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Economic Analysis of the Scope of Pharmacy Services | Findings Report

Pharmacy Guild of Australia, Victoria Branch

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Deloitte Access Economics

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Executive Summary (1/3)

The findings report quantifies potential economic impacts of the Community Pharmacist Program in Victoria, which enables community pharmacists to treat certain common health conditions within the expanded scope of pharmacy practice.

Study Overview

The Victorian Government has committed **$18 million to support a staged expansion of the Community Pharmacist Program** ('the Program').[1] This commitment builds on the Program activity to date, which has delivered more than 100,000 services across over 900 participating Victorian community pharmacies.[2]

This report, commissioned by the Pharmacy Guild of Australia, Victoria Branch (PGA VIC) and delivered by Deloitte Access Economics, **assesses and quantifies the economic impacts of pharmacists practising to their expanded scope as defined by the Program**. Benefits are quantified across three categories: avoided costs to the Victorian government, productivity gains, and wellbeing gains.

The analysis draws on publicly available service and administrative datasets, academic literature, market research and is informed by a series of modelling assumptions, combining available evidence on service utilisation, care pathways and health outcomes to estimate these impacts in Victoria. It evaluated **23 conditions and wellbeing services** within the scope of this analysis, as agreed with PGA VIC. A Technical Appendix has been prepared in conjunction with this report and documents the analytical framework, data sources, assumptions and modelling approach underpinning these estimates.

The findings report presents the key findings on the potential economic impacts of expanded scope pharmacy services in Victoria, together with an overview of the methodology and key assumptions. Further detail on assumptions, limitations and benefit specific considerations is documented in a separate Technical Appendix prepared alongside this report.

The Program

The Program enables appropriately trained community pharmacists to treat certain health conditions under a structured prescribing model.[2] Pharmacists assess and treat patients, provide ongoing management, and refer to other healthcare providers when required.[2]

The Program covers a defined set of conditions and wellbeing services for low-acuity patient cohorts, spanning wellbeing services, acute health condition management, and chronic disease management. It operates through community pharmacies across Victoria, including in regional and rural communities where access to primary care is more limited.

Assessment Framework

By providing care in community settings, the Program is expected to improve access to treatment, reduce barriers related to time, geography and service availability, and support patients to receive care. This framework attributes benefits through three drivers:

- **Early intervention, prevention** and **improved accessibility** enable timely care and reduce condition escalation and barriers to access.
- **Care substitution** refers to the safe and timely care delivered in community pharmacies that substitute for low-acuity emergency department and hospital outpatient services.
- **Improved medication adherence**[3] further supports better condition management and improvements in patient's wellbeing.

Together, these drivers form the basis of the economic framework used in the findings report, linking expanded scope pharmacy services to avoided costs to government, productivity gains and wellbeing gains.

1. Victorian Government, Making It Easier For Victorians To Get Care At The Chemist, media release, 19 December 2025
2. State Government of Victoria, More Care Closer To Home At Your Local Pharmacy, media release, 7 October 2026

3. Cutler, Rachelle et al, 'Pharmacist-led medication non-adherence intervention: reducing the economic burden placed on the Australian health care system' (2023) 23 Patient Prefer Adherence.

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Executive Summary (2/3)

Benefits were assessed across healthcare system, productivity and wellbeing outcomes, using evidence-based assumptions on service utilisation and outcomes.

Overview of benefits

This analysis quantifies the benefits associated with expanded community pharmacy services across three outcome categories: avoided healthcare costs, productivity gains and wellbeing gains. These benefits arise from early intervention, improved access to care and better health outcomes for patients.

Findings should be interpreted as a monetised representation of potential system-wide benefits rather than immediate cashable savings.



Avoided costs
The value of public healthcare services avoided through early intervention and management in community pharmacy.



Productivity gains
The additional economic output generated when people are better able to participate in the workforce.



Wellbeing gains
The improvements in people's health and quality of life arising from more timely, accessible and effective care.

Overview of assumptions underpinning the analysis

The analysis relies on a set of assumptions that inform service utilisation, health outcomes and the resulting avoided costs, productivity gains and wellbeing gains. The purpose of these assumptions is to define who is likely to access expanded scope pharmacy services, the extent to which they are likely to benefit, and the costs of delivering those services, enabling a balanced assessment of overall economic impact. Key assumptions are summarised below, with further detail provided throughout this report and Technical Appendix.

Eligible cohort

Eligible cohort covers a set of assumptions that defines the population likely to experience a condition, present for care, and be suitable for management through an expanded scope pharmacy services. These assumptions establish the potential scale of service demand and form the foundation for estimating overall impact.

Adoption rate

The adoption rate estimates the proportion of eligible patients expected to use expanded scope pharmacy services. The rate is informed by Victorian consumer research.

Rate of adherence to treatment

Applied to productivity and wellbeing gains only, the rate of adherence to treatment assumption captures the extent to which eligible patients are likely to adhere to a recommended treatment plan prescribed through the Program, and therefore realise benefits. This assumption influences the degree to which expanded scope services translate into improved health outcomes and downstream economic benefits.

Consultation model

The consultation model is used to estimate how services are delivered in practice, including the frequency and cost of ongoing patient management. These assumptions are a key determinant of the cost of delivering each service.

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Executive Summary (3/3)

Potential annual health-system and community benefits from expanded scope of pharmacy services in Victoria

Annual potential economic benefits across the Victorian economy at the highest adoption rate for the Program — up to **$867.3m**

In terms of direct health-system benefits, the Program has the potential to increase Victorian public hospital service capacity annually by up to:

- 31,900 hours of ED treatment capacity during regular hours
- 79,000 hospital bed days
- 32,100 outpatient service events

Direct health-system benefits

Annual avoided costs attributable to the Victorian public hospital system of up to **$44.8m***

- Estimated potential economic benefit from avoided **potentially preventable hospitalisations** — up to **$38.3m**
- Estimated potential economic benefit from avoided **emergency department presentations** — up to **$3.7m**
- Estimated potential economic benefit from **avoided outpatient appointments** — up to **$2.7m**

Estimated potential economic benefit from **avoided healthcare activity in:**

- **regional communities** — up to **35%****

Broader benefits to the Victorian economy and community

Annual productivity gains for the Victorian economy up to **$789.6m**

- Estimated potential economic benefit from **reduced absenteeism** — up to **$199.3m**
- Estimated potential economic benefit from **reduced presenteeism** — up to **$465.6m**
- Estimated potential economic benefit from **reduced carer burdens** — up to **$124.7m**

Annual wellbeing gains for the Victorian economy up to **$32.9m**

- Estimated potential economic benefit from **reduced time in ill-health** — up to **$1.8m**
- Estimated potential economic benefit from **improved medication adherence** — up to **$31.1m**

Up to **483 quality adjusted life years gained** for Victorians.

These results should be interpreted as **indicative estimates** of the economic value that could be realised under the assumptions and conditions set out in this report. The analysis assumes a minimum and maximum adoption rate and therefore presents an interval of potential benefits, from low to high uptake scenarios. **This page presents the benefits based on the highest uptake scenario.**

The estimated benefits **do not represent immediate, cashable savings**. Avoided costs are realised primarily through capacity release, while productivity and wellbeing gains represent broader economic and social value rather than direct budget impacts. The extent to which value is realised will depend on factors including program uptake, service delivery and stakeholder behaviour.

Further detail on assumptions, limitations and benefit-specific considerations is set out in the Technical Appendix prepared alongside the findings report.



Note: Benefits are presented on an annual basis and represent the potential benefits at the highest assumed adoption rate. These benefit values should be read alongside the interpretations set out in Section 3.1.

** The avoided costs presented here, and through the findings report, specifically relate to those accruing to the Victorian state government.*

*** Regional communities: avoided costs relate to emergency department presentations only. The estimated potential economic benefit from avoided healthcare activity in regional communities is estimated to be 30% for outpatient appointments and 25% for potentially preventable hospitalisations.*

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1. Introduction and scope



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1.1 Introduction and scope of analysis

The findings report estimates the potential avoided costs to government, productivity gains and wellbeing gains from expanded scope pharmacy services in Victoria.

Background and context

The scope of pharmacy practice has expanded across Australia and New Zealand, with pharmacists now delivering healthcare services including vaccinations and treatments for common, uncomplicated health conditions. These changes respond to increasing pressure on primary care and limited GP access, particularly in regional communities. Implementation varies by jurisdiction, with each jurisdiction implementing community pharmacy expanded scope in varying ways, including through pilots and trials, and varying scopes of practice.

In 2025, the Victorian Government made the Victorian Community Pharmacist Program ("the Program") permanent, enabling services including contraceptive resupply, treatment of selected conditions, and a broader range of vaccinations. Building on the Program that has delivered over 100,000 services across more than 900 Victorian community pharmacies, the Victorian Government has committed $18 million to cover the patient consultation fees. The in-scope services for this analysis are shown Section 1.2.

Purpose of this Project

Deloitte Access Economics was engaged by the Pharmacy Guild of Australia, Victoria Branch (PGA VIC) to assess the economic impacts of community pharmacists practising to their expanded scope under the Program. The analysis estimates the potential economic benefits of expanded scope pharmacy services across three benefit categories: avoided costs to government, productivity gains and wellbeing gains.

The findings report presents an overview of the methodology and findings of the analysis. A Technical Appendix has been prepared alongside this report and documents the methodology, data sources, and assumptions underpinning the analysis. The remainder of this report includes Section 2 outlining the analytical framework, methodology and key limitations while Section 3 presents results of the analysis.

Victorian scope

The findings report assesses impacts in Victoria only. It does not consider costs beyond the cost of delivering Program services. Victorian data has been used where available, with national estimates applied where it is not. Benefits are only estimated where there is sufficient evidence to indicate they can be realised through the Program.

Interpretation

The estimated benefits do not represent immediate, cashable savings. Avoided costs are realised primarily through capacity release, while productivity and wellbeing gains represent broader economic and social value rather than direct budget impacts. The extent to which value is realised depends on factors including program uptake, service delivery and stakeholder behaviour.

Use restriction

This report is prepared solely for the Pharmacy Guild of Australia (Victorian Branch) for the purpose set out in Section 1.1 and should not be relied upon by any other party or for any other purpose.

The Scope of the Program

Under the Program, community pharmacists practising to their expanded scope can provide access to assessment, treatment and ongoing management for a range of conditions and wellbeing needs that can be appropriately managed in community pharmacy settings. The Program encompasses services across three broad categories:

- Wellbeing services – prevention, health promotion and lifestyle support.
- Acute health conditions – timely treatment and short-term care for urgent health needs.
- Chronic disease management – ongoing care and coordination for long-term health conditions.

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1.2 Services considered in the economic analysis

The Program services are mapped to three service categories, forming the basis for the economic analysis and the assumptions applied to each category.

Table 1 presents the range of pharmacist services mapped across three key service categories:

- **Wellbeing services**: Services focused on prevention, health promotion, and lifestyle support, aimed at maintaining health, and reducing risk factors.
- **Acute health condition management**: Services providing timely assessment and short-term management of low-acuity conditions.
- **Chronic disease management services**: Services supporting ongoing care, monitoring, and coordination for long-term conditions and helping to manage symptoms.

The 23 services analysed were chosen with PGA VIC and grouped in line with the Program structure throughout the analysis. This included services originally introduced as part of the Pilot, all current services, and future planned services that had been planned but were not yet being delivered as at October 2026. This categorisation supports the analytical approach used in the economic analysis.

Table 1: Scope of pharmacist services and categorisation

Service category	Services			
Wellbeing services	Oral health screening and fluoride application	Travel health	Smoking cessation	
	Hormonal contraception (initiation and resupply)	Menopausal Hormone Therapy (MHT) (resupply)	Weight management for obesity	
Acute health conditions	Impetigo (school sores)	Herpes zoster (shingles)	Uncomplicated urinary tract infection	Acute nausea and vomiting
	Mild acute musculoskeletal pain	Allergic and nonallergic Rhinitis	Gastro-Oesophageal Reflux (GOR) and GOR Disease	Minor acute wound management
	Ear infections	Mild acne	Mild to moderate dermatitis	
Chronic disease management	Cardiovascular disease / hypertension	Cardiovascular disease / dyslipidaemia	Cardiovascular disease / type 2 diabetes	Chronic obstructive pulmonary disease
	Asthma and exercise induced bronchoconstriction	Long-acting Injectable Buprenorphine		

Key ☐ Permanent service ☐ Planned service

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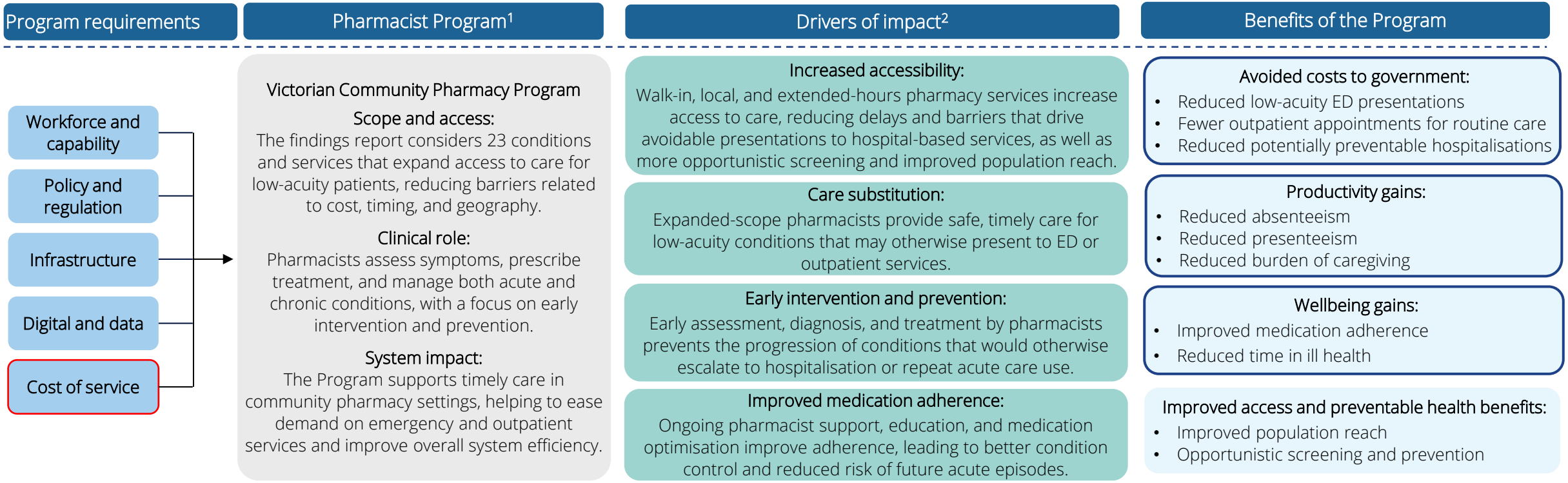
1.3 How the Program generates economic benefits

The Program logic map outlines how service delivery translates into avoided costs to government, productivity gains and wellbeing gains.

Figure 1 illustrates the pathways through which expanded scope pharmacy services may generate economic benefits, linking Program inputs and service delivery to patient, workforce and health system outcomes. The analysis accounts for the cost of delivering pharmacist consultations, as set out in Section 3. Broader implementation requirements, such as workforce training, infrastructure and digital systems, are necessary to deliver the Program but are not costed in the analysis. The findings therefore do not represent a full cost-benefit analysis. The map then identifies the mechanisms through which pharmacist-led interventions drive impacts and the resulting quantified and qualitative benefits attributed to the model. Benefits are quantified only where a plausible pathway and suitable evidence are available.



1. The Program may reduce reliance on other primary healthcare professionals. A multidisciplinary model of care may still be required to support patient outcomes and the benefits related to avoided health service use, such as potentially preventable hospitalisations.
2. Drivers contribute to multiple benefit categories; relevance and strength vary by service and condition

Figure 1: Drivers and benefits of the Program.

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2. Approach to the economic analysis



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2.1 Approach to economic analysis

The analytical framework outlines the approach used to map services to outcomes and quantify avoided healthcare costs, productivity gains and wellbeing gains.

The analytical framework outlines the approach used to estimate the benefits associated with expanded scope of community pharmacy services. The framework maps services to evidence-based benefit pathways, establishes key modelling assumptions, identifies eligible cohorts, and attributes impacts across avoided healthcare costs, productivity gains and wellbeing gains. Steps 1 to 3 are described in this section, defining the scope of services included in the analysis, identifying benefits that can reasonably be attributed to pharmacist-delivered care, and developing the evidence-informed quantification approach used to estimate those benefits. Steps 4 and 5 are described in Section 3. Together, these steps establish the benefit pathways, assumptions and calculation methods that underpin the modelling of avoided healthcare costs, productivity gains and wellbeing benefits.

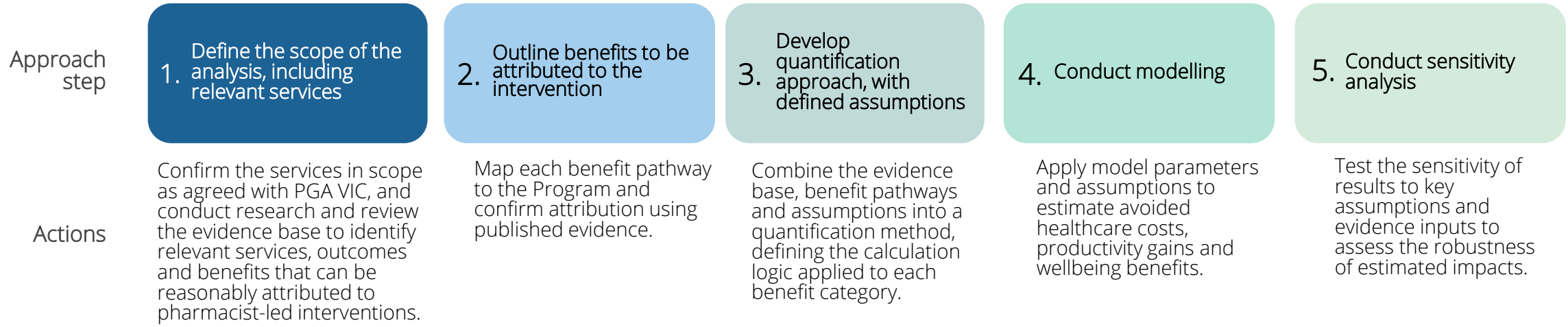

Figure 2: Analytical framework applied in this analysis

Steps 1 to 3 are described in this section. Steps 4 and 5 are applied in Section 3.

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2.2 Define the scope of the analysis, including relevant services

This section sets out the services assessed and the outcomes quantified across avoided costs, productivity gains and wellbeing gains.

The potential benefits of the Program are quantified across avoided healthcare service utilisation, productivity gains and wellbeing gains.

Avoided healthcare utilisation has been mapped to the following acute and subacute health services:

- **Avoided potentially preventable hospitalisations,** through early intervention preventing the escalation of medical condition and hospital admission.
- **Avoided emergency department presentations**, by redirecting low-acuity cases to accessible services at a community pharmacy.
- **Avoided outpatient clinic appointments,** reflecting earlier management of low-acuity cases within the community pharmacy setting, complementing existing primary and community care services.

Productivity gains and wellbeing gains were quantified for a subset of services and conditions where evidence supported the estimation of these benefits. This is reflected in the mapping in Table 2, with further detail documented in the Technical Appendix prepared alongside this report.

Table 2: Benefits accruing to each condition and service[1]

		Avoided acute and subacute healthcare services			Productivity gains	Wellbeing gains
Category	Service	Potentially preventable hospitalisations	Emergency department presentations	Outpatient services		
Wellbeing services	Oral health screening and fluoride application	✓			✓	
	Travel health			✓		
	Smoking cessation			✓		
	Hormonal contraception (initiation and resupply)			✓		
	Menopausal Hormone Replacement (MHT) (resupply)			✓		
	Weight management for obesity			✓		
Acute health conditions	Impetigo (school sores)			✓	✓	
	Uncomplicated urinary tract infection	✓	✓		✓	✓
	Herpes zoster (shingles)		✓	✓	✓	
	Acute nausea and vomiting		✓		✓	
	Mild acute musculoskeletal pain		✓			
	Allergic and non-allergic rhinitis		✓	✓	✓	
	Gastro-oesophageal reflux (GOR) and GOR disease		✓	✓	✓	
	Minor acute wound management		✓			
	Ear infection (acute otitis externa and acute otitis media)	✓	✓		✓	✓
	Mild acne			✓		
	Mild to moderate dermatitis			✓	✓	
Chronic disease management	Cardiovascular disease/ hypertension	✓		✓	✓	✓
	Cardiovascular disease/ dyslipidaemia	✓		✓	✓	✓
	Cardiovascular disease/ type 2 diabetes	✓	✓	✓	✓	✓
	Chronic obstructive pulmonary disease	✓	✓	✓	✓	✓
	Asthma and exercise induced bronchoconstriction	✓	✓	✓	✓	✓
	Long-acting injectable buprenorphine		✓	✓	✓	

1. Benefits have been quantified where it can be reasonably assumed that a particular service provided in community pharmacy can be attributed to a redirection of activity, or an improvement in productivity or wellbeing outcomes, and there is available evidence that supports the quantification of the relevant benefit for this service. As a result, benefits that have not been quantified may reflect those that do not meet either, or both, of these requirements. In particular, psoriasis has been excluded from the analysis on this basis.

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2.3 Benefit pathways captured in the economic analysis

Benefits are assessed across avoided costs to the Victorian public healthcare system, as well as productivity and wellbeing outcomes, reflecting the pathways where evidence supports quantification.

Avoided costs

The value of Victorian public healthcare services utilisation avoided through early intervention, treatment and ongoing management in community pharmacy settings, and are assessed through the following measures:

- **Capacity gain** – Quantifies hospital bed-days, emergency department hours and outpatient service events released for other patients.
- **Net avoided cost** – Quantifies the value of reduced demand on healthcare services, accounting for the cost of delivering the Program.

Productivity gains

The additional economic output generated when improved health outcomes reduce time away from work and improve productivity while working. These benefits are quantified in monetary terms and reflect gains experienced by both patients and informal carers, and are assessed through the following measures:

- **Absenteeism** – Quantifies the amount of time spent absent from work due to health issues or caregiving obligations
- **Presenteeism** – Quantifies the reduced productivity while at work, often caused by illness or exhaustion
- **Burden of care** – Quantifies the amount of time spent absent from work, or non-productive at work due to providing care-giving support.

Wellbeing gains

The improvements in people's health and quality of life arising from more timely, accessible and effective care. These benefits are expressed as changes in health-related quality of life (HRQoL), quantified as quality-adjusted life years (QALYs)[1]. The benefits are attributed through the following measures:

- **Improved medication adherence** – Quantifies improvements in patients taking medicines as prescribed following the Program.
- **Reduced time in ill health** – Quantifies reductions in the time spent experiencing illness or symptoms due to avoided condition progression.

Improved access and preventable health benefits represent broader population health benefits that may arise from the Program but have not been quantified in the analysis. These benefits reflect the ability of community pharmacies to engage people who may otherwise delay or forgo care and to create additional opportunities for early intervention and prevention. Potential benefits include:

- **Improved population reach** – Describes increased access to care for underserved groups, including people in regional areas and those who may be less likely to seek care through traditional primary care settings.
- **Opportunistic screening and prevention** – Describes increased opportunities to identify unmet healthcare needs, risk factors or undiagnosed conditions during routine pharmacy interactions, enabling earlier intervention, referral and preventive care. This may be particularly important for individuals who would otherwise delay, avoid or face barriers to accessing traditional primary care.

Key Quantified benefit Qualitative benefit

1. HRQoL reflects an individual's physical and mental health, functioning and overall quality of life.

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2.4 Framework for the quantification of benefits

Net benefit is estimated by comparing the value of avoided costs, productivity gains and wellbeing gains against the cost of delivering the Program.

This section sets out the framework used to quantify net benefit for the analysis commissioned by the Pharmacy Guild of Australia, Victoria Branch, including the population expected to benefit, the assumptions applied and the treatment of costs. The approach first defines the population expected to access each service, as these individuals form the basis for attributing both benefits and costs. The value of benefits is then estimated using a layered set of evidence-based assumptions drawn from academic literature, publicly available data and consumer research. Benefits are then quantified across three categories: avoided costs, productivity gains and wellbeing gains. Finally, the cost of delivering pharmacist consultations is deducted from the total value of benefits to estimate net benefit. Consistent with the scope of this analysis, only the direct cost of the pharmacist consultation is included, rather than the full cost of implementing and operating the Program.

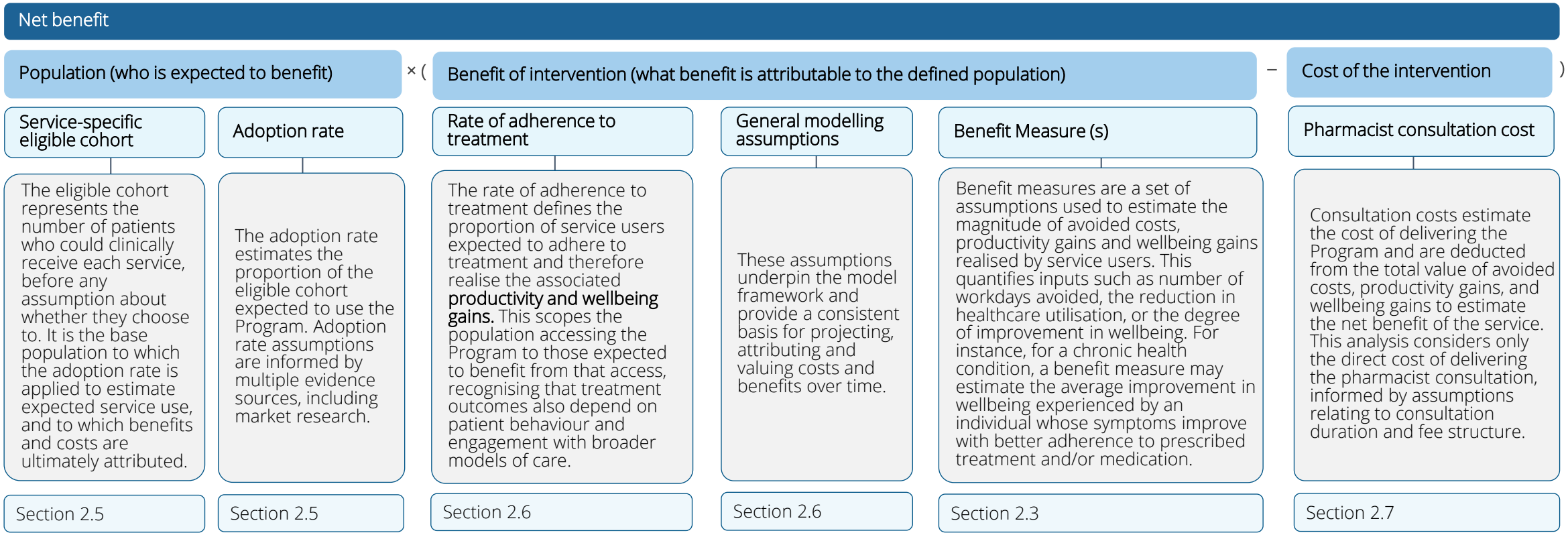

Figure 3: Framework for the quantification of net benefit

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2.5 Key assumptions: population expected to benefit

Eligible cohort and adoption rate assumptions are applied to estimate the population expected to receive the Program, to which benefits and costs are attributed

Service-specific eligible cohort

Approach to estimating service-specific eligible cohorts

The eligible cohort represents patients who could clinically receive each service, before any assumption about uptake. Cohorts were estimated separately for avoided costs and for productivity and wellbeing gains, supplemented by service-specific assumptions where published data was unavailable.

How the cohort is estimated

Two approaches are applied, reflecting the different evidence bases available:

- Avoided costs – Cohorts were derived from Victorian hospital activity data, capturing emergency department presentations, admissions and outpatient events that as close as possible, align to the conditions in scope for the Program.
- Productivity and wellbeing gains – Cohorts were primarily derived from incidence and prevalence rates for the relevant conditions in the Victorian population, reflecting that these benefits accrue to patients irrespective of whether they would otherwise have presented to hospital.*

Filters were then applied to both, including restrictions relating to clinical scope and low-acuity presentations, and eligibility criteria specified within the clinical protocols (for example, age requirements). Further detail on cohort refinement is documented in the Technical Appendix prepared alongside this report.

Application

The resulting eligible cohort is the base to which the adoption rate is applied and benefits and costs are attributed. Because the two approaches draw on different sources, cohort sizes may differ between avoided costs and productivity or wellbeing gains for the same condition.

*Benefits related to a reduced carer burden and improved medication adherence, captured in the productivity and wellbeing gains, were also partially derived from the cohort of avoided admissions based on the Potentially Preventable Hospitalisations (PPH) dataset.

Adoption rate

Approach to estimating adoption rates

The adoption rate represents the proportion of the eligible cohort expected to receive each service through a community pharmacy. Adoption rates were estimated using a blended approach, combining published Australian and international evidence with Victorian consumer research commissioned by the Guild. Published studies suggest uptake of pharmacy-based services typically ranges from 33% [1] to 60% [2], providing a benchmark for potential diversion from hospital settings. Condition-specific rates were informed by a Victorian-representative consumer research survey[3] commissioned by PGA VIC, documented in the Technical Appendix prepared alongside this report.

How adoption ranges are estimated

Adoption rates were derived by applying levels of consumer awareness alongside reported willingness to receive care in community pharmacy for each service with:

- A low adoption rate reflecting consumers who are highly comfortable receiving the service in a community pharmacy
- A high adoption rate reflecting the broader group of consumers who are open to receiving care in this setting.

Application and key considerations

The low and high adoption rates were applied across all services to reflect a plausible range of uptake and, as a key driver of estimated reductions in healthcare utilisation and economic value, are tested across this range in the sensitivity analysis. For chronic condition management services, an additional 50% reduction in the adoption rate was applied, reflecting the greater complexity of ongoing care and its lower substitutability in community pharmacy.

1 Karia et al. (2025) Consumer perceptions and preferences of pharmacist-led professional services and attributes in Australia.
2 Heller et al. (2016) Evaluating the attractiveness of the availability of injectable progestogen contraceptives at the community pharmacy setting in the UK.
3 Scope of Practice Track 5 Voter Research, independent research has been commissioned by Pharmacy Guild of Australia in November 2024 to inform on full scope voter opinion.

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2.6 Key assumptions: benefits attributed to the population

Adoption and adherence assumptions are applied to estimate the proportion of eligible patients who receive pharmacist-delivered care and experience the associated health, productivity and wellbeing benefits.

Rate of adherence to treatment

Approach to estimating the rate of adherence to treatment

Applied only to productivity and wellbeing gains, the rate of adherence to treatment reflects the proportion of patients who continue to follow their recommended treatment plan after receiving care. Consistent with the World Health Organization's definition, adherence includes the extent to which a person's behaviour aligns with recommendations from a healthcare professional, such as taking medication, following lifestyle advice or attending ongoing care.

How rate of adherence to treatment is estimated

The World Health Organization estimates that adherence to long-term therapies in developed countries averages approximately 50%[1]. This rate was applied to services where productivity and wellbeing benefits are realised, capturing the long-term treatment seeking behaviours that are required to realise these benefits. Naturally, this assumption of adherence varies by condition in practice. Hence this rate represents a simplified assumption.

Application

The rate of adherence to treatment was applied to the estimated eligible cohort to identify the proportion of patients who are expected to follow their recommended treatment plan and therefore realise the associated benefits of the Program. All patients in the eligible cohort were assumed to receive the Program and incur the associated service delivery cost, while only those who adhere to treatment were assumed to experience the productivity and wellbeing benefits. As a single rate was applied across services, results are tested against this assumption in the sensitivity analysis.

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

Overview of general modelling assumptions

General modelling assumptions govern how service activity, costs and benefits are estimated over time and are applied consistently across all services. Assumptions have been applied to best reflect implementation settings and healthcare utilisation patterns.

Key assumptions include:

- Scheduled rollout of the Program – Immediate availability of eligible services assumed.
- Time horizons – Period over which benefits accrue.
- Activity projections – Future growth in service demand.
- Pharmacy operating hours – Eligible opportunities for ED substitution.
- Funding attribution – Allocation of benefits across governments.
- Health inflation – Escalation of future healthcare costs.
- Discount rate – Present value of future benefits.
- Cost inclusions and exclusions – Scope of costs captured.
- Regional disaggregation – Geographic allocation of benefits.
- Demand and capacity assumptions – Ability to meet projected demand.
- Implementation assumptions – Treatment of workforce and ramp-up effects.

Application and key considerations

Assumption values and supporting evidence are documented in the Technical Appendix prepared alongside this report. Where assumptions materially influence estimated benefits, their effect is tested in the sensitivity analysis.

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2.7 Key assumptions: cost of the Program

The cost of delivering the Program is based on a tiered consultation structure that reflects variation in consultation time and complexity across service types, informed by existing pricing benchmarks.

Cost of the Program

The cost of the Program is informed by two key assumptions: the assumed consultation model and the applicable consultation fee structure. Together, these assumptions determine the estimated cost of delivering the Program and are used to calculate the total intervention cost applied within the economic model, which is deducted from estimated benefits to derive net benefit.

Consultation Frequency

The assumed consultation frequency was used to estimate the cost of ongoing patient management. It is intended solely for modelling purposes and should not be interpreted as a recommended model of care.

For chronic condition management only, patients were assumed to require a follow-up consultation within 4–6 weeks of commencing or changing treatment, followed by 6-monthly reviews for stable conditions. After the single follow-up consultation, patients were assumed to either stabilise and attend periodic reviews associated with prescription renewal or be referred to a general practitioner for further management.

Assumptions were informed by the Queensland Health prescribing guidelines. For example, the hypertension guideline recommends review 4–6 weeks after treatment initiation or modification, with review intervals extending to up to six months once blood pressure is stable and treatment goals have been achieved.

Application for avoided costs

Consultation costs were applied at a service category level (ie. wellbeing services, acute health conditions, chronic disease management) for avoided costs and scaled based on modelled activity across emergency department, potentially preventable hospitalisations and outpatient settings. Cost estimates were based on the Queensland community pharmacy pricing structure in the absence of known Victorian consultation fees as more services continue to be added to the Victorian Program.

Key considerations

This analysis captures only the direct cost of delivering pharmacist consultations. Broader costs of implementing and operating the Program, including workforce training, infrastructure and digital systems, are not included, as set out in Figure 1. The findings therefore do not represent a full cost-benefit analysis. Further detail on the consultation model and fee structure is documented in the Technical Appendix prepared alongside this report.

Consultation Fee Structure

The Victorian Government currently funds eligible consultations at a flat rate of $20 per service. However, this analysis applies the Queensland tiered fee structure to reflect variation in consultation duration and complexity across the services modelled. Consultation costs were estimated using a tiered structure, with a weighted distribution applied:

- 20% Brief consultation
- 60% Standard consultation
- 20% Long consultation

This results in an estimated cost per service event, reflecting the weighted variation in consultation complexity across service types (refer to Table 3).

Table 3: Tiered consultation cost structure

Consultation length	Fee ($)	Weight (%)	Weight Cost ($)
Brief	19.50	20%	3.90
Standard	36.70	60%	22.02
Long	70.50	20%	14.10
Weighted average cost per service event			40.02

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2.8 Data sources informing the economic analysis

The analysis is informed by publicly available data and research evidence, informing the development of economic analysis methodology and key modelling assumptions.

Table 4 presents the key evidence sources used to inform the economic analysis. The analysis has been developed using an evidence-based approach, with key methodological decisions, modelling assumptions and input parameters informed by publicly available datasets, published research and government sources. Sources were selected to reflect the best available evidence on healthcare utilisation, population health needs, intervention uptake, treatment adherence, workforce impacts and health-related quality of life. Victorian-specific data has been used where available, with national and international evidence applied where local evidence was unavailable. Where multiple sources were available for the same input, preference was given to government and peer-reviewed sources.

Table 4: Data sources used to inform modelling assumptions and inputs.

Modelling input	Dataset or evidence used	Source
Potentially preventable hospitalisations	Admitted patient care: Information related to safety and quality of the health system	AIHW
Emergency department presentations	National Non-admitted Patient Emergency Department Care Database	AIHW
Outpatient services	Non-admitted patient care data tables	AIHW
Cost of health services	National Hospital Cost Data Collection: NHCDC Public Sector Appendix Tables	Independent Health and Aged Care Pricing Authority (IHACPA)
Health inflation	Health expenditure Australia 2023-24	AIHW
Adoption rate	Scope of Practice Track 5 Voter Opinion Research[1]	PGA
Cost of Program	How much does it cost? Queensland Community Pharmacy Chronic Conditions Management Pilot[2]	Queensland Government
Consultation frequency	Queensland community pharmacy clinical protocols	Queensland Government
Rate of adherence to treatment	Adherence to long-term therapies: evidence for action	World Health Organization
Condition prevalence rates	National Health Survey, 2022 Condition-specific prevalence and incidence estimates Population estimates: VIF2023 Victoria Demographic Projects to 2051	Australian Bureau of Statistics (ABS) Academic literature and publicly available datasets Data VIC
Employment rate	Working age population estimates: VIF2023 Victoria Demographic Projects to 2051 Condition-specific employment rates (data available for chronic conditions): National Health Survey, 2022 Labour Force, Australia Survey	Data VIC ABS ABS
Absenteeism and presenteeism impact estimates	Condition-specific academic estimates	Academic literature
Health-related quality of life estimates	Condition-specific academic estimates	Academic literature
Quality-adjusted life year	TPG23-08 NSW Government Cost-Benefit Analysis Guidelines – technical note	NSW Government

[1] Scope of Practice Track 5 Voter Research, independent research has been commissioned by Pharmacy Guild of Australia in November 2024 to inform on full scope voter opinion.

[2] Queensland Health. Community pharmacy pilot – how much does it cost? Queensland Government. Available at: https://www.qld.gov.au/health/contacts/community-pharmacy-pilot/how-much-does-it-cost

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3. Economic analysis results



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3.1 Economic Analysis – Interpretation

The economic analysis should be interpreted with an understanding of the conditions necessary to realise these benefits, alongside a range of benefit-specific context, documented in the Technical Appendix.

How can these benefits be realised?

In general, the benefits of the Program can be realised through early intervention and prevention, which reduce condition escalation and improve timely access to care. In terms of the avoided costs, the intervention is assumed to redirect some patient activity from high-cost hospital settings to lower-cost community pharmacy care, alongside improved medication adherence supporting better condition management and reduces repeat health service use, collectively reducing system pressure.

Benefits are also realised through the awareness and willingness to uptake pharmacy services. The analysis incorporates an adoption rate to estimate the range of potential benefits, from the minimum to the maximum level achievable based on service uptake.

What is required to realise benefits?

The Program requires system-level preparation - including training, pharmacy infrastructure and regulatory changes, and digital enablement - beyond consultation costs. However, this analysis assumes these are in place and evaluates only the cost of pharmacist consultations. This analysis also does not consider the cost of the pharmacotherapy (e.g. cost of antibiotics). It is also recognised that the realisation of some benefits, for example potentially preventable hospitalisations (PPH), may require the involvement of a multidisciplinary team, including other primary and allied care health professionals.

How should the Avoided Costs be interpreted?

The analysis estimates the benefits of the Program through reductions in acute and subacute healthcare utilisation. These benefits are expressed in monetary terms as the avoided costs, relative to the expected cost of a pharmacist consultation. These look to specifically capture the benefits accruing to the Victorian Government. The avoided costs do not represent immediate savings to the Victorian health budget. Under activity-based funding, real budget savings would require the decommissioning of capacity. In practice, benefits are more likely to be realised as reduced demand pressures and capacity release to treat higher acuity patients, rather than direct, cashable savings.

How are capacity gains realised for the Victorian health system?

The direct avoided cost benefit is primarily realised through capacity release (e.g. fewer bed days and reduced ED wait times), as opposed to immediate financial savings. This released capacity can be redeployed to manage patients with higher-acuity conditions and greater clinical need.

How should productivity gains be interpreted?

The productivity gains presented reflect the additional economic output generated when people are better able to participate in the workforce. In this analysis, productivity gains are measured to capture the broader economic benefits that may arise from more timely access to assessment and treatment through expanded pharmacy services. By providing more timely access to assessment, treatment, and follow-up care, pharmacists help patients better manage their conditions and avoid severe clinical deterioration, such as hospitalisation, that may pull them out of the workforce. The mechanisms through which productivity gains are considered have been detailed further in the Technical Appendix prepared alongside this report.

How should wellbeing gains be interpreted?

In this context, wellbeing gains are the improvements in people's health and quality of life that may arise from more timely, accessible and effective care. They capture the value of outcomes that matter to patients, including better day-to-day functioning, fewer symptoms, and less time spent in ill health.

In the analysis, gains may be considered through 1) a reduced time in ill health through improved access to care and medication preventing severe clinical deterioration and hospitalisation, and 2) improved medication adherence for individuals through ongoing medication management. This analysis does not assess the clinical efficacy of individual interventions but considers wellbeing impacts where supported by available evidence.

Why are some benefits quantified for some conditions, and not for others?

Benefits have been quantified where 1) it can be reasonably assumed that a particular service provided in community pharmacy can be attributed to a redirection of activity, or an improvement in productivity or wellbeing outcomes, and 2) there is available evidence that supports the quantification of the relevant benefit for this service. As a result, benefits that have not been quantified may reflect those that do not meet either, or both, of these requirements.

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3.2 Economic analysis results – total benefits

Expanded community pharmacy practice could deliver up to $867.3m in annual benefits across the Victorian economy, with productivity and wellbeing gains driving a significant share.

Avoided costs

Expanded scope pharmacy services could generate up to $44.8m in avoided healthcare costs annually through reduced emergency department presentations, hospital admissions and outpatient service utilisation.

Benefit accrues to the Victorian Government, as funder of public hospital services, and the broader Victorian community who receive earlier care.

Productivity gains

Improved health outcomes associated with expanded scope pharmacy services could generate up to $789.6m in annual productivity gains through reduced absenteeism, presenteeism and caregiving burden.

Benefit accrues to individuals, employers and the broader Victorian economy.

Wellbeing gains

Expanded scope of pharmacy services could generate up to $32.9m in annual wellbeing gains through improvements in health-related quality of life and reductions in disease burden.

Benefit accrues to individuals and their carers.

Estimated potential economic benefit from avoided potentially preventable hospitalisations — up to $38.3m	Estimated productivity gains from reduced absenteeism — up to $199.3m	Estimated wellbeing gains from reduced time in ill-health — up to $1.8m
Estimated potential economic benefit from avoided emergency department presentations — up to $3.7m	Estimates productivity gains from reduced presenteeism — up to $465.6m	Estimated potential economic benefit from improved medication adherence — up to $31.1m
Estimated potential economic benefit from avoided outpatient appointments — up to $2.7m	Estimated productivity gains from a reduced carer burden — up to $124.7m	

Reflects the **total quantifiable benefits** that could be realised through an expanded scope of pharmacy practice, against each of the benefit categories.

The drivers of each of these benefits are shown below.

Each of these individual monetary benefits drive the total quantifiable benefits in each category.

Section 3.6 captures the non-monetary benefits associated with each of these individual benefits.

These benefits should be read alongside the interpretation in Section 3.1 and takeaways in Section 3.5.

Figure 4: Total potential benefits derived from an expanded scope of pharmacy practice in Victoria (annual, FY27).

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3.3 Economic analysis results – avoided costs

Driven by the capacity gain in public hospitals, the expanded scope of community pharmacy practice could result in a cost saving to the Victorian Government of up to $44.8m annually, with a significant share of this being derived from service delivery in regional and remote communities.

	Emergency department	Outpatients	Potentially preventable hospitalisations	Regional disaggregation
Unit net cost avoidance	**Diverting ED presentations** to community pharmacy could realise a potential net benefit of $387 per presentation, on average. This could result in an annual benefit of $3.7m to VIC Health based on 9,700 potential low-acuity presentations.	**Diverting outpatient service events** to community pharmacy could realise a potential net benefit of $84 per presentation, on average. This could free an additional 32,000 avoided allied health and clinical nurse specialist appointments annually, resulting in an annual benefit of $2.7m to VIC Health.	**Early intervention in a community pharmacy** setting could drive a potential benefit of $1,826 **avoided** per admitted separation, on average. This potential reduction of 21,000 **separations** could avoid 78,963 bed days and result in an annual saving of $38.3m.	Of every 100 hours of ED presentation time avoided across Victoria, 35 hours would be avoided in regional and remote communities, with corresponding potential economic benefits. Of every 100 outpatient service events diverted across Victoria, 30 of these would be diverted in regional and remote communities, with corresponding potential economic benefits. Of every 100 hospitalisations avoided across Victoria, 25 of these would be in regional and remote communities, with corresponding potential economic benefits.
Capacity generated	For every 100 hours of ED presentation time saved through community pharmacy diversion, hospitals could generate 30 available ED treatment bays for more critical patients, at a given point in time.*	For every 100 service events diverted to community pharmacy, VIC Health could generate 33 hours of clinic capacity. Annually, this results in freeing up the capacity of 6 full time clinical staff across the allied health and clinical nurse specialist teams.	For every 100 hospitalisations avoided, early intervention could generate 376 total bed days of capacity, equivalent to freeing up one 24-bed ward for 16 nights annually.	

Notes: (1) Unit Net Cost Avoidance measures the net financial saving per patient/event. (2) Capacity generated translates the time saved in each setting into measurable, tangible assets (bays, clinical staff and wards) for resource planning. (3) Regional disaggregation is based on the reported share of patients by place of residence accessing the relevant service, and assumes consistent uptake of the Program by community pharmacies in regional areas. **This is based on the median length of emergency department stay of 3.3 hours for non-admitted patients in Victoria in 2024-25 (AIHW).*

These benefits should be read alongside the interpretation in Section 3.1 and takeaways in Section 3.5.

Figure 5: Key system-level benefits resulting from an expanded scope of pharmacy practice in Victoria.

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3.4 Economic analysis results – productivity gains and wellbeing gains

Reduced presenteeism and improved management of chronic conditions are key drivers of the potential productivity and wellbeing gains arising out of expanded scope of pharmacy services.

Productivity gains		
Estimated benefit	**Time returned to the economy**	**Per 100 working age Victorian adults****
Reduced **absenteeism** could generate up to **$199.3m annually**, representing 25% of total productivity gains.	Equivalent to **531,000 working days returned** to the workforce each year through reduced illness and healthcare utilisation.*	**11.7 working days** returned to the economy
Reduced **presenteeism** could generate up to **$465.6m annually**, representing 59% of total productivity gains	Improved symptom management and associated health outcomes could restore **8.8m productive working hours** that would otherwise be lost to unproductive time while at work.	**26.0 productive working days** returned to the economy.
Reduced **caregiving burden** could generate up to **$124.7m annually**, representing 16% of total productivity gains.	Reduced caregiving associated with hospitalisations in older people and conditions affecting children could return **312,000 working days** to informal carers each year	**3.9 additional working days** from carers returned to the economy.

Wellbeing gains	
Estimated benefit	**Primary drivers**
Improved medication adherence could generate an estimated **457 quality-adjusted life years**, representing 94% of total wellbeing gains	The largest gains are driven by services relating to Cardiovascular diseases (e.g. hypertension), as well as other chronic conditions.***
Reduced duration of ill health could generate an estimated **27 quality-adjusted life years**, representing 6% of total wellbeing gains	The largest gains are driven by chronic conditions, though acute conditions are also a major driver of impact, where earlier treatment can reduce symptom duration and improve recovery.

These benefits should be read alongside the interpretation in Section 3.1 and takeaways in Section 3.5.

Notes: (1) Productivity gains reflect the additional economic output generated when people are better able to participate in the workforce. (2) Wellbeing gains are measured in quality-adjusted life years and valued in monetary terms in the total benefits reported in Section 3.2. *Based on an average workday of 7.5 hours. **Apportions the captured gains across the relevant Victorian adult population projection in 2027.*** In-pharmacy services for chronic conditions are expected to be included under the Victorian Program by the end of the 2026-2027 Financial Year, as per the State Government's commitment in May 2026 (Victorian Government. (2026) Victorian Budget 26/27. https://www.budget.vic.gov.au/making-it-easier-get-free-healthcare).

Figure 6: Key productivity and wellbeing benefits resulting from an expanded scope of pharmacy practice in Victoria.

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3.5 Economic analysis – takeaways (1/2)

Expanded scope pharmacy services create value through multiple pathways, with productivity and wellbeing gains accounting for the largest share of benefits.

Overarching Results

The program has the potential to generate an estimated $495.0 million to $867.3 million in annual benefits for the Victorian Government and broader community. This includes an estimated $23.4 million to $44.8million in annual avoided healthcare costs, alongside approximately $455.6 million to $789.6 million in productivity gains and $15.9 million to $32.9 million in wellbeing gains each year.

Avoided healthcare costs are estimated to generate $23.4 million to $44.8million in annual savings through reduced utilisation of emergency department, inpatient and outpatient services. The findings demonstrate the potential for the Program to reduce demand on the Victorian public healthcare system by avoiding the need for higher-cost healthcare services.

Productivity gains account for the largest share of estimated benefits, generating between $455.6 million and $789.6 million in annual value and representing up to15.0 million productive working hours gained each year. This reflects the broader population captured within this benefit category. Unlike avoided costs to the Victorian public healthcare system, which are primarily attributable to reductions in emergency department, inpatient and outpatient service utilisation, productivity gains are estimated across a wider cohort of individuals who may benefit from improved access to care. This includes, for example, employed Victorians living with low-severity allergic and non-allergic rhinitis. The inclusion of this cohort alone expands the population considered by more than 400,000 Victorians. This reflects the diverse ways in which expanded scope of pharmacy services could generate value, with benefits accruing not only through reduced healthcare utilisation but also through improved productivity and wellbeing outcomes across a broader population.

Wellbeing gains generate between $15.9 million and $32.9 million annually and represent up to 483 healthy life years gained each year. These benefits largely reflect improvements in health-related quality of life associated with reduced chronic disease burden, while also capturing benefits across a range of acute and wellbeing services.

Avoided costs

The program could generate an estimated potential economic benefit of $23.4 million to $44.8 million annually through reduced acute and subacute costs, compared to Program costs of $1.1 million to $2.0 million. Over four years, total potential economic benefits are projected to increase to between $91.6 million and $175.2 million. The largest share of this benefit is realised through reductions in ED presentations for acute conditions and potentially preventable hospitalisations for chronic conditions.

In total, 27% of the capacity gain and avoided cost benefits resulting from this program are estimated to accrue in regional and remote communities. This is especially pronounced for reduced ED presentations, accounting for 35% of the total capacity gain and avoided costs through reduced ED presentations).

Key Service Impacts

Key areas of impact are Chronic Condition Management and Acute Health Condition Management:

Chronic Condition Management: This service category delivers the largest share of annual avoided costs to the Victorian Government, with an estimated range of $11.5 million to $23.9 million in acute and subacute cost benefits compared to pharmacist consultation costs between $0.6 million and $1.1 million. This reflects the high volume and prevalence of activity, particularly PPHs associated with cardiovascular disease with over 31,000 bed days avoided annually.

Acute Health Condition Management: For an estimated community pharmacy intervention cost between $0.3 million to $0.5 million, up to $16.5 million in acute and subacute healthcare annual costs could be avoided. These benefits are realised through reductions of between 16,700 to 29,700 ED presentation hours annually, which can be reallocated to other patients with higher acuity need. Benefits are primarily driven by the management of uncomplicated urinary tract infections (UTIs).

Detailed results for each benefit category are documented in the Technical Appendix prepared alongside this report.

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3.5 Economic analysis – takeaways (2/2)

Productivity gains are driven primarily by improvements in workplace functioning, while wellbeing gains are largely attributable to improved medication adherence and chronic disease management.

Productivity gains

Productivity gains are estimated to deliver between $455.6 million and $789.6 million in annual benefits, representing up to 15.1 million productive working hours gained each year. These benefits are generated through reduced absenteeism, presenteeism and carer burden, reflecting the value of improved health outcomes for both individuals and those who provide informal care.

Presenteeism is the largest driver of productivity gains, generating an estimated $274.6 million to $465.6 million in annual benefits. Allergic and non-allergic rhinitis and GORD are the primary contributors due to both their high prevalence across the Victorian population and the persistent nature of symptoms, which can affect productivity over extended periods without necessarily resulting in workforce absence. Collectively, these conditions are estimated to generate $183.6 million to $298.2 million in annual benefits through improved symptom management and workplace functioning.

Absenteeism is the second largest driver, generating an estimated $110.2 million to $199.3 million in annual benefits. The largest contributors are the MHT and acute nausea and vomiting, which collectively account for approximately $87.5 million to $159.0 million in annual benefits. Given the analysis for MHT includes only employed Victorian women aged 45-54 years, the sizeable benefits associated demonstrate the significant productivity gains that can be generated through improved management of menopause-related symptoms alone.

Reduced carer burden contributes an additional $70.8 million to $124.7 million in annual benefits. The majority of these benefits are attributable to improved management of impetigo (school sores), which is estimated to generate $67.8 million to $118.6 million in annual benefits through reductions in the time parents and caregivers spend providing care and taking time away from paid employment. This substantial contribution reflects the high incidence of impetigo among children and the requirement for many children to remain at home while infectious, creating significant caregiving demands and productivity impacts for working parents and carers.

Wellbeing gains

Wellbeing gains are estimated to generate between $15.9 million and $32.9 million in annual benefits, representing up to 483 healthy life years gained each year. These benefits reflect improvements HRQoL associated with expanded scope of pharmacy services and are driven by improved management of chronic disease, which continues to represent one of the largest contributors to disease burden in Australia. [1] Chronic disease management accounts for approximately 98% of total wellbeing benefits, contributing $15.6 million to $32.3 million annually, highlighting the important role community pharmacy can play in supporting ongoing disease management, improving medication adherence and reducing long-term disease burden.

Improved medication adherence is the primary driver of wellbeing gains, generating $14.9 million to $30.8 million in annual benefits and accounting for approximately 94% of total wellbeing outcomes. The largest contribution is associated with dyslipidaemia, which contributes $6.4 million to $13.4 million annually. This reflects both the high prevalence of the condition and the significant health benefits that can be realised through improved adherence to treatment, as poorly managed dyslipidaemia is a major risk factor for acute cardiovascular events and potentially preventable hospitalisations. As a result, supporting individuals to better manage dyslipidaemia generates substantial wellbeing benefits through reduced chronic disease burden and improved health outcomes over time.

Reduced time spent in ill health contributes a further $0.9 million to $1.8 million in annual benefits, representing approximately 6% of total wellbeing gains. The relatively small contribution of this benefit category indicates that the majority of wellbeing value is generated through better long-term management of chronic conditions, rather than short-term reductions in illness duration. Consistent with the medication adherence results, dyslipidaemia is the largest contributor, generating $0.4 million to $0.8 million in annual benefits through reduced time spent experiencing the impacts of disease. The analysis also captures wellbeing gains beyond chronic disease management, including acute conditions such as Uncomplicated UTI which is estimated to generate $0.2 million to $0.4 million in annual benefits through improvements in quality of life and reductions in time spent in ill health.

1 AIHW. (2024) Australian Burden of Disease Study 2024. https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024/related-material.

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3.6 Key results (1/2)

The estimated capacity gain across the hospital system resulting from expanded scope of pharmacy services, with the corresponding avoided costs to the Victorian Government resulting from this shown below.

Table 5: Estimated potential avoided costs and capacity gain resulting from an expanded scope of pharmacy services across three different time horizons.

	Potential economic benefit (Annual, FY27)		Capacity gain (Annual, FY27)					
	Healthcare costs ($ million)		Avoided emergency department presentations (hours)		Avoided potentially preventable hospitalisations (bed days)		Avoided outpatient consultations (service events)	
	Benefit to VIC Health		Benefit to VIC Health		Benefit to VIC Health		Benefit to VIC Health	
Service Category	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
Wellbeing services	2.6	4.5	0	0	2,235	3,877	9,390	15,043
Acute health conditions	9.3	16.5	16,725	29,723	16,278	28,789	2,237	3,622
Chronic disease management	11.5	23.9	1,073	2,152	22,321	46,297	7,310	13,419
Total	23.4	44.8	17,799	31,875	40,834	78,963	18,938	32,084

	Potential economic benefit (4-years, FY27-FY30)		Capacity gain (4-years, FY27-FY30)					
	Healthcare costs ($ million)		Avoided emergency department presentations (hours)		Avoided potentially preventable hospitalisations (bed days)		Avoided outpatient consultations (service events)	
	Benefit to VIC Health		Benefit to VIC Health		Benefit to VIC Health		Benefit to VIC Health	
Service Category	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
Wellbeing services	10.1	17.4	0	0	9,261	16,065	38,561	61,773
Acute health conditions	36.4	64.3	68,681	122,055	67,447	119,282	9,188	14,875
Chronic disease management	45.1	93.4	4,408	8,835	92,485	191,828	30,019	55,104
Total	91.6	175.2	73,089	130,891	169,192	327,175	77,768	131,752

	Potential economic benefit (PGA VIC Towards 2035 Vision, FY27-FY35)		Capacity gain (PGA VIC Towards 2035 Vision, FY27-FY35)					
	Healthcare costs ($ million)		Avoided emergency department presentations (hours)		Avoided potentially preventable hospitalisations (bed days)		Avoided outpatient consultations (service events)	
	Benefit to VIC Health		Benefit to VIC Health		Benefit to VIC Health		Benefit to VIC Health	
Service Category	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
Wellbeing services	23.4	40.2	0	0	21,990	38,146	90,173	144,453
Acute health conditions	84.0	148.6	160,606	285,421	160,151	283,234	21,486	34,784
Chronic disease management	104.5	216.5	10,308	20,661	219,603	455,492	70,198	128,857
Total	211.9	405.3	170,914	306,082	401,743	776,872	181,856	308,095

** Cost to treat in the Pharmacy captures the cohort at risk for using these services. It is anticipated that other people accessing pharmacy services may benefit from accessing these services, which may not be captured within potential economic benefit. For managing some conditions and ensuring that the escalation of the condition is averted may require the involvement of other health care professionals through a multidisciplinary model of care.*

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3.6 Key results (2/2)

The broader economic benefits derived from Productivity Gains and Wellbeing gains resulting from an expanded scope of pharmacy services are shown below.

Table 6: Estimated productivity gains and wellbeing gains resulting from an expanded scope of pharmacy services across three different time horizons.

	Potential economic benefit (Annual, FY27)							
	Productivity Gains ($ million)		Wellbeing Gains ($ million)		Productive working hours gained (millions)		Quality Adjusted Life Years (QALYs) gained	
Service Category	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
Wellbeing services	70.7	141.3	0.0	0.0	1.3	2.6	0	0
Acute health conditions	370.4	620.0	0.3	0.6	7.1	11.8	5	9
Chronic disease management	14.6	28.3	15.6	32.3	0.3	0.6	230	475
Total	455.6	789.6	15.9	32.9	8.7	15.0	235	483

	Potential economic benefit (4-years, FY27-FY30)							
	Productivity Gains ($ million)		Wellbeing Gains ($ million)		Productive working hours gained (millions)		Quality Adjusted Life Years (QALYs) gained	
Service Category	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
Wellbeing services	277.8	555.6	0.0	0.0	5.4	10.8	0	0
Acute health conditions	1461.1	2440.5	1.3	2.4	29.5	49.2	22	38
Chronic disease management	56.8	110.3	61.2	126.6	1.3	2.5	994	2,056
Total	1795.7	3106.4	62.5	128.9	36.2	62.4	1,016	2,095

	Potential economic benefit (PGA VIC Towards 2035 Vision, FY27-FY35)							
	Productivity Gains ($ million)		Wellbeing Gains ($ million)		Productive working hours gained (millions)		Quality Adjusted Life Years (QALYs) gained	
Service Category	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
Wellbeing services	648.4	1296.7	0.0	0.0	12.9	25.8	0	0
Acute health conditions	3440.7	5725.1	3.1	5.5	71.3	118.5	56	99
Chronic disease management	130.5	253.6	141.7	293.0	3.1	5.9	2,556	5,285
Total	4219.5	7275.5	144.8	298.5	87.3	150.1	2,612	5,384

** Cost to treat in the Pharmacy captures the cohort at risk for using these services. It is anticipated that other people accessing pharmacy services may benefit from accessing these services, which may not be captured within potential economic benefit. For managing some conditions and ensuring that the escalation of the condition is averted may require the involvement of other health care professionals through a multidisciplinary model of care.*

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