Pharmaceutical Society of Australia

PSA 2026-2027 FEDERAL BUDGET SUBMISSION

PSA Empowering pharmacists

Contents

About PSA

PSA is the only Australian Government-recognised peak national professional pharmacy organisation representing all of Australia's 41,000 pharmacists working in all sectors and across all locations.

PSA is committed to supporting pharmacists to help Australians access quality, safe, equitable, efficient and effective health care. PSA believes the expertise of pharmacists can be better utilised to address the healthcare needs of all Australians.

PSA works to identify, unlock, and advance opportunities for pharmacists to realise their full potential, to be appropriately recognised and remunerated.

PSA has a strong and engaged membership base that provides high-quality health care and are the custodians for safe and effective medicine use for the Australian community.

PSA's roles include:

- custodian of setting and maintaining **professional practice standards** for pharmacists and **practice guidelines**
- custodian of setting and maintaining pharmacist **Code of Ethics** and the **Competency Standards Framework for pharmacists**
- credentialing of **consultant pharmacists** to provide government-funded medication review services, such as Home Medicines Reviews and aged care services
- providing **practice support** and **continuous education** to pharmacists
- providing **training** to pharmacy assistants as a Registered Training Organisation

First Pharmacy Programs Reform Package

Patients need safe, timely and equitable access to medication management services, including in aged care, and rural and remote communities.

PSA proposes a single, staged reform package that restores sustainability, equity and safety by resetting and protecting remuneration through service fee indexation, removing access barriers including monthly HMR service caps, and strengthening program delivery through targeted refinements and streamlined program rules.

The First Pharmacy Programs Reform Package features three targeted reform levers to improve access, efficiency and workforce sustainability in pharmacy programs.

Many elements of this package involve changes to program design and delivery within existing funding arrangements. However, some measures — most notably indexation of service fees for complex medicine review services — require additional investment.

REFORM LEVERS	1. Indexation	2. Lifting of Caps	3. Flexibility
What is the issue	Service fees have not been indexed since 2019, eroding real value	Monthly caps artificially ration clinically indicated services	Rigid program rules limit local service optimisation
What we are asking for	Reinstate annual indexation aligned to comparable health programs and services and address the retrospective indexation shortfall	Lift caps to improve access where demand and workforce capacity exist	Enable controlled local flexibility with appropriate safeguards
Why these reforms matter	Declining real remuneration undermines workforce participation and service sustainability	Volume limits constrain delivery regardless of patient need or available capacity	Prescriptive settings reduce reach, particularly in rural and underserved areas
Outcome	Sustainable remuneration that supports workforce participation and continuity of care	Services delivered where need exists, without artificial constraints	Improved access and efficiency, especially in rural, remote and underserved communities

Figure 1. A targeted reform package addressing the structural barriers to inequity, constrained access and inefficient delivery across pharmacy programs. Reforms are designed to be phased, fiscally controlled and reviewed through 1PPA program governance.

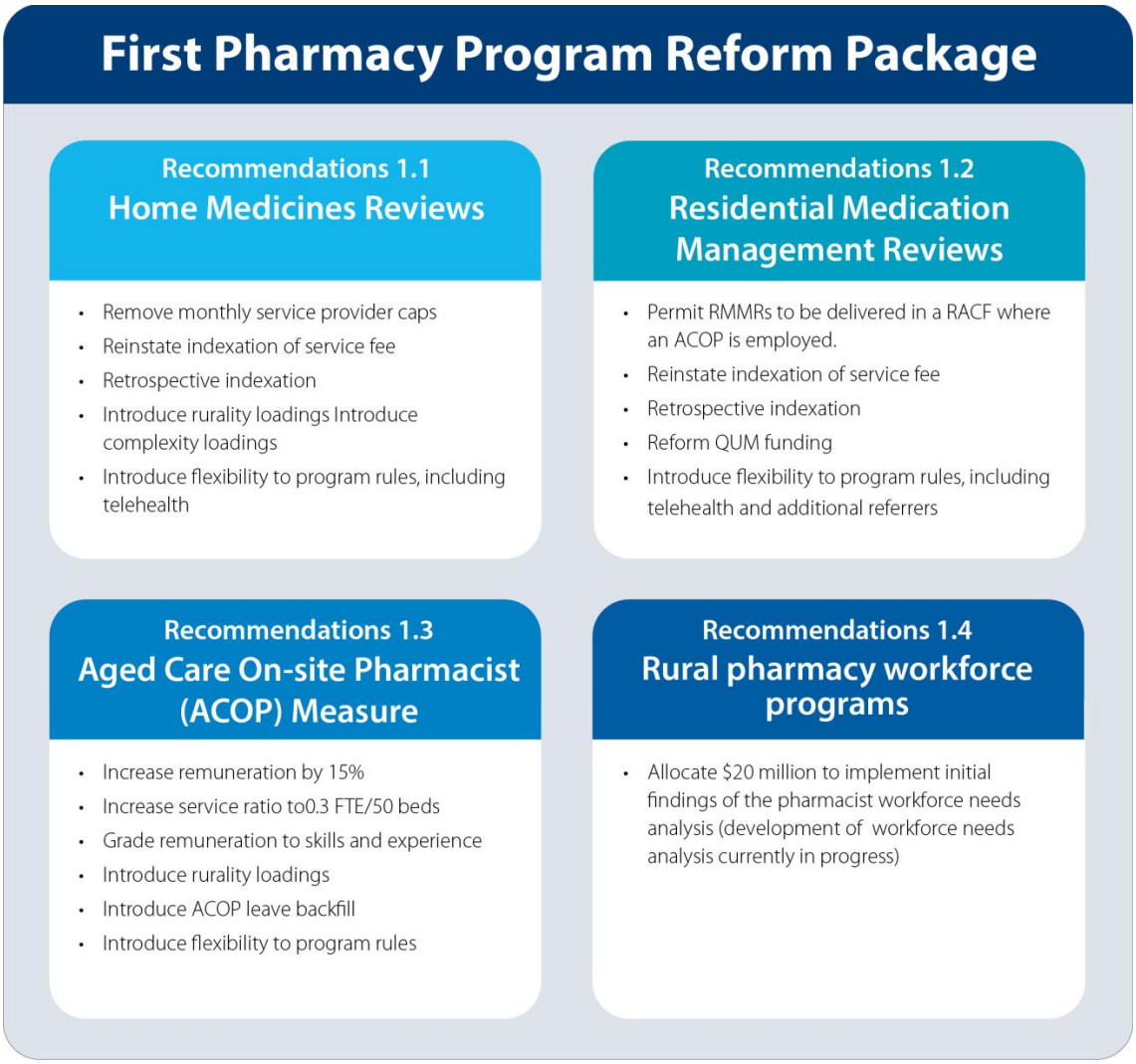


Figure 2. A targeted, system-wide reform package to improve access, sustainability and value for money across pharmacy programs.

Background

How current access constraints emerged: HMR caps and the indexation freeze

HMRs commenced in October 2001 as a structured, GP-initiated medication review service designed to improve quality use of medicines, reduce medication-related harm, and support coordinated care for people at higher risk due to chronic and complex conditions. While the clinical intent has remained, program settings have progressively shifted to improve fiscal predictability as utilisation grew.

A key inflection point occurred in early 2014, when the government introduced a hard monthly cap on the number of HMR services that credentialed pharmacists could be remunerated for (initially 20 per month), alongside a broader tightening of payment and program integrity settings[1]. In practice, this marked a move from a largely demand-led model to a volume-controlled approach, with post-hoc evaluations of the period linking the policy package to a sustained reduction in service volumes[2].

A second major turning point relates to indexation. The HMR service fee reached $222.77 on 1 July 2019, and no indexation has been applied to service fees since.

Taken together, caps constrain service availability even where clinical need exists, while a prolonged indexation pause erodes the real value of remuneration over time, tightening delivery capacity and reinforcing access constraints.

The cap was later increased from 20 to 30 per month from 1 March 2020, framed as an access-focused adjustment, but the underlying structure remains a hard volume control coupled with a fee that has not kept pace with costs (see Figure 3).

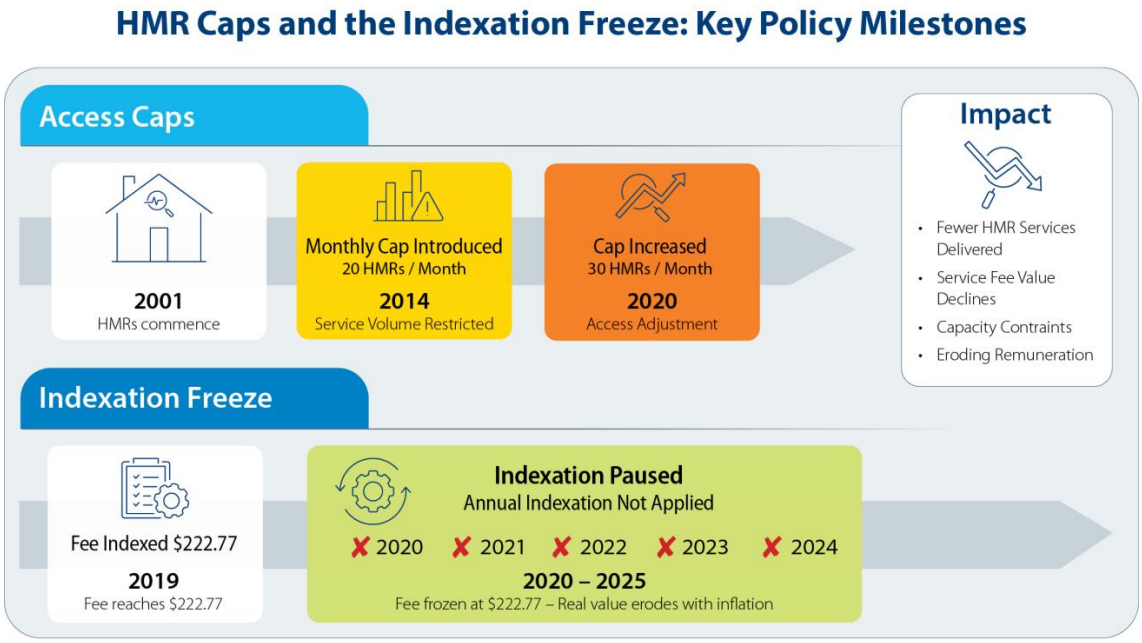


Figure 3: Two policy settings have progressively constrained HMR delivery: a hard monthly service cap introduced in early 2014 (partially relaxed in 2020) and a remuneration setting that has remained at the 2019–20 fee level. Together, these settings shift the program from demand-led and/or needs-based delivery to administratively rationed volume while the real value of the service fee erodes over time.

A shifting landscape: narrowing of programs included in the 8CPA

When the Seventh Community Pharmacy Agreement (7CPA) transitioned to the Eighth (8CPA), the range of programs formally covered by the Agreement was substantially reduced. Programs previously grouped under the 7CPA, including medication management services, rural workforce supports, and Aboriginal and Torres Strait Islander–specific initiatives, were no longer included within the 8CPA framework.

These programs continued to operate outside the Agreement on an ongoing basis. This separation has made the pharmacy program landscape more fragmented and has created ongoing uncertainty for pharmacists and service providers about future funding, governance and reform.

In August 2025, Minister for Health, Disability and Ageing Mark Butler MP announced that formal negotiations had begun with PSA for a dedicated Pharmacy Programs Agreement.

An appetite for change: the First Pharmacy Programs Agreement

The First Pharmacy Programs Agreement (1PPA) is currently under negotiation between PSA and the Department of Health, Disability and Ageing. This agreement will cover pharmacy programs outside of the 8CPA, including:

- Medication management programs (e.g. HMRs)
- Aged care programs (e.g. RMMRs and QUM)
- Pharmacy workforce programs, including rural support programs, and First Nations programs.

PSA is seeking to modernise pharmacy program design and delivery under this agreement, and the recently signed Heads of Agreement establishes an agreed pathway between the Department of Health, Disability and Ageing and PSA to deliver a suite of common-sense reforms to these programs pending commitment through the 2026-27 budgetary process.

An inflection point: the Pharmacy Programs Cost Effectiveness Review

The 2025 Deloitte *Pharmacy Programs Cost Effectiveness Review – Final Report*,[3] commissioned by the Department of Health, Disability and Ageing, assessed the cost-effectiveness and sustainability of pharmacist-led programs to be included in the 1PPA. The review was undertaken in a capped funding environment under the Community Pharmacy Agreement (CPA), where fixed budget envelopes constrained utilisation and access irrespective of underlying clinical need.

Deloitte's eight recommendations - spanning funding settings, simpler and more flexible program rules, and a fit-for-purpose evaluation framework - were shaped by this fiscal constraint. Now that these programs have moved out of the CPA and are funded as demand-driven ongoing programs, that constraint no longer applies. This shift is a clear turning point: reforms originally designed to improve efficiency in a capped system can now be fully realised, enabling proven cost-effectiveness to support needs-based access while maintaining fiscal discipline.

Medicines safety and quality use of medicines as a national priority

In 2019, Quality Use of Medicines and Medicines Safety were formally recognised as Australia's 10th National Health Priority Area, reflecting the scale of preventable medicine-related harm and the central role of medication management in improving health system safety, efficiency and outcomes. Medication-related problems remain a leading cause of avoidable hospitalisation, particularly among older Australians and people with complex, chronic conditions[4].

The access constraints and remuneration settings described above directly limit the system's ability to deliver on this nationally agreed priority. Hard volume caps

and prolonged fee erosion restrict the availability of clinically indicated medication reviews precisely where the risk of harm is highest. The reforms proposed under the 1PPA translate the national health priority on medicines safety from policy intent into practical, scalable delivery, while remaining consistent with fiscal discipline and value-for-money principles.

Quality and accountability: the Strategic Agreement on Pharmacist Professional Practice

In June 2024, the Hon. Minister Butler MP and PSA signed the Strategic Agreement on Pharmacist Professional Practice. Under this Agreement, the signatories commit to upholding the highest standards of professionalism in the pharmacy sector, recognising that effective program delivery relies on regularly maintaining, reviewing and updating professional practice standards and guidelines, as well as incorporating performance measures to strengthen accountability and assess pharmacist practice at all levels.

This agreement also provides the assurance and accountability framework needed for the 1PPA by linking program reform to enhanced professionalism, contemporary practice standards, and measurable outcomes. This approach aligns with Recommendation 1 in Deloitte's final report for the Department to implement a Monitoring and Evaluation Plan with agreed outcome indicators and appropriate data collection tools. It addresses the challenge of limited outcomes data in assessing pharmacy program performance and demonstrating value for money.

Why is this reform package needed?

Medicines safety is a national priority because preventable harm is common, costly and concentrated in people with complex conditions and those in aged care. Put simply the funding arrangements, restrictive program rules and evaluation measures are not fit-for-purpose and require urgent modernisation.

The real service fee for medicine reviews has declined by 15.7% since service fees were frozen in 2019.

The 1PPA is the vehicle to modernise these programs. The reforms we propose will prioritise patients.

Lifting caps enables clinicians to see people when risks peak, annual Wage Cost Index (WCI) indexation preserves critical workforce capacity in labour-intensive services, and flexible rules (e.g. telehealth, rationalised consent, expanded referrers) reduce delays and duplication so patients receive care sooner. The approach is staged, fiscally controlled, and measurable, with outcomes that can be tracked through 1PPA governance arrangements.

Without adequate budget provision, the 1PPA risks formalising existing funding and access constraints rather than resolving them. Medication management programs such as HMRs and RMMRs require funding and program rule adjustments as current settings are no longer fit-for-purpose, creating risks to program viability and sustainability:

- **Real value remuneration erosion:** the real service fee for medication reviews, both HMRs and RMMRs has declined ~15.7% since the service fees were frozen in 2019 (see Graph 1). This undermines provider viability and supply as it reduces the capacity of pharmacists to deliver these services as a sustainable component of their practice.

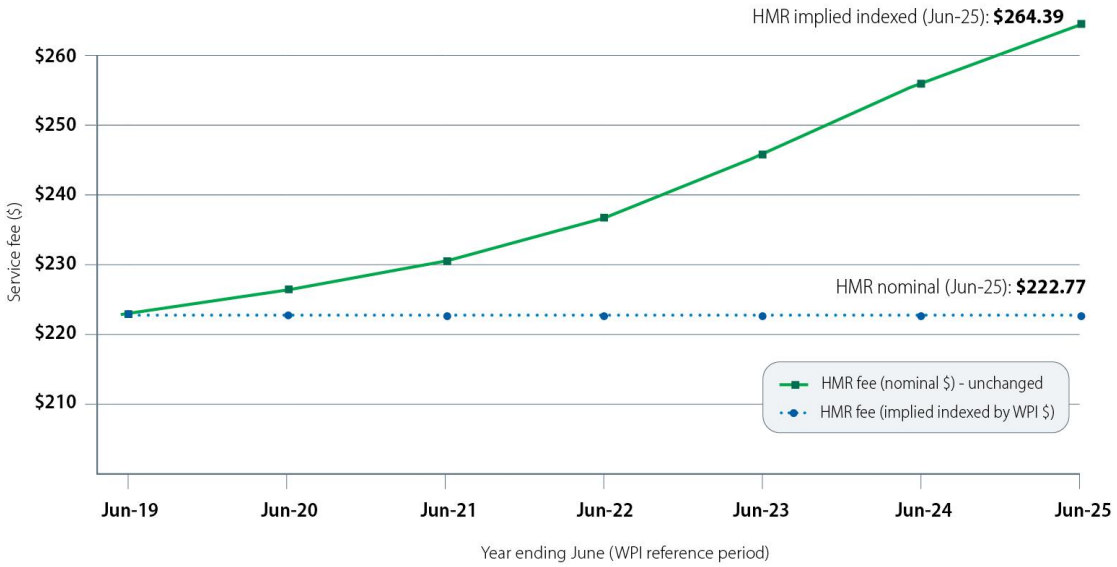
- **Artificial rationing:** initially introduced to prevent program overspends under a capped funding model, monthly caps on HMRs are now misaligned with the demand-driven context of these programs. Patient access is restricted despite urgent clinical need, with pharmacists forced to prioritise which patients are seen and when, distorting workforce behaviour, limiting program effectiveness and increasing patient risk.

- **Thin-market fragility:** rural and remote markets face the greatest supply and access risk. High travel time, unreimbursed costs, and opportunity cost associated with servicing dispersed communities mean pharmacists are increasingly required to limit travel distance or reduce rural service delivery. This is not due to unwillingness to service these communities, but because current funding settings do not adequately recognise travel burden, lost clinical time, or the higher prevalence of chronic disease and medication complexity in rural population

- **Administrative duplication:** inconsistent and duplicative rules consume clinical time and reduce capacity. This represents a productivity failure from program design, not a workforce failure.

These are structural constraints, not operational inefficiencies. The response must therefore be structural and multifactorial.

Effect of freeze in real terms: HMR remuneration vs WPI



Graph 1: Since the HMR fee was last indexed on 1 July 2019, WPI has risen by 18.7%. With the fee unchanged at $222.77, its real value has fallen by around 15.7%. If the fee had been indexed annually in line with WPI, it would be approximately $264.39.

Provider caps mean HMRs are increasingly unviable

"It is becoming highly unsustainable to do high quality reviews.

When you do complex patients, I allow often between an hour and an hour and a half for my reviews because patients need time to talk. I need time to dig, to find the problems, get through everything.

And by the time you have done inhaler education, checked on their diabetes, figured out why or how they're taking their medications and what else is in the drawer of weird and bizarre things cleaned out of cupboard, you have easily used that amount of time.

And that's before you even consider preparation, travel time and report writing."

Bente Hart MPS, credentialed pharmacist (Braidwood, NSW)

HMR barriers impact patient health

"HMRs when done well and in authentic collaboration with prescribers are a very powerful tool for medication appropriateness and safety.

Their utility is often the greatest when they can be done in a responsive manner in relation to a patient's needs. This requires flexibility and agility in the way they are delivered (e.g. home visit, in clinic settings or via virtual care modalities)

It also means arbitrary caps may become a barrier to responsiveness, for example, a patient following a transition of care; or commencement on a high risk medication and so on.

Dr Paresh Dawda, Next Practice Deakin (ACT)

Kelly's story

Kelly Abbott MPS is a credentialed pharmacist from Traralgon, a regional city in Victoria's Gippsland.

Kelly has been a credentialed pharmacist for about 15 years. Kelly loves providing HMRs. In collaboration with the patient's GP, Kelly's HMRs can dramatically improve the health of patients she visits. Outcomes of recent reviews include:

- deprescribing medicines which were causing dementia-like symptoms,
- medicine optimisation which has stopped falls in a person who experienced on average two falls each month, and
- provision of advice resulting in drastic improvement to a patient's blood sugar control (reduction in HbA1C)

In 2025, Kelly provided a HMR to an adult who was taking 47 different medicines, which consisted of >60 tablets a day, and a range of other inhaled medicines, eye drops, ear drops, creams and patches. The GP was unaware of 11 of these medicines; and the patient was at high risk of opioid toxicity and serotonin toxicity. Through the HMR, Kelly helped reduce the risk these medicines posed and a tapering plan acceptable to the patient to reduce the number of medicines she uses.

The HMR caps routinely prevent Kelly from providing timely HMRs:

"I hit my cap every month without fail – usually within the first 5-10 business days of each month. I have not had a month under 30 [HMRs] since September 2023. If I receive a referral today, I might see you in six-weeks' time, at the earliest."

"I received 486 referrals for Home Medication Reviews in 2025 but the HMR cap of 30 patients per month meant I only saw 360 of these patients and only few of them in within a month of receiving the referral."

"Today, I drove past the homes of eight patients who are waiting to be seen. I got home before 12pm. I could see three of their front doors. I could easily have visited at least two of these people this afternoon, if it wasn't for the cap. They will wait."

Unfortunately for at-risk patients in Gippsland, Victoria – just 90 minutes' drive from Melbourne - there are few other credentialed pharmacists to provide HMRs in the area until Kelly is available.

"There are four credentialed pharmacists in Traralgon. The nearest credentialed pharmacist beyond the ones in my town are over an hour's drive away."

Last week, a pharmacy called me saying the GP clinic was concerned about the delay in me seeing the patient - was there anyone else locally who could do the HMR sooner than I? I put it in our little four-person [credentialled pharmacist] group chat and no, none of us have space in the cap, they've got to wait.

These delays to care cause harm to patients:

"I've knocked on a door to have the husband tell me 'oh, she died'. That's happened multiple times. There's been multiple HMR cancellations because of patients being hospitalised."

Image: Yallourn power station and Lake Narracan near Traralgon

A fit-for-purpose proposal

The First Pharmacy Programs Reform Package has been designed to address longstanding challenges while supporting government priorities.

PSA developed the reform package proposal using the following principles:

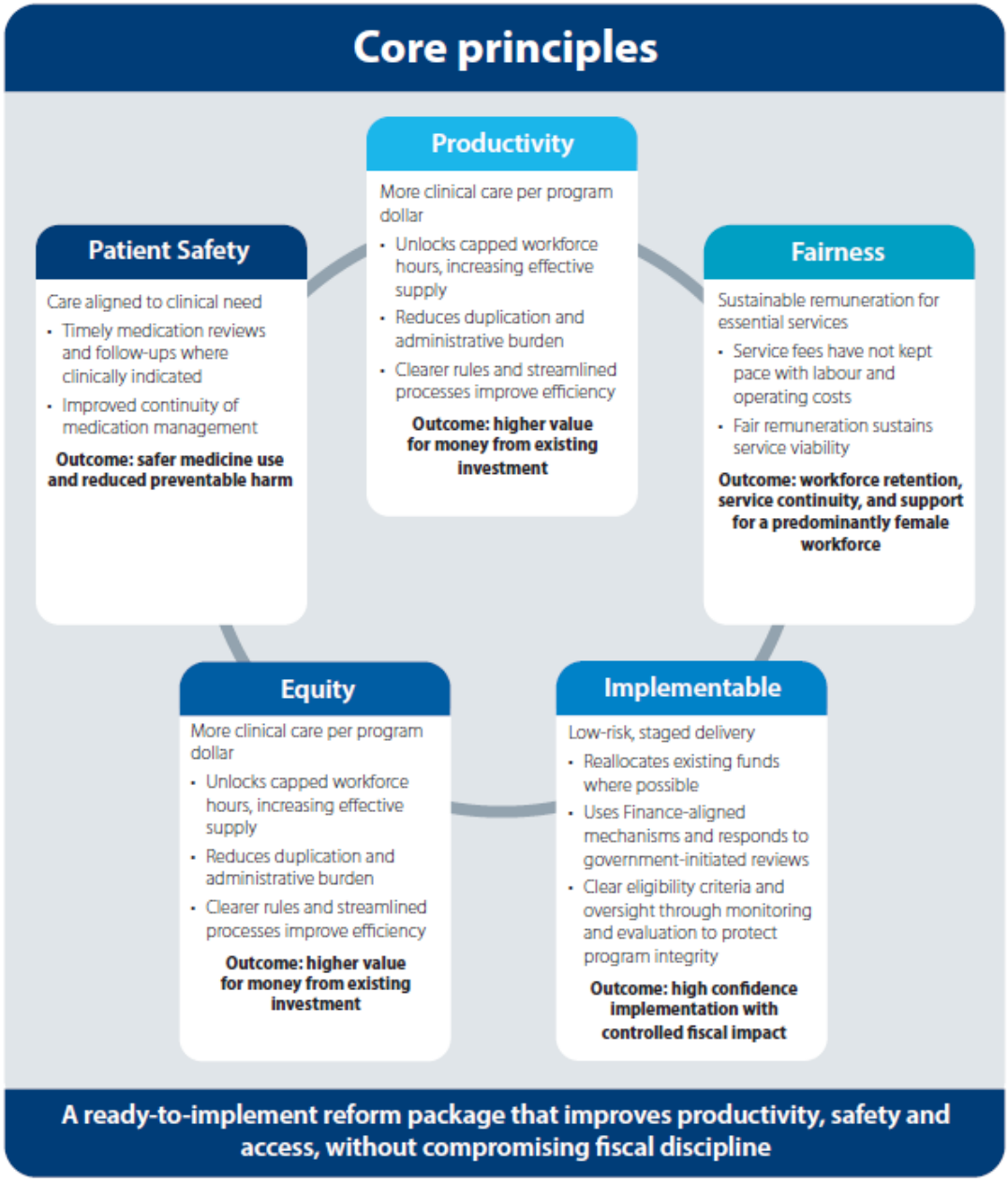


Figure 4: The five core principles used in development of the First Pharmacy Programs Reform Package.

Recommendation 1: First Pharmacy Programs Reform Package

The First Pharmacy Programs Reform package incorporates four discrete elements. The PSA identifies the First Pharmacy Programs Reform Package, to be delivered through the 1PPA, as its highest priority for the 2026–27 Federal Budget.

1.1 – Home Medicines Review Program

Introduce reforms to Home Medicines Review Program to increase productivity, program sustainability and patient access

PSA recommends eight changes to the HMR program rules and funding to provide access to more timely HMRs for patients when and where they need them most.

The challenge

HMRs are recognised as essential to safeguard at-risk patients from preventable harm from their medicines.[5] The program has not kept pace over time, with remuneration to service providers frozen at 2019 levels and provider caps constraining workforce capacity and preventing credentialed pharmacists from being able to provide the service as a career.[3]

The proposed approach

PSA recommends the adoption of eight measures to the HMR program be funded within the 1PPA:

- Removal of monthly provider service caps in a staged transition, commencing with an increase in HMR provider caps to 60 HMRs per month on 1 July 2026 (*Recommendation 1.1.1*)
- Apply annual WCI-5 indexation to HMR service fees from 1 July 2026, and rebase HMR service fees from 1 July 2026 to preserve the real value since service fees were last indexed (retrospective indexation) (*Recommendation 1.1.2*)
- Introduce HMR payments linked to rurality (MMM3-7) (*Recommendation 1.1.3*)
- Introduce payments linked to HMR complexity (*Recommendation 1.1.4*)
- Introduce increased flexibility in service delivery through updating the HMR program rules to:
    - remove requirement for pre-approval for HMRs conducted outside of a person's home (*Recommendation 1.1.5*)
    - reinstate option to provide some services via telehealth (*Recommendation 1.1.6*)
    - expand the list of providers who can refer a patient for a HMR (*Recommendation 1.1.7*)

- Remove discrepancy between MBS Item 900 requirements and HMR Program Rules (*Recommendation 1.1.8*).

Why it will work

The Department of Finance frames indexation as a standard mechanism to adjust program values for changes in wages and price and notes that Wage Cost Indices (WCIs) are used where labour comprises a substantial share of program costs.[6]

The recent Pharmacy Cost Effectiveness Review explicitly recommended the removal of the cap on the number of HMRs a credentialed pharmacist can complete, as well as recommending a stronger quality and regulatory approach.[3] This will provide an immediate program capacity increase and improve patient access to HMRs.

Recommendation 1.1.2 resets real value for HMR service fees to the 1 July 2019 baseline from 1 July 2026, then protects it via annual indexation using a Department of Finance-determined parameter (e.g. WCI-5), consistent with Commonwealth practice for labour-intensive arrangements. This safeguards long-term sustainability of pharmacist-delivered medication management services.

Consistent with recommendations of multiple reviews,[3,7] PSA supports the establishment of a monitoring and evaluation plan with agreed indicators and data mechanisms to measure and monitor program cost-effectiveness.

Benefits for Australians

The HMR reforms recommended in the First Pharmacy Programs Reform Package will:

- **improve patient access to HMRs** via increase in utilisation of the existing workforce through increase, and subsequent removal of service provider caps, and improved thin-market viability through rural loading (MMM 3–7)
- **improve workforce retention** by addressing real-terms devaluation remuneration inequities experienced by credentialed pharmacist workforce
- **support a predominantly female workforce** to sustain services patients rely on by more equitably remunerating a cognitive healthcare program primarily provided by women.[8]

Economic benefits include:

- **fewer medicine-related hospitalisations/ED visits,** targeting a ≥250k p.a. burden (over half of which is preventable). Pharmacist reviews reduce drug-related readmissions and ED use
- **lower PBS outlays and wastage** via deprescribing, dose optimisation and medicines reconciliation
- **reduced unplanned primary care demand** with fewer urgent GP reviews/investigations through reviews that lead to structured follow-up and goal-setting
- **increase productivity and capacity** with credentialed pharmacists able to spend more time on clinical activities through introduction of flexibility in service delivery, particularly with respect to telehealth services and associated reduction in travel time to/from a person's home for Follow-up visits.

Budget implications and funding model

PSA estimates adoption of the measures in Recommendation 1.1 would require an additional investment of **$135.1 million** over the forward estimates.

	Estimated investment required ($million)				
HMR Reform Measures (Recommendation 1.1)	**FY26/27**	**FY27/28**	**FY28/29**	**FY29/30**	**Total (over 4 years)**
1.1.1 Remove HMR provider caps	$26.7	$31.0	$35.9	$41.5	**$135.1**
1.1.2 Annual WCI-5 indexation to HMR service fees (including rebase)					
1.1.3 Fee loading for rurality					
1.1.4 Fee loading for complexity					
1.1.5 Removal of HMR pre-approval for offsite service					
1.1.6 Reinstate telehealth follow-ups					
1.1.7 Increase eligible referrers					
1.1.8 Align MBS and HMR rules					

See Appendix 2 for modelling assumptions

Case example: Rachel Hill MPS, Port Macquarie (NSW)

Rachel has been a credentialed pharmacist for 11 years and recently moved from the ACT to Port Macquarie. While Rachel has capacity and drive to deliver HMR's as a full-time role, current remuneration and service provider caps prevent this, leading to delays in patient's accessing the service:

"I was getting 50-60 referrals a month in Canberra. I declined or gave away most of my referrals. I'm getting 10 referrals a month currently and establishing relationships [in the Port Macquarie region]."

"I've dramatically reduced how many [HMRs] I do because of the remuneration – they are becoming less and less worth it. If viable, I would do it full time. I've reduced from 3 days a week, to 2 days a week, to 1 day a fortnight.

"Even though all of us [credentialed pharmacists] love it, it doesn't make financial sense. We all do HMR's out of love"

Rachel often has to wait for a number of referrals to patients in a close geographical location to be referred to make travel worthwhile – which often delays care by months. This places patients – including complex, high-risk patients - at risk of hospitalisation or institutionalisation.

Case example: Stewart Mearns MPS, Ulverstone (Tasmania)

Stewart has been a credentialed pharmacist for approximately 10 years and currently provides approximately 10 HMR/month to patients in Northern Tasmania:

"The current remuneration disincentivises timely provision of HMRs… it's a labour of love."

"If indexation restarts at the current fee [without catch-up indexation], it maintains a 'nearly unviable' service as 'nearly unviable' into the future".

Stewart would like to see the reintroduction of telehealth for provision of HMR follow-up services to improve the efficacy of his HMRs:

"We were on of the early adopters of follow-up services. A lot of the time you'd make recommendations to the GP at the HMR where they'd adopt one of your recommendations. Sometimes the follow up visit helps the deprescribing pathway get to a second or third medicine deprescribed.

"I don't do follow-up for HMRs at all anymore. When there was telehealth, we did. [The follow-up review] could all have been done in a single phone call, whereas the requirement for an in-person follow-up service means is the same commitment as a HMR".

1.2 – Residential Medication Management Review and Quality Use of Medicines Programs

Introduce reforms to Residential Medication Management Review and Quality Use of Medicines Programs to increase productivity, program sustainability and patient access

PSA recommends seven changes to the RMMR and QUM program rules and funding to provide access to more timely RMMRs for patients when and where they need them most.

The challenge

Despite the introduction of the Aged Care On-site Pharmacist (ACOP) Measure in July 2024, the RMMR and QUM Programs will need to continue for the foreseeable future until there is near universal ACOP uptake.

Pharmacist remuneration for RMMR services has not been indexed since 2019, and program rules are no longer fit for the contemporary needs of residents in residential aged care facilities (RACFs).

The proposed approach

PSA recommends the adoption of six measures to the RMMR and QUM programs be funded within the 1PPA:

- Allow RMMRs to be conducted in a RACF that is participating in the ACOP Measure (*Recommendation 1.2.1*)
- Reform QUM funding predicated on the implementation of Recommendation 1.2.1 (*Recommendation 1.2.2*)
- Apply annual WCI-5 indexation to RMMR service fees from 1 July 2026, and rebase RMMR service fees from 1 July 2026 to preserve the real value since service fees were last indexed (retrospective indexation) (*Recommendation 1.2.3*)
- Introduce increased flexibility in service delivery through updating program rules to:
    - remove requirement for separate formal consent for RMMRs on the basis that residents already provide consent for health information use on residential aged care facility (RACF) admission (*Recommendation 1.2.4*)
    - reinstate option to provide RMMR follow-up services via telehealth (*Recommendation 1.2.5*)
    - expand the list of providers who can refer a patient for an RMMR (*Recommendation 1.2.6*).

Why it will work

Comprehensive medication review services are complex and depend on the time and skills of credentialed pharmacists.[5] Importantly, the WCI approach incorporates a productivity offset to maintain an efficiency incentive while reflecting wages and supplier cost movements.[6]

Benefits for Australians

The RMMR and QUM Program reforms recommended in the First Pharmacy Programs Reform Package will:

- **increase medicines safety** as ACOP uptake increases by facilitating as-needed resident access to comprehensive RMMRs in a RACF participating in the ACOP Measure
- **increase workforce availability** by addressing real-terms devaluation remuneration inequities experienced by credentialed pharmacist workforce and thin-market viability through a rural loading (MMM 3–7)
- **support a predominantly female workforce** to sustain services patients rely on by more equitably remunerating a cognitive healthcare program primarily provided by women.

Economic benefits include:

- **fewer medicine-related hospitalisations/ED transfers from RACFs** via timely RMMRs, targeting a high-risk cohort where 98% of residents have ≥1 medication-related problem and >50% receive a potentially inappropriate medicine**.**
- **lower PBS outlays and wastage through** deprescribing, dose optimisation and medicines reconciliation
- **reduced use of low-value/high-risk medicines** (psychotropics, opioids, antimicrobials) through audit, feedback and pharmacist review – cutting falls, delirium, infections and hospital transfers
- **productivity and capacity gains** from telehealth follow-ups and flexible delivery – less travel time, more RMMRs per pharmacist FTE and better coverage where ACOP uptake is not yet universal
- **program sustainability in thin markets** via annual indexation and rural loadings, supporting workforce supply where preventable hospitalisations are highest in remote areas.

Budget implications and funding model

PSA estimates adoption of the measures in Recommendation 1.2 would require an allocation of **$33.3 million** over the forward estimates.

	Estimated investment required ($million)				
RMMR and QUM Reform Measures (Recommendation 1.2)	**FY26/27**	**FY27/28**	**FY28/29**	**FY29/30**	**Total (over 4 years)**
1.2.1 Permit RMMRs in an RACF participating in the ACOP Measure	$7.1	$7.9	$8.7	$9.6	**$33.3**
1.2.2 Reform QUM Program funding					
1.2.3 Annual WCI-5 indexation to RMMR service fees (including rebase)					
1.2.4 Streamlined patient consent					
1.2.5 Reinstate telehealth RMMR follow-ups					
1.2.6 Increase eligible RMMR referrers					

See Appendix 3 for modelling assumptions

1.3 – Aged Care On-site Pharmacist Measure

Introduce reforms to the Aged Care On-site Pharmacist (ACOP) Measure to improve uptake and implementation

PSA recommends ten changes to the ACOP Measure program rules to increase program uptake, effectiveness and productivity.

The challenge

The Aged Care Royal Commission made clear the need for pharmacists to be engaged by aged care facilities to protect residents from medicine-related harm.[9] A strong evidence base for on-site pharmacists providing patient review, clinical governance and staff education in residential aged care saw the ACOP Measure introduced in July 2024.[10–12] However, uptake of this program has been slow, and the anticipated benefits not realised due to limitations in program design and implementation.

Specifically, remuneration is inadequate to attract enough experienced credentialed pharmacists to the roles, and the program rules are too inflexible to optimise productivity, performance and workforce distribution.

The proposed approach

PSA recommends the adoption of ten measures for the ACOP Measure to be funded within the 1PPA:

- Increase ACOP remuneration by 15% (*Recommendation 1.3.1*)
- Increase ACOP FTE allocation from 0.2 FTE per 50 beds to 0.3 FTE per 50 beds (*Recommendation 1.3.2*)
- Introduce ACOP payments linked to rurality (MMM3-7) (*Recommendation 1.3.3*)
- Introduce a ACOP graded remuneration model offering incremental pay progression based on experience, postgraduate qualifications, and recognition of advanced practice (*Recommendation 1.3.4*)
- Introduce funding for a replacement ACOP during periods of where the regular ACOP is on leave (e.g. annual leave, personal leave) (*Recommendation 1.3.5*)
- Introduce increased flexibility in service delivery through updating program rules to:
    - allow on-site attendance to be delivered in flexible time blocks between 3.8 and 7.6 hours (*Recommendation 1.3.6*)
    - increase provision for remote work to include medication advisory committee meetings and answering queries, up to a maximum of 20% of total hours (*Recommendation 1.3.7*)

- allow direct payment to credentialed pharmacists or eligible organisations under Tier 2 arrangements (*Recommendation 1.3.8*)
- replace weekly timesheet verification with a monthly timesheet and activity signed by the RACF representative (*Recommendation 1.3.9*)

- Amend the MBS Item 903 and 249 explanatory notes to explicitly include medication reviews conducted under the ACOP Measure (*Recommendation 1.3.10*).

Why it will work

The evidence base is clear that pharmacists embedded within residential care facilities reduces the number of potentially inappropriate medicines – including chemical restraint – which residents are exposed to.[10] The proposed changes more closely align ACOP Measure program rules and funding models with setting in place in those successful trials.

Through deep consultation and engagement, PSA is confident removal of the above collective barriers and a redesign within existing funding arrangements will incentivise more pharmacists with suitable experience and expertise for this role to transition from provision of RMMRs to that of an ACOP role, with its additional clinical leadership and accountability obligations.

Flexibility measures have similarly been adopted in similar health care program within aged care.

Benefits for Australians

The ACOP reforms recommended in the First Pharmacy Programs Reform Package will:

- **improve service capacity** through increase in service levels (FTE uplift from 0.2 FTE to 0.3 FTE per 50 beds) and backfill service during planned leave
- **increase workforce availability** through remuneration increase (+15%) and grading remuneration to practitioner skill and experience
- **strengthen equity and thin-market viability** through a rural loading (MMM 3–7)

Economic benefits include:

- **fewer medicine-related hospitalisations/ED transfers** in RACFs via embedded pharmacist oversight and reduced high-risk psychotropic use
- **lower PBS outlays and wastage** through routine deprescribing, dose optimisation and reconciliation embedded in ACOP activities
- **reduced avoidable GP appointments and transfer events** by providing continuity of medication management and prompt issue resolution on site
- **productivity and capacity gains** through introducing of flexibility in service delivery and reduction in administration burden associated with changes to program rules that improve implementation (e.g. flexible on-site time blocks, expanded remote work provisions, direct payments).

Budget implications and funding model

PSA estimates that implementing Recommendation 1.3, using a within-envelope redesign and reprofiling of previous ACOP Measure appropriation, would be budget neutral over the forward estimates.

All measures in Recommendation 1.3 are design and efficiency reforms delivered within existing appropriations.

The PSA anticipates **no net impact on the budget** over the forward estimates.

Reform category	PSA proposed budget measures included	FY26/27 – FY29/30 impact	Net budget impact ($million)
Workforce remuneration	1.3.1, 1.3.3, 1.3.4	Changes within existing funding arrangements	$0.0
Workforce capacity and continuity	1.3.2, 1.3.5	Changes within existing funding arrangements	$0.0
Productivity and flexibility	1.3.6, 1.3.7, 1.3.9	Operational efficiency gains	$0.0
Administrative and technical	1.3.8, 1.3.10	Design clarification	$0.0
Total ACOP reforms	**10 measures**	**Budget neutral**	**$0.0**

1.4 – Pharmacist workforce needs analysis

PSA recommends the allocation of funds to enable a rapid and targeted response to the outcomes of the national pharmacist workforce needs analysis

The challenge

Australia's pharmacist workforce is rapidly growing but faces maldistribution of labour – particularly in rural, remote and First Nations communities. The workforce is challenged by a rapidly changing health landscape, surging demands for care and evolving skills/knowledge requirements of roles[8,13–15].

To address this, PSA is currently undertaking a comprehensive national analysis of pharmacist workforce needs for the Department of Health, Disability and Ageing. This work will establish an integrated, policy-ready evidence base on pharmacist supply, demand, distribution, skills mix and the future workforce requirements across all practice settings, with a strong focus on rural, remote and First Nations health needs. The analysis is due to be delivered in this financial year and will include clear, actionable recommendations for government.

Without provision for implementation funding in the 2026-27 Federal Budget, there is a significant risk that these recommendations, once delivered, will remain uncommitted and unfunded for at least 12 months, delaying reform and limiting the value of the analysis itself.

The proposed approach

As part of the 1PPA, PSA recommends that the government reserve approximately $20 million over two years to implement urgent, evidence-based fixes from the national pharmacist workforce needs analysis (Recommendation 1.4).

This funding will provide government with the flexibility to respond quickly to identified workforce gaps and pressures, including those affecting rural and remote communities, First Nations health services, and workforce-intensive pharmacy programs such as medication management, aged care, immunisation, opioid dependence treatment, and public health initiatives.

Why it will work

The quarantining of funds in anticipation of recommendations from the workforce analysis will provide government with capacity to rapidly implement urgent recommendations emanating from the pharmacist workforce analysis.

Benefits for Australians

The allocation of funds to support rapid implementation of the workforce needs analysis will:

- **enable timely action** on urgent workforce issues identified from the needs analysis
- **support more equitable distribution** of pharmacists, particularly in rural, remote and First Nations communities
- **improve patient access** to pharmacist-delivered health services aligned to population need
- **strengthen the sustainability and effectiveness** of pharmacy programs that underpin primary care, aged care and public health delivery.

Budget implications and funding model

PSA estimates adoption of the measures in Recommendation 1.4 would require an allocation of **$20.0 million** over the 2026/27 and 2027/28 financial years.

	Estimated investment required ($million)				
Workforce Measure (Recommendation 1.4)	**FY26/27**	**FY27/28**	**FY28/29**	**FY29/30**	**Total (over 4 years)**
Response to the pharmacy workforce review	$10.0	$10.0	-	-	**$20.0**

Recommendation 2

Implement four changes to the National Immunisation Program Vaccinations in Pharmacy (NIPVIP) program rules to increase uptake of NIP vaccines by the Australian population

PSA recommends introduction of a tiered payment model for NIPVIP to increase vaccination rates, particularly within vulnerable priority population groups.

The challenge

Australia's rates of vaccination against preventable diseases such as pertussis, measles and HPV have declined since the COVID-19 pandemic. This decline is particularly marked in priority populations such as children, older Australians and culturally and linguistically diverse (CALD) communities.

While pharmacists now administer over a quarter of all influenza vaccines,[16] the number of other NIP-funded vaccines administered by pharmacists remains low.[17] This is despite the introduction of the NIPVIP program in January 2024. Pharmacists have told PSA this is largely because the current level of remuneration available via NIPVIP does not reflect the time and complexity of care needed to engage with at-risk eligible individuals.

The proposed approach

Implement the following reforms to the NIPVIP program:

- Remove minimum patient age restriction within NIPVIP Program Rules (Recommendation 2.1).
- Introduce a higher-tier NIPVIP administration fee for initiation and administration of NIP vaccines in consultations which are more complex and require additional clinical time (Recommendation 2.2).
- Introduce flag fall payments to increase NIP vaccine coverage rates in residential aged care facilities and disability care facilities (Recommendation 2.3).
- Remove premises location restrictions from NIPVIP eligibility criteria (Recommendation 2.4).

Why it will work

These reforms will enable pharmacists to be more proactive in identifying at-risk individuals eligible for vaccination and administering NIP vaccines through substantial reduction in program complexity and increasing program output and efficiency.

Each of these reforms uses established, successful strategies which exist or have previously existed in Australia or overseas to increase uptake of government-funded vaccines.

Benefits for Australians

- Increased access to vaccination, particularly at patient-preferred and convenient locations, after-hours, outreach sites and as a walk-in service.
- Increased protection from vaccine-preventable diseases (e.g. pneumonia, influenza, shingles), many of which people experience long-term symptoms or never fully recover from
- Increased vaccination rates in priority populations (e.g. CALD communities, older people, adolescents, children).

Budget implications and funding model

PSA estimates this change could see an additional 1.46 million NIP vaccine doses (Year 1) administered, at a cost increase of $34.3 million (Year 1).

Measure (million)	FY26/27	FY27/28	FY28/29	FY29/30
2.1 Remove minimum age	$1.5	$1.7	$1.9	$2.0
2.2 Longer consultation fee	$11.6	$12.2	$12.8	$13.4
2.3 Residential care flag fall	$11.2	$11.7	$12.3	$13.0
2.4 Remove premises location restriction	$10.0	$10.7	$11.4	$13.0
Total	**$34.3**	**$36.3**	**$38.4**	**$41.4**

Recommendation 3

Fund integrated pharmacists within Aboriginal and Torres Strait Islander Primary Health Services

PSA recommends providing permanent funding for Aboriginal and Torres Strait Islander Primary Health Services to employ pharmacists as part of their primary healthcare teams, as supported by MSAC.

The challenge

Aboriginal and Torres Strait Islander people continue to face challenges in equitable access to medicines and quality use of medicines. Reasons include financial and geographic constraints, sub-optimal interactions with clinicians and system barriers related to transfer of patient information between community pharmacists and Aboriginal and Torres Strait Islander Primary Health Services.

While there are programs aimed at addressing barriers to medicines access and quality use of medicines for Aboriginal and Torres Strait Islander people, much more needs to be done to lessen health inequities.

The Strengthening Medicare Taskforce report (December 2022) recommended better funding systems for team-based care models in primary care, and more flexible funding approaches.[18] It also recommended government 'grow and invest in Aboriginal Community Controlled Health Organisations (ACCHOs) to commission primary care services for their communities, building on their expertise and networks in local community need.[19]

The proposed approach

Provide funding to integrate pharmacists within the primary care team of all eligible Aboriginal and Torres Strait Primary Health Services. The integrated pharmacist primarily provides education and support for medicine use, medicine reviews and clinical governance oversight. They do not dispense medicines.

Consistent with the option preferred by all stakeholders in the MSAC consultation process in 2022,[19] PSA recommends funding is provided to the National Aboriginal Community Controlled Health Organisation (NACCHO) to implement this program. This would include funding for PSA to provide administrative support and delivery of education, training and mentoring for pharmacists and the establishment and operation of a community of practice.

Why it will work

The Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management (IPAC) project was a large multistate project that saw pharmacists embedded on-site within the primary care team of Aboriginal Community Controlled Health Services across Queensland, the Northern Territory and Victoria.

Integrated pharmacists functioned within the existing primary healthcare delivery system and their role included delivering culturally safe preventive care to Aboriginal and Torres Strait Islander peoples, facilitating communication with external healthcare providers, undertaking medication reviews, and providing education and guidance to people with chronic health conditions.

The IPAC project demonstrated that investment in integrated pharmacists improves care quality and reduces medicine-related harm through better coordination and prescribing practices. In March 2023, MSAC supported the application, based on the evidence gathered under IPAC, for public funding to integrate pharmacists within Aboriginal Health Services.[16] MSAC considered that the estimated cost of providing this integrated, collaborative, culturally appropriate and person-centred care was justified by the improvement in health outcomes for Aboriginal and Torres Strait Islander peoples.

Benefits for Australians

Improved health outcomes and overall quality of life for Aboriginal and Torres Strait Islander peoples through:

- **more empowered individuals** who better understand their condition and their medicines, are more adherent with medicine regimens, and therefore are able to maximise health benefits from their medicines and reduce PBS wastage
- **reduced avoidable emergency presentations** and hospital admissions from medicine-related adverse events
- **better access to medicines** through strengthened relationships between ACCHOs and community pharmacies.

Budget implications and funding model

The estimated budget impact for the IPAC program, modelled by the Department of Health and Aged Care in 2023, is $61.0 million over six years, equivalent to $40.7 million on a pro-rata forward estimates basis.

Recommendation 4

Double funding of the Workforce Incentive Payment (WIP) – Practice Stream, with targeted support for general practice-based pharmacists

PSA recommends doubling funding under the Workforce Incentive Program (WIP) – Practice Stream, with targeted support for general practice-based pharmacists to work as part of multidisciplinary teams caring for people with chronic and complex health conditions.

The challenge

Australia's population is ageing with increasingly complex health needs, particularly with chronic and complex conditions. General practice pharmacists are essential to meeting this need.

While WIP funding is available to fund nurse practitioners and other allied health professionals (including pharmacists), >80% funded hours are provided by nurses. This uneven distribution significantly reduces the ability of general practices to employ other allied health professionals such as pharmacists, who play a key role in managing medication safety.

The proposed approach

Double funding of the WIP (up to $130,000) to allow the practice to employ general practice pharmacists to work primarily on-site in general practices with patients and other health professionals to improve safety and efficacy of medicine use. A portion of the increased WIP funding would be quarantined to ensure practices are able to meaningfully employ general practice-based pharmacists as part of their multidisciplinary teams.

Why it will work

In the UK, general practice pharmacists work as part of a multidisciplinary team, alongside other healthcare professionals. They work closely with GPs to resolve medicines issues and enable GPs to focus on diagnosing and treating patients[20].

In Australia, some general practices already employ pharmacists. These pharmacists help inform better, more coordinated patient care, particularly with respect to medicine use. This occurs through conducting pre-consultation appointments to gather health information, consulting notes, assessing pathology results and making recommendations to GPs to adjust medicine choice and medicine doses[14,21].

Economic analysis has shown integrating of GP pharmacists could deliver $545 million in net savings to the health system over four years, primarily through fewer preventable hospitalisations and a reduction in the use of medicines[22].

Benefits for Australians
General practice pharmacists in Australia and other countries are recognised for achieving: • improved patient safety and outcomes • reductions in medicine-related hospital admissions • improved patient health literacy. The proposal also supports: • better prescribing and reduced prescribing costs • reduced GP waiting times • reduced PBS wastage • additional opportunities for career progression for pharmacists.

Budget implications and funding model

This measure represents the pharmacist-specific component of the broader Workforce Incentive Program (WIP) – Practice Stream uplift to support general practice-based multidisciplinary teams.

	Estimated investment required ($million)				
Measure (Recommendation 4)	**FY26/27**	**FY27/28**	**FY28/29**	**FY29/30**	**Total (over 4 years)**
Target additional WIP funding to general practice-based pharmacists	$17.7	$28.1	$39.7	$41.4	$126.9

This measure directly supports the Government's Budget initiative to build general practice-based multidisciplinary teams, with targeted support for pharmacists.

GP pharmacists

"Any increase in funding for non-dispensing [GP] pharmacists would be really really welcome.

We lose money on it as a practice – but it's adding value to clinicians, to patients and to their health outcomes."

Dr Paresh Dawda, Next Practice Deakin (ACT)

Recommendation 5

Fund pharmacist participation in multidisciplinary case conferences

PSA recommends the Australian Government immediately enable pharmacists to claim reimbursement through the MBS for participating in multidisciplinary case conferences.

The challenge

From 1 November 2021, new MBS items became available for eligible allied health practitioners participating in multidisciplinary case conferences. Despite being eligible to participate in case conferences, and specific recommendations of the MBS Review Taskforce to the contrary, pharmacists are the only health professionals not eligible to claim payment for their participation.

Multidisciplinary case conferences are reserved for patients with complex medical conditions, whose treatment will often involve multiple medicines. Pharmacists are experts in medicines and medication management and play a critical professional role in medicine safety and quality use of medicines (i.e. focusing on the safe, appropriate, judicious and effective use of medicines). Thus, pharmacist participation in case conferences is crucial in minimising potential harms that may result from the use of medicines and in driving optimal and cost-effective use of medicines – key priorities in Australia's 10th National Health Priority Area (Quality Use of Medicines and Medicines Safety) declared in 2019.

The proposed approach

PSA recommends pharmacists be included in the list of eligible allied health practitioners in legislative instruments under the *Health Insurance Act 1973* who are remunerated for their participation in multidisciplinary case conferences with medical practitioners.

Why it will work

Creating MBS items for all health practitioners to align with the equivalent GP items will foster better collaboration and enhanced safe and quality use of medicine outcomes for patients. It recognises the extensive evidence base which supports case conferencing as necessary for effective, safe, patient-centred team-based care.

Pharmacist participation in case conferences is essential to optimise a person's medicine therapy, including through identification and resolution of medicine safety issues such as drug interactions, overuse of medicines and reducing preventable side effects as well as avoidable hospitalisations.

Benefits for Australians
• More coordinated health care, reducing medicine safety problems and avoidable hospitalisations. • Better quality of life for people with chronic health conditions. • Enhanced patient outcomes through the safe and effective use of medicines in multidisciplinary care.

Budget implications and funding model

PSA estimates this proposal will require a budget allocation of **$6.6 million** over four years.

Measure ($million)	FY26/27	FY27/28	FY28/29	FY29/30	4-year total
Multidisciplinary case conferencing	$1.6	$1.6	$1.7	$1.7	$6.6
Total	**$1.6**	**$1.6**	**$1.7**	**$1.7**	**$6.6**

This assumes that pharmacists would participate in approximately 40% of case conferences[1] and is based on current MBS payments[2] for allied health practitioner participation in case conferences:

- $48.45 per case conference of 15-20 minutes (MBS Item 10955)
- $83.10 per case conference of 20-40 minutes (MBS Item 10957)
- $138.25 per case conference of >40 minutes (MBS Item 10959)

While this represents an immediate investment, the long-term benefits, including reduced hospital admissions and medication-related harm, are expected to reduce pressure on hospital services and improve health system efficiency.

[1] assuming moderate growth of total case conferences from 2022/23 *https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data*

[2] assumption annual CPI adjustment of 3.0%

Appendices

Appendix 1: Summary of recommendations

1. First Pharmacy Programs Reform Package (implemented through the First Pharmacy Programs Agreement)		
1.1 Introduce reforms to Home Medicines Review Program to increase productivity, program sustainability and patient access		
Budget element	Estimated investment (over 4 years)	Benefits
1.1.1 Removal of monthly provider service caps in a staged transition, commencing with an increase in HMR provider caps to 60 HMRs per /month on 1 July 2026	**$135.1m**	• Lifts artificial rationing so clinically indicated HMRs are delivered when and where needed. • Reduce wait times and prevent avoidable harm for people at highest risk without new compliance burden. • Shortens wait times for high-risk patients, reducing avoidable harm and admissions.
1.1.2 Apply annual WCI-5 indexation to HMR service fees from 1 July 2026, and rebase HMR service fees from 1 July 2026 to preserve the July 2019 real value (retrospective indexation)		• Restores real value and protects it over time, stabilising supply and continuity of care. • Supports retention of experienced (majority-female) clinicians in a thin market. • Reduces churn and service disruption, improving value for money per program dollar.
1.1.3 Introduce HMR payments linked to rurality (MMM3-7)		• Makes rural/remote service delivery viable (travel/time/opportunity costs recognised). • Improves access for underserved communities, including First Nations patients. • Reduces preventable hospital presentations in regions with limited primary care.
1.1.4 Introduce payments linked to HMR complexity		• Targets effort and funding to higher-risk, multi-morbid patients where returns are greatest. • Incentivises comprehensive reviews that prevent adverse events and duplicative prescribing. • Improves equity by recognising the additional time required for complex care.
1.1.5 Introduce increased flexibility in service delivery through updating the HMR program rules to: *remove requirement for pre-approval for HMRs conducted outside of a person's home*		• Cuts red tape and speeds up clinically appropriate care in RACFs, clinics and hospitals. • Maintains safeguards through existing eligibility and documentation requirements. • Frees pharmacist time for clinical activity rather than administrative workflow.
1.1.6 Introduce increased flexibility in service delivery through updating the HMR program rules to: *reinstate option to provide some services via telehealth*		• Enables timely follow-ups and case coordination while reducing unproductive travel time. • Improves reach to rural/remote and mobility-limited patients. • Increases program throughput without compromising quality.
1.1.7 Introduce increased flexibility in service delivery through updating the HMR program rules to: e*xpand the list of providers who can refer a patient for an HMR*		• Enables timely referrals from treating practitioners, including non-medical prescribers. • Catches high-risk medicine issues at care transitions, reducing downstream medicine-related harm. • Simplifies local pathways while preserving GP involvement and program integrity.
1.1.8 Remove discrepancy between MBS Item 900 requirements and HMR Program Rules		• Removes contradictory rules that cause refusals, delays and re-work. • Streamlines administration and compliance, improving provider certainty and patient access. • Enhances program integrity through single, consistent requirements.

1.2 Introduce reforms to RMMR and QUM Programs to increase productivity, program sustainability and patient access		
Budget element	Estimated investment (over 4 years)	Benefits
1.2.1 Allow RMMRs to be conducted in a RACF that is participating in the ACOP Measure	**$34.3m**	• Preserves resident access to comprehensive reviews alongside ACOP, avoiding service gaps. • Directs pharmacist time to residents with complex needs identified on-site. • Strengthens medicines governance and safety while ACOP uptake scales.
1.2.2 Reform QUM funding predicated on the implementation of Recommendation 1.2.1		• Re-balances facility-level quality activities to complement ACOP and reduce duplication. • Targets education, stewardship and governance to highest-impact areas. • Improves measurable safety outcomes (e.g., antipsychotic and sedative use).
1.2.3 Apply annual WCI indexation to RMMR provider fees, including retrospective indexation		• Stabilises supply by restoring real remuneration and protecting it over time. • Retains experienced clinicians to maintain continuity and quality. • Reduces the risk of thin-market failure in regional aged care.
1.2.4 Introduce increased flexibility in service delivery through updating program rules to: *remove requirement for separate formal consent for RMMRs on the basis that residents already provide consent for health information use on RACF admission*.		• Removes duplicative paperwork that delays care without adding protection. • Speeds commencement of reviews for high-risk residents. • Keeps accountability through existing privacy and clinical documentation.
1.2.5 Introduce increased flexibility in service delivery through updating program rules to: *reinstate option to provide RMMR follow-up services via telehealth*		• Enables timely monitoring and medication optimisation post-review. • Reduces non-value travel, increasing clinician productivity. • Improves access for facilities in dispersed or remote locations.
1.2.6 Introduce increased flexibility in service delivery through updating program rules to: *expand the list of providers who can refer a patient for an RMMR*		• Facilitates timely identification of residents needing review (e.g., NPs, ACOP pharmacists, geriatric teams). • Intercepts medicine-related risk at point of care, reducing escalation. • Streamlines multidisciplinary workflows in aged care.
1.3 Introduce reforms to the Aged Care On-site Pharmacist (ACOP) Measure to improve uptake and implementation		
Budget element	Estimated investment (over 4 years)	Benefits
1.3.1 Increase ACOP remuneration by 15%	**$0.0m** **(Budget neutral)**	• Attracts and retains suitably experienced pharmacists into on-site roles. • Reduces vacancies and churn that undermine continuity and safety. • Aligns remuneration with the advanced scope and accountability of the role.
1.3.2 Increase ACOP FTE allocation from 0.2 FTE per / 50 beds to 0.3 FTE per / 50 beds		• Provides sufficient on-site time for resident reviews, governance and education. • Improves medication safety metrics (e.g., deprescribing and reduced high-risk medicine exposure). • Enables proactive, not just reactive, medicines management.

Budget element	Estimated investment (over 4 years)	Benefits
1.3.3 Introduce ACOP payments linked to rurality (MMM3-7)		• Makes roles viable in hard-to-recruit areas, lifting program uptake. • Reduces inequity in resident access to on-site medicines expertise. • Supports sustainable service continuity in regional RACFs.
1.3.4 Introduce a ACOP graded remuneration model offering incremental pay progression based on experience, postgraduate qualifications, and recognition of advanced practice		• Creates a clear career pathway that rewards skills and performance. • Incentivises postgraduate training and advanced practice standards. • Drives quality improvement and retention.
1.3.5 Introduce funding for a replacement ACOP during periods of where the regular ACOP is on leave (e.g. annual leave, personal leave)		• Maintains continuous medicines governance and resident safety when staff are on leave. • Prevents backlog and risk accumulation. • Supports RACF operational planning and compliance.
1.3.6 Introduce increased flexibility in service delivery through updating program rules to: *allow on-site attendance to be delivered in flexible time blocks between 3.8 hours and 7.6 hours*		• Matches staffing to facility workflows and resident needs. • Reduces travel inefficiency and idle time. • Increases productive clinical hours within existing resources.
1.3.7 Introduce increased flexibility in service delivery through updating program rules to: i*ncrease provision for remote work to include medication advisory committee meetings and answering queries, up to a maximum of 20% of total hours*		• Ensures timely advice and governance tasks without unnecessary travel. • Particularly valuable for small or geographically dispersed facilities. • Lifts overall program efficiency and responsiveness.
1.3.8 Introduce increased flexibility in service delivery through updating program rules to: *allow direct payment to credentialed pharmacists or eligible organisations under Tier 2 arrangements*		• Simplifies payment pathways and participation barriers. • Broadens provider participation while retaining accountability. • Reduces administrative friction for RACFs.
1.3.9 Introduce increased flexibility in service delivery through updating program rules to: *replace weekly timesheet verification with a monthly timesheet and activity signed by the RACF representative*		• Cuts administrative burden while preserving oversight. • Frees time for clinical activity and quality initiatives. • Simplifies audit processes.
1.3.10 Amend the MBS Item 903 and 249 explanatory notes to explicitly include medication reviews conducted under the ACOP Measure		• Clarifies eligibility for prescribers and credentialed pharmacists • Supports integrated, team-based funding flows for resident care. • Minimises administrative burden.
1.4 Pharmacist workforce needs analysis		
Budget element	Estimated investment (over 4 years)	Benefits
Allocate funds to enable a rapid and targeted response to the outcomes of the national pharmacist workforce needs analysis.	**$20.0m** ($10.0m FY26/27 +	• Accelerates implementation of evidence-based fixes for maldistribution and skills gaps (inc. rural & First Nations). • Protects critical programs by addressing supply pressures. • Delivers early benefits while full reforms are progressed through 1PPA governance arrangements.

	$10.0m FY27/28)	

2. National Immunisation Program Vaccinations in Pharmacy (NIPVIP) reforms		
Budget element	Estimated investment (over 4 years)	Benefits
2. Implement four changes to the National Immunisation Program Vaccinations in Pharmacy (NIPVIP) program rules to increase uptake of NIP vaccines by the Australian population	**$149.4m**	• Raises coverage – especially in priority populations – by recognising complexity, enabling outreach, and removing age/location limits. • Improves convenience (after-hours, RACF/disability outreach, walk-in) to convert intent into vaccinations. • Reduces preventable illness, hospitalisations from vaccine-preventable disease.

3. Pharmacists in Aboriginal and Torres Strait Islander Primary Health Services		
Budget element	Estimated investment (over 4 years)	Benefits
3. Provide funding to integrate pharmacists within Aboriginal and Torres Strait Islander Primary Health Services	**$40.7m**	• Delivers culturally safe medicines care that improves adherence and chronic disease outcomes. • Prevents avoidable ED presentations and hospitalisations from medicine-related harm. • Strengthens coordination between AHSs and community pharmacies, improving access to medicines.

4. Workforce Incentive Payment (WIP) reforms		
Budget element	Estimated investment (over 4 years)	Benefits
4. Double funding of the Workforce Incentive Payment (WIP) to general practices who employ an on-site pharmacist	**$126.9m**	• Expands team-based care capacity for chronic and complex conditions; improved QUM/medicine optimisation. • Eases GP workload and reduces wait times by shifting medicines optimisation to pharmacists. • Supports better prescribing quality and reduces downstream medicine-related harm.

5. Pharmacist participation in multidisciplinary case conferences		
Budget element	Estimated investment (over 4 years)	Benefits
5. Fund pharmacist participation in multidisciplinary case conferences	**$6.6m**	• Improves coordination and early medicines optimisation for complex patients. • Reduces adverse events and preventable hospitalisations. • Embeds pharmacists in team-based care consistent with the National Medicines Safety Priority.

Appendix 2: HMR modelling assumptions

PSA's RMMR modelling is based on the following assumptions:

- Estimated spend is additional investment above our best estimate of the forecasted annual spend.
- HMR services (including HMR Follow-up consultations) have been modelled with 8% growth using published data to June 2025.[23,24] This is consistent with apparent growth in HMR services over the past 5 years.
- HMR service payments and HMR Follow-up consultation payments have annual indexation applied at 3.4% annually over the forward estimates. This is consistent with the seasonally adjusted annual all sector Wage Price Index (WPI) as of June 2025.[25]
- Retrospective indexation was applied to HMR service and Follow-up payments since indexation was last applied in June 2019 using the seasonally adjusted annual all sector WPI as of June 2025.
- Monthly HMR caps were lifted from 30 HMRs per month to 60 HMRs per month. This was estimated to result in a 10% growth in services delivered (both HMRs and Follow-ups).
- Follow-up services were modelled at 50% of initial HMRs for first Follow-ups and 25% of initial HMRs for second Follow-ups. This is a significant increase on the current rate of approximately 16.5% first Follow-ups and 3.5% second Follow-ups. This growth is assumed based on the more favourable environment created by the application of all recommendations to enhance the policy setting in which the program operates.

Appendix 3: RMMR modelling assumptions

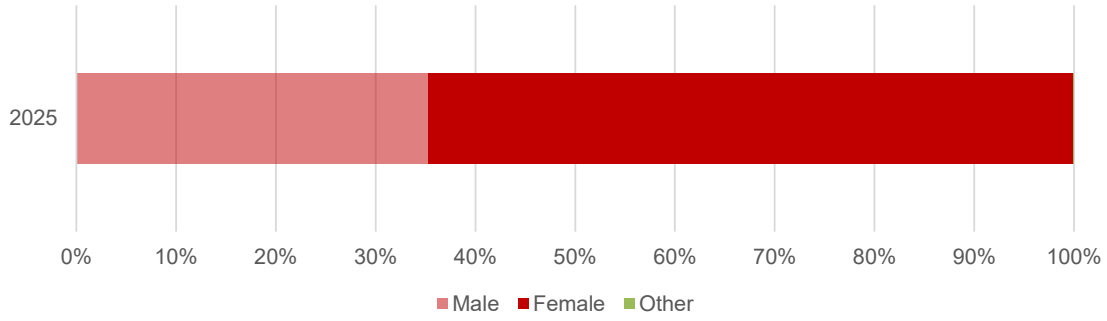
PSA's RMMR modelling is based on the following assumptions:

- Estimated spend is additional investment above our best estimate of the forecasted annual spend.
- RMMR services (including Follow-ups) have been modelled with fixed growth using published data to June 2025.[23,24] This is consistent with flat growth in RMMR services over the past 5 years and limited by the absence of available data on uptake of the ACOP Measure.
- Service payments and Follow-ups payments have annual indexation applied at 3.4% annually over the forward estimates. This is consistent with the seasonally adjusted annual all sector Wage Price Index (WPI) as of June 2025.[25]
- Retrospective indexation was applied to RMMR service and Follow-up payments since indexation was last applied in June 2019 using the seasonally adjusted annual all sector WPI as of June 2025.
- Follow-up services were modelled at 50% of initial RMMRs for first Follow-ups and 25% of initial RMMRs for second Follow-ups. This is a significant increase on the current rate of approximately 16.5% first Follow-ups and 3.5% second Follow-ups. This growth is assumed based on the more favourable environment created by the application of all recommendations to enhance the policy setting in which the program operates.

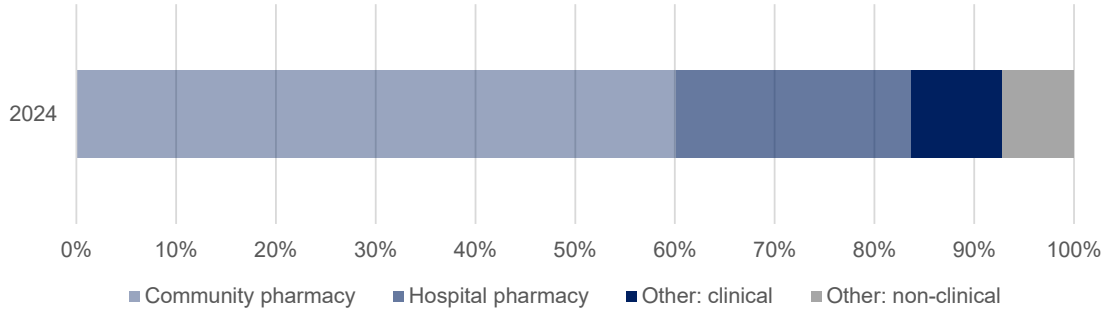
Appendix 4: Pharmacists in Australia

41,451

pharmacists in Australia



Sex distribution: pharmacists in Australia (September 2025)[8]



Principle work setting: pharmacists in Australia[26]

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