient safety and the optimization of medicines use.

2. Secure the future of patient care by ensuring community pharmacy funding models incorporate the five essential elements of viability, responsiveness, equity, separation and efficiency.

3. Invest in and leverage community pharmacy as a strategic health asset to build more accessible, efficient, and resilient healthcare systems for all citizens.

Appendix A: The multifaceted professional elements of dispensing

Dispensing is a comprehensive, highly regulated, person-centred clinical service that extends far beyond the physical supply of a medicine. It requires the application of expert pharmaceutical care and clinical judgment at multiple stages to ensure patient safety and optimal health outcomes are achieved from prescription medicines. A prescription is not a simple order to be fulfilled; it is a clinical request that is subject to the pharmacist's professional review and duty of care. The pharmacist is the final checkpoint before a patient uses a highly effective but potentially dangerous product.

The table below outlines the key elements integral to dispensing, illustrating its clinical depth and value.

Phase of Dispensing	Key Elements & Professional Responsibilities
1. Legal & Patient Validation	Verifying the prescription's legal validity and authenticity, and confirming the identity of the patient. This foundational step protects against counterfeit prescriptions, thereby ensuring the integrity of prescribing and the medication supply chain.
2. Professional Clinical Review	The pharmacist applies their professional duty of care to assess the prescribed medicine for safety, efficacy, and suitability for the individual patient. This involves a comprehensive review of factors including the patient's clinical condition, purpose of the treatment, treatment duration, previous experience with the medication, comorbidities, allergies, adherence issues, and interactions with concurrent medications. The purpose of the review is to prevent medication errors, optimize therapy, and minimise the risk of patient harm. If this review identifies a problem requiring intervention, it will be resolved in collaboration with the patient during the consultation (see below) and may include contact with the prescribing doctor.
3. Patient Consultation, Risk Identification & Risk Management	Patient consultation when dispensing provides pharmacists the opportunity to proactively identify and resolve medication-related issues. Such issues may include adverse drug reactions, interactions with other medicines or substances, polypharmacy risks, duplication, and barriers to medication adherence. This is a critical opportunity to optimise

	pharmacotherapy and guide patients toward better health outcomes, creating a high level of public trust in the pharmacy profession to provide personalized advice and care.
4. Professional Collaboration & Care Coordination	Community pharmacists work as part of the wider healthcare team to resolve medication-related issues, including liaising with prescribers to clarify orders or suggest alternatives. This is especially critical for managing the global problem of medicine shortages. It is also vital to ensure continuity of care when a patient is transitioning to a new stage of care. Moves between care settings - for example, post-discharge from hospital or when entering into aged care – require careful coordination, involving transfer of records, medication reconciliation, proactive engagement with facilities and carers, and effective communication with the multidisciplinary team to provide ongoing support.
5. Professional Supply, Counselling & Education	**Professional provision of each medicine:** Overseeing and ensuring the accurate selection, counting/measuring, and labelling of the medication in compliance with all legal and professional standards, including measures to prevent counterfeit medicines from being stocked or dispensed. **Patient counselling & health literacy:** Providing clear, evidence-based information about the medicine, including its purpose, correct administration, potential side effects, and storage. This crucial education ensures the patient understands their therapy, improves health literacy, and empowers them to manage their health effectively.
6. System Management, Cost-Containment & Patient Follow-up	While these steps are not always clinical, their importance to healthcare system efficiency, medicine affordability and medicine safety should not be underestimated. **Inventory management & supply chain integrity:** Managing the physical inventory to maintain the quantity, quality and integrity of the medicine supply chain. This includes maintaining optimal storage conditions, preventing the use of expired products, and adhering to strict procurement protocols to ensure all medicines originate from legitimate sources, thereby protecting patients from the risks of

	counterfeit or substandard products. It also involves forecasting local patient needs while managing complex supply chains to mitigate the impact of medicine shortages. In many countries pharmacies also provide services to safely and securely dispose of unused medicines. **Record-keeping:** Maintaining accurate and contemporaneous records of the dispensing event, clinical interventions, and communications with other healthcare providers. This includes interacting with patient health records where available. Depending on regulations, some categories of drugs require additional record-keeping steps. **Administration & cost-containment for patients and payers:** Ensuring administrative activities and inputs comply with complex public/private third-party reimbursement schemes, and help patients to navigate their entitlements under those schemes. This includes managing and minimising out-of-pocket costs on behalf of patients and payers (for example, through the appropriate use of generic and biosimilar medicines). **Monitoring & pharmacovigilance:** Establishing plans for monitoring therapy where appropriate and contributing to national pharmacovigilance systems by identifying and reporting adverse drug reactions.

Appendix B: The clinical value of dispensing

The dispensing of medication is not a logistical task but a critical, front-line clinical service. An extensive body of international evidence reveals that the interventions performed by pharmacists during dispensing are a frequent, necessary, and highly impactful component of patient care. This synthesis presents a compelling, data-driven case for the indispensable clinical value of dispensing by highlighting key evidence on the frequency, nature, and significance of these interventions.

It is critical to recognize that the intervention rates documented in research studies represent only a fraction of the true clinical value delivered by pharmacists. The data presented below are based on documented interventions, which are known to be significantly under-reported due to the intense workload and time pressures of community pharmacy practice. Documenting an intervention requires time away from patient care, meaning that many resolved issues are never formally recorded. Therefore, the figures in these studies should be interpreted as a **conservative, evidence-based minimum** - the visible tip of a much larger iceberg of clinical activity that protects patients daily.

The evidence at a glance: Key data from landmark studies

The following table summarizes the powerful data from major studies across multiple countries, quantifying the consistent and vital role of pharmacists during dispensing.

Study & Focus	**Key Metric: Frequency & Nature of Interventions**	**Key Finding: Clinical Significance & Impact**
Hawksworth et al. (1999) *Foundational UK Study*	0.75% of all dispensed items resulted in a recorded clinical intervention. Interventions focused on safety and efficacy beyond simple clarifications.	32% involved an intervention that may have prevented potential patient harm, as assessed by an independent panel. 50% involved an intervention that improved clinical outcomes and could have saved a GP visit.
Ekedahl (2010)	Pharmacists contacted the prescribers for 1% of all new	Errors that may compromise patient safety and medication

Swedish study of problem prescriptions	prescriptions before dispensing.	outcome constituted almost 60% of the problems.
PROMISe Trial (2011) *Large-Scale Australian Documentation Study*	Of the 6,230 interventions recorded, 31% were for drug selection problems; 24% were educational.	Pharmacists self-rated 42% of their interventions as being of high clinical significance.
Pizetta et al. (2021) *International Systematic Review*	Synthesized findings from multiple studies on dispensing services. Identified a consistent pattern of positive influence.	Concluded that dispensing has a positive impact on clinical, humanistic, and economic health outcomes.
Clarenne et al. (2022) *French Care Transitions Study*	Prescriptions originating from hospitals were significantly more likely to contain a drug-related problem.	Highlights the community pharmacist's critical role as a safety net during high-risk transitions of care.

Synthesizing the Evidence

1. **Interventions are a frequent and integral part of dispensing:** The documented rates of intervention represent millions of safety events prevented annually. The evidence consistently shows a documented intervention rate of approximately 0.75% to 1% for every prescription dispensed. While this may appear to be a small percentage, it is crucial to understand these numbers in two contexts: the limitations of study methodologies and the immense scale of dispensing volumes. For example, in a country where 1 billion items are dispensed annually, this documented rate translates to 7.5 to 10 million clinical interventions each year - millions of potential medication errors identified and harms averted. The recorded data, representing only the formally documented interventions – a conservative, evidence-based minimum - provides undeniable proof of the scale and importance of the pharmacist's role.

2. **Each intervention carries significant clinical effect:** The data demonstrates that these are not trivial clarifications. Across multiple studies, independent professional panels and pharmacists themselves have judged that one-third to one-half of all documented interventions are of high clinical significance, directly

preventing patient harm or improving therapeutic outcomes. This confirms that when pharmacists intervene, their actions have a tangible and vital impact on patient health and safety.

3. **Dispensing is a final, essential safety net in high-risk scenarios:** Dispensing serves as the ultimate checkpoint before a medication reaches the patient. This role is especially critical during high-risk scenarios, such as when a patient is discharged from the hospital. The evidence shows that pharmacists are uniquely positioned to catch and rectify errors that have slipped through other parts of the healthcare system, preventing adverse events and ensuring continuity of care.

Conclusion

The extensive evidence, gathered from decades of international research, is unequivocal. Even when viewed through the lens of conservative, under-reported data, pharmacist interventions during dispensing represent millions of annual safety events. These are not minor administrative checks. They are high-impact clinical actions that prevent harm and optimize treatment. This body of evidence proves that dispensing is a high-impact, evidence-based practice that consistently protects patients and delivers profound value to the entire healthcare system.

Appendix C: The pharmacist's critical role in enhancing medication adherence

Medication non-adherence is a significant global health challenge, leading to poor health outcomes, increased hospitalizations, and substantial avoidable healthcare costs. It is estimated that in developed countries, adherence to long-term therapies averages only 50% (WHO, 2003). The consequences are severe - research has found that morbidity and mortality associated with poor medication adherence costs the U.S. healthcare system an estimated $528.4 billion annually (PAN Foundation, 2020).

Community pharmacists are uniquely positioned to detect and address medication non-adherence through conversations with patients and monitoring of dispensing intervals. The regular interactions during dispensing provide invaluable opportunities to:

- **Educate and counsel:** Explain the importance of medication, how to take it correctly, and manage potential side effects.
- **Identify barriers:** Uncover patient-specific challenges to adherence, such as forgetfulness, complex regimens, cost concerns, or health literacy issues.
- **Provide solutions:** Offer practical solutions like medication dosage packing, reminder systems, dispensing synchronisation, and liaising with prescribers to simplify regimens.
- **Monitor and support:** Offer ongoing support and follow-up as part of repeat dispensing, reinforcing the importance of adherence and addressing any emerging issues.

The value of these interventions is confirmed by extensive evidence. Pharmacist-led adherence support has been consistently shown to improve patient outcomes across a range of chronic conditions (Nieuwlaat et al., 2014). By improving medication adherence, pharmacists not only enhance the clinical effectiveness of therapies but also generate significant health system efficiencies. Investment in community pharmacist's core role is therefore a direct and cost-effective strategy to address the profound clinical and economic burden of medication non-adherence.

Appendix D: Dispensing as a pathway to other care

Dispensing is the primary and most frequent interaction through which patients access the clinical expertise of their pharmacist. This regular contact provides an essential opportunity to not only enhance pharmaceutical care but also to identify health risks, initiate clinical conversations, and signpost patients to the further care they may need. This improves the quality of person-centred healthcare and provides economic and accessibility benefits through early intervention and by reducing the demand on other parts of the healthcare system.

The viability of this entire ecosystem of care is anchored to the dispensing service. Without a sustainable core funding model for dispensing, the opportunities to deliver these valuable ancillary services are compromised, preventing their reliable and equitable delivery. Furthermore, while dispensing acts as the gateway, it is crucial - in line with the funding principle of "separation" - that these additional services are also structured and funded to be individually viable, ensuring a robust and comprehensive service model.

Examples of services and interventions facilitated by the dispensing encounter and carried out within community pharmacies include those listed below. In many other cases, patients are signposted or formally referred to care from other healthcare providers.

- **Long-term condition management:** Repeat dispensing allows pharmacists to monitor adherence and detect issues with control by monitoring clinical markers (for example, blood pressure or glucose levels), often forming the basis for structured management programs and medication optimization (Newman et al., 2020).
- **Identifying the need for medication review:** Dispensing allows pharmacists to detect drug-related problems - such as interactions, contraindications, polypharmacy, or adherence issues - that signal the need for a comprehensive medication review. This targeted identification ensures that comprehensive medication reviews, which are proven to reduce drug-related morbidity and mortality, are directed to the patients who will benefit most. The service is also highly cost-effective, with studies showing a return on investment of over €3 for every €1 spent (Martínez-Martínez F, et al., 2014; Varas-Doval R, et al., 2020).
- **Medication reconciliation and transitions of care:** Dispensing following hospital discharge provides a critical opportunity to reconcile medications, resolve discrepancies, and educate patients, helping to prevent readmissions and adverse events, and to maintain patient safety (Lussier et al., 2019).
- **Medicine shortages and continuity of care:** Pharmacists identify and recommend therapeutic alternatives, liaise with prescribers, and counsel patients on treatment

modifications to maintain safety and adherence during shortages (Teixeira et al., 2022).

- **Acute and minor ailment care:** When patients present prescriptions for acute conditions or request help with addressing a common health problem, pharmacists can assess symptoms, recommend appropriate treatments, and triage patients to other providers when necessary. This service, often linked to established pharmacist-initiated treatment pathways, is proven to be both clinically effective and highly cost-effective, reducing pressure on general practice and emergency departments (Fielding et al., 2015; Amador-Fernández N, et al., 2021).
- **Public health interventions:** The interaction enables opportunistic delivery of services such as vaccinations, dietary advice, smoking cessation, harm minimization, point-of-care testing, and health screening (Steed et al., 2019).
- **Lifestyle and preventive health support:** Pharmacists utilize dispensing encounters to encourage lifestyle changes for at-risk patients and improve health literacy.

Appendix E: Investment in new technologies to augment clinical practice

Sustainable and responsive core funding arrangements give pharmacy owners the confidence to invest capital into new services and advanced technologies that improve and streamline patient care. Pharmacy owners can only commit to these investments with the financial stability and assurance provided by dependable funding arrangements.

The importance of capital investment in new technologies

Innovative technologies, such as automation and artificial intelligence, complement and augment the community pharmacist's role by streamlining workflows and administrative tasks. However, it is crucial to understand that these technological advancements cannot replicate or replace the core cognitive components of dispensing and pharmaceutical care. These uniquely human elements include clinical judgment, professional discretion, and empathetic patient interaction, all of which are grounded in professional accountability and the established trust between pharmacists and their communities.

Strategic and appropriate investment in technology can free up pharmacists' time, enabling them to dedicate more of their expertise to direct patient engagement, complex clinical problem-solving, and personalized care. In this model, technology serves not as a replacement for the professional, but as a powerful tool to enhance the value of every clinical encounter and improve patient outcomes.

Integrating digital health to enhance person-centred care

Beyond workflow automation, technology investment is crucial for integrating pharmacies into the broader digital health ecosystem. This includes adopting platforms for telehealth to expand access to care for remote or homebound patients, secure connectivity with shared patient health records, and implementation of measures to monitor and protect against cybersecurity threats.

Technological integration also involves equipping community pharmacists to support patients using digital health tools, such as mobile health apps and wearable devices, helping them to interpret data and manage their medicines and conditions more effectively.

By acting as trusted, personal navigators in the digital health landscape, pharmacists can combine technology with human expertise to lead to more individualized, accessible, and efficient patient care, enhancing their role as essential health hubs in the community.

Appendix F: The economic consequences of underfunding

The chronic underfunding of community pharmacy's core role is not a contained issue - it creates significant and costly ripple effects across the entire healthcare ecosystem. When the financial viability of pharmacies is compromised, it triggers a cascade of negative consequences that shifts burden onto capacity-constrained, more expensive parts of the health system, increases costs of access, and disproportionately harms the most vulnerable patients. This appendix outlines the clear economic impact of this underfunding.

Direct consequences: The erosion of "Healthcare's Front Door"

Sustained financial pressure directly degrades the pharmacy network, leading to a quantifiable loss of access for patients. An independent economic analysis in England, for instance, found that the cost of delivering NHS pharmaceutical services outstripped funding by over £2 billion, concluding that **99% of pharmacies were not sustainable in the long term** under the existing model (The Pharmaceutical Journal, May 2025). This economic reality manifests in several ways:

- **Accelerating closures:** Pharmacies are closing at an alarming rate. In England, nearly **800 pharmacies permanently closed** between the start of 2021 and the end of 2024, leaving the country with its lowest number in nearly two decades (BBC News, December 2024). This trend is mirrored in other developed nations; Germany saw its pharmacy numbers fall to the lowest level since 1978 after **losing over 500 pharmacies in a single year** (The Munich Eye, April 2025).
- **Reduced services and staffing:** To survive, pharmacies are forced to reduce opening hours, cut staffing, and limit the scope of services they can offer. This directly impacts the quality and accessibility of care, leading to longer wait times and reduced capacity for essential patient counseling.
- **Creation of "pharmacy deserts":** Closures are not evenly distributed. They disproportionately affect rural and remote communities, as well as deprived urban areas, creating "pharmacy deserts" where patients face significant travel barriers to access essential medicines and health advice (Healthwatch England, September 2024).

System-wide effects: Shifting costs and worsening inequity

The degradation of the pharmacy network does not save money for the health system; it merely shifts costs to patients and to less efficient, more expensive settings, while also deepening health inequities.

- **Increased burden on primary and emergency care:** When patients cannot access their local pharmacist for advice or treatment of minor ailments, they turn to general practitioners (GPs) and hospital emergency departments (EDs). Research has consistently shown that difficult access to pharmacies leads to

"increased medical care costs from increased hospitalizations or emergency department visits" (U.S. Pharmacist, April 2024).

- **Counteracting the Inverse Care Law:** Community pharmacies are uniquely positioned to fight health inequality. The "Inverse Care Law" dictates that those most in need of medical care are least likely to receive it (Hart, J. T., 1971). However, research demonstrates that community pharmacies buck this trend. A key UK study found that while general medical practices are less available in deprived areas, **community pharmacies are more prevalent in these same areas**. The authors concluded that "community pharmacy is a potential vehicle to reduce health inequalities in primary care" (Todd et al., BMJ Open, 2014). Underfunding this accessible network directly undermines a powerful tool for promoting health equity.
- **Increased patient travel burdens:** When a local pharmacy closes, patients are forced to travel further, which imposes direct costs in time and money. A U.S. study modeling the impact of pharmacy closures found that residents in medically underserved areas already travel nearly twice as far to reach a pharmacy. A single closure can increase their travel distance by over 100%, leading to significant annual economic costs (Adepoju et al., PLoS One, 2023).

Disproportionate Impact on Vulnerable Populations

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 is not a convenience but a lifeline. Its 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. The loss of this relationship leads to poorer health outcomes and higher long-term care costs.
- **Other vulnerable groups:** For example, those with language barriers, reduced social interaction, or low levels of education or health literacy.

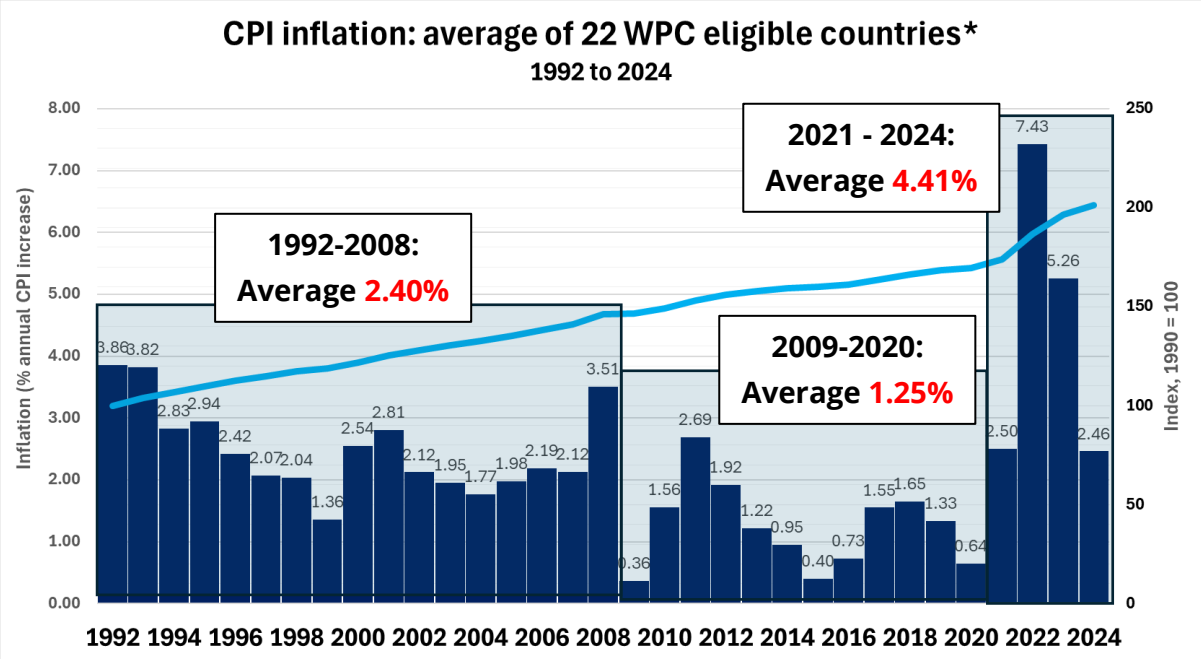
Underfunding community pharmacy dismantles the most accessible part of the healthcare system, leading to predictable and significant cost increases in other areas, while simultaneously worsening health outcomes and deepening inequities for the most vulnerable members of society.

The Economic Reality of Service Sector Inflation

It is important to recognise that a once-off boost to funding is not enough to resolve a problem of chronic underfunding. If funding does not keep pace with inflation in the broader economy, it is in reality going backwards.

A new phase of inflationary pressures

The years between the 2008 Global Financial Crisis and the 2020 COVID-19 pandemic represented an unprecedented period of low global inflation. Since 2021, inflationary pressures have spiked. The consequences have been stark for community pharmacies in countries that have not had regular or automatic inflation-linked review in remuneration levels.



** Three eligible countries – Greece, Israel and Poland – were excluded due to periods of extremely high inflation.*

Baumol's Cost Disease exacerbates the inflationary problem

National rates of inflation only tell one part of the story. Accepted economic theory, and empirical evidence, shows that rates of inflation are higher in service-based sectors than in industrial or manufacturing sectors.

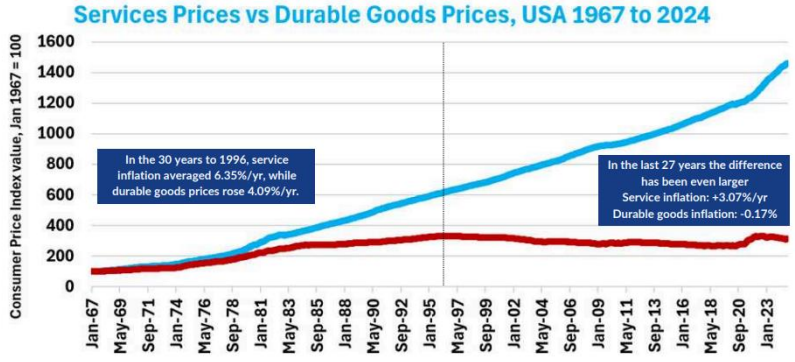
Opportunities for productivity improvements - through economies of scale or via new technology - are far more limited in professionally skilled, highly personal service sectors such as healthcare than they are in a manufacturing process, where the product is known and standardised and where the production process can be optimised. Productivity growth lets manufacturing raise wages and cut prices, but the service industries, with their lower productivity growth, cannot do both. To keep attracting workers, the service sectors must raise wages. Without corresponding productivity gains, this drives up their unit costs per service, which they can only pass on to the final payer. In economics, this principle is known as *Baumol's Cost Disease*, named after NYU Professor of Economics, William J. Baumol.

The principle has been well accepted since Baumol proposed it in the 1960s. For example, in a 2024 paper, the OECD explicitly referenced this Baumol effect as contributing 21% of its base projection for growth in health spending across 33 countries through to 2040 (almost as high a contribution as the ageing of the population, at 24%).

The chart below provides stark empirical evidence of the truth of Baumol's Cost Disease, with services prices far outstripping durable goods prices in the USA. This has also been shown to be evident in Europe, through recent research published by the European Central Bank.

Patient contributions, drug reimbursement rates, margins, and prescription fees are typically determined by external policy and funding constraints. Unlike other businesses, community pharmacies cannot respond to cost pressures by independently adjusting their prices. To remain viable without diminishing service quality, pharmacies depend on appropriate funding adjustments that recognize inflationary pressures in a timely and predictable manner.

Baumol's Cost Disease explains why, in a world of rapid technological advances in manufacturing, we expect prices of goods like cars and electronics to fall, while the costs of labour-intensive services like healthcare and education steadily increase. This cost growth in services isn't a sign of inefficiency but rather an inherent economic reality for service-based industries where human expertise remains central.



Source: WPC, 2024

References

ABDA – Federal Union of German Associations of Pharmacists. (2024). *German pharmacies: Figures, data, facts 2024*. ABDA. https://www.abda.de/fileadmin/user_upload/assets/ZDF/Zahlen-Daten-Fakten-24/ABDA_ZDF_2024_Brosch_english.pdf

Adepoju, O. E., Kiaghadi, A., Shokouhi Niaki, D., Karunwi, A., Chen, H., & Woodard, L. (2023). Rethinking access to care: A spatial-economic analysis of community pharmacy closures and their impact on vulnerable populations. *PLOS ONE*, *18*(7), e0289284. https://doi.org/10.1371/journal.pone.0289284

Amador-Fernández N, et al. A cost utility analysis alongside a cluster-randomised trial evaluating a minor ailment service compared to usual care in community pharmacy. BMC Health Serv Res. 2021;21(1):1253. doi: 10.1186/s12913-021-07188-4

Baena MI, et al. Negative clinical outcomes of medication resulting in emergency department visits. Eur J Clin Pharmacol. 2014;70(1):79-87. doi: 10.1007/s00228-013-1562-0

Clarenne, J., Gravoulet, J., Lestrade, A., Aubert, L., Slimano, F., Dupuis, F., & Mongaret, C. (2021). Clinical and organizational impacts of medical ordering settings on patient pathway and community pharmacy dispensing process: The prospective ORDHOSPIVILLE study. *Pharmacy*, *10*(1), 2. https://doi.org/10.3390/pharmacy10010002

Ekedahl, A. (2010). Problem prescriptions in Sweden necessitating contact with the prescriber before dispensing. *Research in Social and Administrative Pharmacy*, *6*(3), 174–184. https://doi.org/10.1016/j.sapharm.2009.09.001

Fielding, S., et al. (2015). Community pharmacy-led minor ailment schemes: A systematic review. *International Journal of Pharmacy Practice*, *23*(5), 309-325.

Hart, J. T. (1971). The Inverse Care Law. The Lancet, 297(7696), 405–412. https://doi.org/10.1016/S0140-6736(71)92410-X

Hawksworth, G., Corlett, A., Wright, D., & Chrystyn, H. (1999). Clinical pharmacy interventions by community pharmacists during the dispensing process. *British Journal of Clinical Pharmacology*, *47*(6), 695–700. https://doi.org/10.1046/j.1365-2125.1999.00964.x

Healthwatch England. (2024, September 26). *Pharmacy closures in England*. Healthwatch. https://www.healthwatch.co.uk/report/2024-09-26/pharmacy-closures-england

Henman, M., et al. (2024). The evolution of pharmaceutical care in community pharmacy. *Journal of Pharmaceutical Policy and Practice*, *17*(1), 45-62.

Lussier, M., et al. (2019). Impact of community pharmacist interventions on transitions of care: A systematic review. *American Journal of Health-System Pharmacy*, *76*(14), 1032-1045.

Martínez-Martínez F, et al. Medida del Impacto clínico, económico y humanístico del servicio de seguimiento farmacoterapéutico en mayores polimedicados, en la farmacia comunitaria española [Measurement of the clinical, economic and humanistic impact of pharmacotherapy monitoring services in polymedicated elderly patients in Spanish community pharmacies]. [Internet]. Madrid: CGCOF; 2014. Available at : https://www.farmaceuticos.com/wp-content/uploads/2020/02/2017-Informe-Resultados-conSIGUE-Implantacion.pdf

Muralidharan, K. M., & Jones, M. (2024, December 20). Impact of 800 pharmacy closures can 'ruin lives'. *BBC News*. https://www.bbc.com/news/articles/cpq9jx3y8jeo

Newman, T., et al. (2020). Community pharmacy contributions to chronic disease management: A global perspective. *Research in Social and Administrative Pharmacy*, *16*(8), 1024-1035.

NHS Business Services Authority. (2025). *Dispensing contractors' data*. NHSBSA. Retrieved June 10, 2025, from https://www.nhsbsa.nhs.uk/prescription-data/dispensing-data/dispensing-contractors-data

OECD. (2021). *Strengthening the frontline: How primary health care helps health systems adapt during the COVID-19 pandemic*. OECD Publishing. https://doi.org/10.1787/9a5ae6da-en

PAN Foundation. (2020, June 2). *Medication non-adherence: A common and costly problem*. https://www.panfoundation.org/medication-non-adherence/

Pizetta, B., Raggi, L. G., Rocha, K. S. S., Nogueira, M. C., Leite, S. N., & Dos Santos, M. A. (2021). Does drug dispensing improve the health outcomes of patients attending community pharmacies? A systematic review. *BMC Health Services Research*, *21*(1), 764. https://doi.org/10.1186/s12913-021-06770-0

Raiche, T., Pammett, R., Dattani, S., Dolovich, L., Hamilton, K., Kennie-Kaulbach, N., McCarthy, L., & Jorgenson, D. (2020). Community pharmacists' evolving role in Canadian primary health care: a vision of harmonization in a patchwork system. *Pharmacy Practice*, *18*(4), 2171. https://doi.org/10.18549/pharmpract.2020.4.2171

Steed, L., et al. (2019). Community pharmacy interventions for health promotion: Effects on professional practice and health outcomes. *Cochrane Database of Systematic Reviews*, Issue 12.

Teixeira, I., et al. (2022). Pharmacist interventions in medicine shortages: A systematic review. *International Journal of Clinical Pharmacy*, *44*(2), 276-288.

The Munich Eye. (2025, April 8). *Continued decline of pharmacies in Germany in early 2025*. https://themunicheye.com/pharmacy-closures-germany-early-2025-16370

Todd, A., Copeland, A., Husband, A., Kasim, A., & Bambra, C. (2014). The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England. *BMJ Open*, *4*(8), e005764. https://doi.org/10.1136/bmjopen-2014-005764

Varas-Doval R, et al. Clinical impact of a pharmacist-led medication review with follow up for aged polypharmacy patients: A cluster randomized controlled trial. Pharm Pract. 2020; 18(4):2133. doi: 10.18549/PharmPract.2020.4.2133; Malet-Larrea A, et al. Cost analysis and cost-benefit analysis of a medication review with follow-up service in aged polypharmacy patients. Eur J Health Econ. 2017;18(9):1069-1078. doi: 10.1007/s10198-016-0853-7

WPC (2020). *Community Pharmacy's Response to COVID-19: A Global Survey*. World Pharmacy Council.

World Health Organization. (2003). *Adherence to long-term therapies: Evidence for action*. World Health Organization. https://iris.who.int/handle/10665/42682