

Prescribing and patient safety

What five years of medico-legal claims tell us about prescribing risk, and what that means for the expansion of community pharmacy prescribing.

Contents

Executive summary	1
1. Prescribing is a high-risk clinical activity	2
2. What Avant’s claims experience shows	3
3. Safe prescribing includes the decision not to prescribe	5
4. Implications for pharmacist prescribers	5
5. The evidence gap	6
6. The way forward	7

IMPORTANT: Avant routinely codes information collected in the course of assisting member doctors in medico-legal matters into a standardised, deidentified dataset. This retrospective analysis was conducted using this dataset. The findings represent the experience of these doctors in the period of time specified, which may not reflect the experience of all doctors in Australia. This publication is not comprehensive and does not constitute legal or medical advice. You should seek legal or other professional advice before relying on any content, and practise proper clinical decision-making with regard to the individual circumstances. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular practice. Compliance with any recommendations will not in any way guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional or practice. Avant is not responsible to you or anyone else for any loss suffered in connection with the use of this information. Information is only current at the date initially published. © Avant Mutual Group Limited 2026. Published and current as of: 09/26



Executive summary

Medication error is the leading cause of avoidable harm in health systems worldwide, according to the World Health Organisation (2017).¹ In Australia, medication-related problems cause an estimated 250,000 hospital admissions each year at a cost of \$1.4 billion, and two-thirds are potentially preventable.² Avant's claims experience shows the same pattern from a medico-legal perspective. A preliminary analysis using high-level data, released by Avant in June 2026, found medication-related issues were one of the leading drivers of medical negligence claims.³ This commentary presents the deeper analysis underpinning that finding, the first of its kind in Australia.

Across five years and 16,000 closed claims and complaints one in six cases involved medication-related claims. In almost 90% of these cases, prescribing was the primary issue. That figure reflects the complexity of prescribing and not the profession performing it. Providing a prescription is never a standalone decision. It is one of the last links in a clinical chain that starts with accurate diagnosis, and the earlier links in that chain carry serious risk of their own. Proposals in which new prescribers also make or confirm the diagnosis must be judged on the whole chain, not the final step. The risk concentrates in the highest-risk medicines and the most complex patients. Schedule 8 medicines, led by opioids, featured in more than a third of prescribing claims, and psychotropics were the most common Schedule 4 medicines involved. Patients with psychiatric conditions accounted for almost 30 per cent of claims. Those with chronic pain, other pain and general symptoms made up a further 18 per cent. Notably, these are the medicines and patients within the scope of proposals to extend autonomous pharmacist prescribing.⁵ While these findings cannot be directly extrapolated to pharmacist prescribers, they identify areas of prescribing risk that any future prescribing model should address.

One of the most important findings in this new data concerns refusal to prescribe or attempts to de-prescribe. Claims arising from decisions to reduce, cease or decline medication were common yet, in final analysis, practitioners involved in these claims were found almost always to have met the standard of care. Safe prescribing frequently means saying 'no.' Any prescribing model must protect decisions not to prescribe. This poses a potential conflict where the prescriber – or their business – benefits from dispensing. The evaluation of Queensland's urinary tract infection (UTI) pilot was candid on this point, reporting that approximately half of participating pharmacists found charging the \$19.95 fee difficult ("strongly agree") when they did not supply an

antibiotic.⁶ That finding does not necessarily criticise the integrity of pharmacists but is intrinsic to the model which makes refusal the one outcome the pharmacist cannot comfortably charge for. It also goes to the heart of the conflict between prescribing and supply, and is why the two functions have always been kept separate. According to the Royal College of Pharmacy in the United Kingdom, formerly known as the Royal Pharmaceutical Society, the UK's professional body for pharmacists, the two functions should normally remain separate in order to protect patient safety.⁷

The evidence base underpinning autonomous prescribing in community pharmacy settings is thin. According to a 2026 Sax Institute Evidence Check, five years of international research yielded only 18 eligible studies, including a single randomised trial, with safety outcomes reported in only two. The reviewers concluded the evidence is too weak for reliable conclusions on clinical effectiveness or safety. In Australia, every jurisdiction has implemented programs but only two have published evaluations – both after implementation into usual care.⁸

The claims experience this commentary describes is the medico-legal environment that pharmacist prescribers will inherit. Medical practitioners have accumulated decades of experience supported by mature professional standards, indemnity arrangements, and a comprehensive evidence base on prescribing.

On 4 September 2026, Federal, State and Territory Health Ministers agreed to develop a National Decision-Making Framework to promote national consistency in prescribing scope of practice, and to update the Australian Health Ministers' Advisory Council (AHMAC) guidance to National Boards on scheduled medicines.⁹ Avant called for a nationally consistent framework of this kind when it released its claims data in June 2026 and welcomes both developments. This will place scope decisions in the national regulatory architecture. What matters now is how the Framework is built and how, and when it applies. Avant recommends it be evidence-based, with safety criteria set in advance and independently verified by the Australian Commission on Safety and Quality in Health Care, and that there be a moratorium on further extension of autonomous prescribing occur until the Framework is in place and implemented.

1. World Health Organisation. Medication Without Harm. WHO Global Patient Safety Challenge. Geneva: WHO; 2017. <https://www.who.int/initiatives/medication-without-harm>

2. Lim R, Ellett LMK, Semple S, Roughead EE. The extent of medication-related hospital admissions in Australia. *Drug Safety*. 2022;45(3):249–257 (<https://link.springer.com/article/10.1007/s40264-021-01144-1>); Pharmaceutical Society of Australia. Medicine Safety: Take Care. Canberra: PSA; 2019. <https://www.psa.org.au/wp-content/uploads/2019/01/PSA-Medicine-Safety-Report.pdf>

3. Avant Mutual Group. Analysis of medical indemnity claims, released June 2026.

4. Avant Mutual Group. Medico-legal risks in prescribing: a claims insights report. Sydney: Avant Mutual; 2026.

5. Joint Pharmacy Organisations. Joint Pharmacy Organisations' Paper for Endorsed Pharmacist Prescribers. October 2025.

6. Queensland University of Technology. The management of urinary tract infections by community pharmacists: a state-wide trial. UTIPP-Q Service Evaluation Report. Brisbane: QUT; 2023. <https://eprints.qut.edu.au/239310/>

7. Royal College of Pharmacy, formerly known as the Royal Pharmaceutical Society. Prescribing and dispensing/supply/administration by the same healthcare professional. Policy position. London: RPS; 2026. <https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/prescribing-and-dispensing>

8. Raghunandan R, Natsky AN, Howard K, Chen W. Community pharmacist prescribing outcomes in Australia and beyond: an Evidence Check rapid review brokered by the Sax Institute. Sydney: Sax Institute; 2026. <https://www.saxinstitute.org.au/evidence-check/community-pharmacist-prescribing-outcomes-in-australia-and-beyond/>

9. Health Ministers' Meeting. Communiqué, 4 September 2026.

1. Prescribing is a high-risk clinical activity

Medicines are the most common intervention in healthcare. In 2024–25, more than 335 million prescriptions were dispensed in Australia under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) alone, before counting private prescriptions and over-the-counter medicines.¹⁰ According to the Pharmaceutical Society of Australia's own Medicine Safety report (2019), medicine-related problems resulted in 250,000 hospital admissions and around 400,000 emergency department presentations each year.¹¹

Harm most commonly arises in the prescribing decision itself. Safe prescribing depends on diagnostic accuracy and strength of indications. These are based on a skilled assessment of the history of the presenting patient, past medical history, physical examination, laboratory and other testing, coupled with ongoing monitoring, communication and documentation. According to the Australian Commission on Safety and Quality in Health Care (2025), more than half of medication errors occur at transitions of care, where information is fragmented across providers.¹² Any reform that adds prescribers without connecting their information risks patient harm.

Medical training explicitly includes how to make a differential diagnosis when faced with a set of symptoms. Medical students are taught to navigate ambiguity. They are trained in highly comprehensive history taking, examination, clinical skills

and nuance around ordering tests and imaging to pinpoint the underlying disease or cause. This process is a core pillar of medical education and is consolidated over years. Beyond undergraduate experience, doctors are further educated about prescribing in their specialty training. This is a further multiple years of prescribing under supervision relevant to their specialty, including general practice.

Every decision to prescribe rests on a contemporaneous diagnosis, and diagnosis carries substantial risk of its own. Asthma illustrates this point. According to the National Asthma Council of Australia, diagnosis requires a physical examination, consideration of other possible causes and spirometry.¹³ Yet a landmark Canadian study published in JAMA found one in three adults diagnosed with asthma did not have the condition when formally reassessed.¹⁴ Chronic obstructive pulmonary disease (COPD) is similar, with studies reporting misdiagnosis in a large share of community-diagnosed cases and with alternative explanations that include heart failure, pneumonia and lung cancer.¹⁵ A prescribing model is only as safe as the diagnostic capability, tools and time behind it. Proposals that describe practitioners diagnosing conditions earlier and initiating treatment are therefore proposals about diagnosis as much as prescribing and should be assessed against the full chain of clinical risk.



10. Australian Institute of Health and Welfare. Medicines in the health system. Canberra: AIHW; 2026 (updated 9 July 2026). Reports 335.1 million PBS and RPBS prescriptions dispensed in 2024–25. <https://www.aihw.gov.au/reports/medicines/medicines-in-the-health-system>

11. Pharmaceutical Society of Australia. Medicine Safety: Take Care. Canberra: PSA; 2019. <https://www.psa.org.au/wp-content/uploads/2019/01/PSA-Medicine-Safety-Report.pdf>

12. Australian Commission on Safety and Quality in Health Care. National effort to cut medicine errors at transitions of care. Sydney: ACSQHC; 2025. <https://www.safetyandquality.gov.au/news-and-media/media-release/national-effort-cut-medicine-errors-transitions-care>

13. National Asthma Council of Australia. How is asthma diagnosed in adults and adolescents. <https://www.nationalasthma.org.au/understanding-asthma/diagnosing-asthma/how-is-asthma-diagnosed-in-adults-and-adolescents>

14. Aaron SD et al, JAMA (2017), cited above.

15. Woolcock Institute of Medical Research. COPD: a tangle of misdiagnosis, no diagnosis. <https://www.woolcock.org.au/news/copd-a-tangle-of-misdiagnosis-no-diagnosis>

2. What Avant's claims experience shows

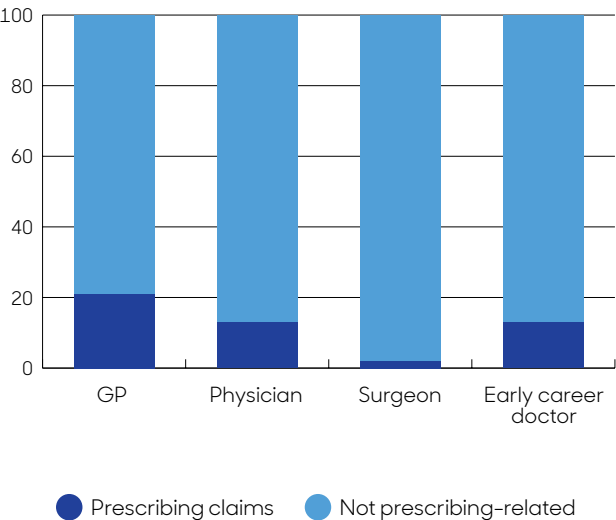
Building on the high-level medication data released in June 2026, Avant undertook the first dedicated nationally scoped analysis of prescribing as a source of medico-legal risk. Our analysis was based on review of more than 16,000 claims and regulatory complaints closed between July 2020 and June 2025. It identified more than 2,600 such matters involving medication.¹⁶ In this commentary, claims include both civil matters in which compensation is sought or paid and complaints made about a practitioner to a regulator or other complaints body. Four findings are significant for future discussions about prescribing policy, particularly the development of the national framework.

Prescribing is a leading source of medico-legal risk

Medication-related allegations were identified in 16 per cent, or 1 in 6, of all claims and complaints. General practitioners, whose prescribing most resembles the primary care prescribing now proposed for expansion, had the highest proportion of any specialty primarily because they are the most frequent prescribers given the nature of their clinical roles.

9 in 10 medication-related claims were primarily about prescribing

General practitioners had the highest proportion of prescribing-related claims, while surgeons had the lowest.



Risk concentrates in high-risk medicines and complex patients

Schedule 8 medicines featured in 36 per cent of prescribing claims, led by opioids. Psychotropics were the most common Schedule 4 category. Patients with psychiatric conditions accounted for almost 30 per cent of claims and chronic pain, other pain and general symptoms, a further 18 per cent. One in five patients sustained a major injury following the medication.

Schedule 8 medications were involved in over one-third of cases

Medication classification	% of claims
Schedule 4	81%
Schedule 8	36%
Other medications	7%

Percentages reflect claims in which patients were prescribed at least one medication from each classification. Percentages do not add up to 100% because patients may have been prescribed multiple medications across different classifications.

Patient conditions	% of claims
Psychiatric conditions	29%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (e.g. pain, chronic pain)	18%
Diseases of the musculoskeletal system and connective tissue (e.g. dorsalgia)	11%
Factors influencing health status and contact with health services (e.g. immunisation)	9%
Diseases of the nervous system (episodic and paroxysmal disorders)	5%
Endocrine, nutritional and metabolic diseases (e.g. obesity, intermediate hyperglycaemia and diabetes)	4%
Diseases of the circulatory system (e.g. heart disease, hypertension)	3%
Other conditions	21%

Results based on prescribing-related claims and complaints.

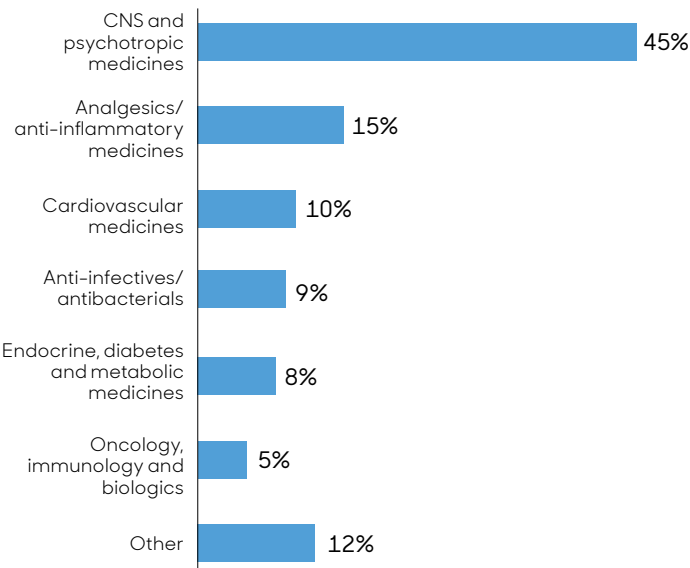
16. Avant Mutual Group. Medico-legal risks in prescribing: a claims insights report. Sydney: Avant Mutual; 2026. All figures in this section are drawn from this analysis.

Psychotropics and opioid analgesic prescriptions were common

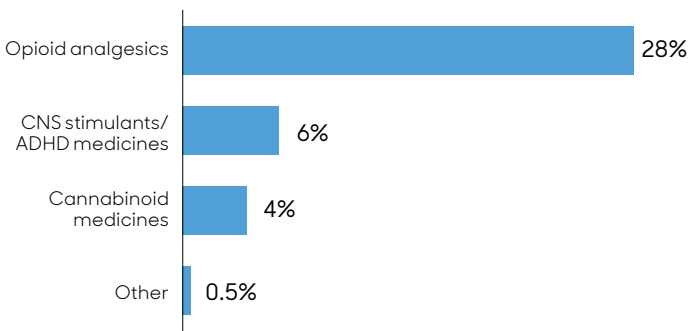
The most frequently prescribed Schedule 4 medications in these claims were Central Nervous System (CNS) and psychotropics followed by analgesic and anti-inflammatory medicines, most of which were codeine preparations.

Opioid analgesics were by far the most frequently prescribed Schedule 8 medication in prescribing claims.

Schedule 4 categories



Schedule 8 categories



(Shown above are percentages of each category out of overall prescribing-related claims and complaints.)

Clinical issues are primary drivers of claims

The leading allegations were overprescribing (33 per cent), inadequate assessment (28 per cent) and inappropriate prescribing (22 per cent). In claims involving overprescribing or inadequate assessment, more than half of practitioners were assessed as below the required standard of care. The dominant failures involve assessment, history-taking and monitoring, the parts of prescribing least amenable to protocol.

Top 5 prescribing-related issues	% of claims
Overprescribing	33%
Inadequate assessment	28%
Inappropriate prescribing	22%
Dose reduction, cessation or refusal	17%
Failure to comply with legislative requirements and reporting	11%

Claims may involve more than one alleged prescribing-related issue.

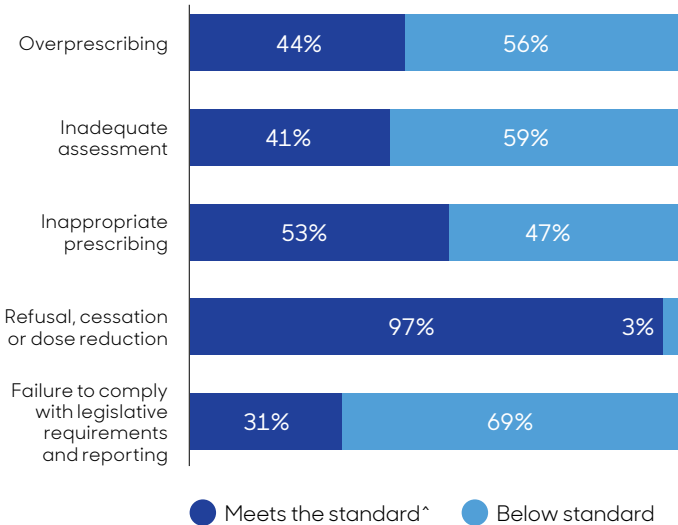
Declining to prescribe generates claims

Dose reduction, cessation or refusal featured in 17 per cent of prescribing claims, most often involving drugs of dependence, yet practitioners in these claims almost always met the standard of care.

This is the risk profile of prescribing performed by the most extensively trained doctors and prescribers in the system. These are practitioners who completed a decade or more of supervised training before prescribing independently, who could examine their patients, order investigations and review the response over time, and who practised within guidelines, professional colleges and continuing education built over generations. Even then, prescribing remained the primary issue in one of every six matters. That number reflects the residual risk that remains after highly developed and mature safeguards have been applied. It measures the complexity of diagnosis and prescribing, not just the prescribing itself nor profession performing it.

Assessment of the care provided

Expert and/or regulatory assessments found that more than half of practitioners involved in claims related to overprescribing, inadequate patient assessment, or failure to comply with legislative requirements and reporting obligations were assessed as having provided care below the required standard. In contrast, nearly all practitioners involved in claims related to dose reduction, cessation or refusal of medications were assessed as having met the required standard of care.



^Includes cases that were not assessed.
Results based on prescribing-related claims and complaints.

3. Safe prescribing includes the decision not to prescribe

The 'refusal to prescribe' issue must be a critical consideration in prescribing reform. A substantial share of prescribing complaints arises from clinically sound decisions to say 'no.' Practitioners make and defend those decisions because their training and standards require it. They also have no financial stake in supply.

Any expansion of prescribing must consider whether the model makes the decision not to prescribe more or less difficult. Where the same business earns the consultation fee and the sale, a pressure exists that no individual professionalism removes. According to the evaluation of Queensland's UTI pilot (2023), around half of participating pharmacists would have found it difficult to charge the consultation fee if they did not supply antibiotics.¹⁷ Similarly, a University of Newcastle evaluation of the *Resupply of Oral Contraception by Community Pharmacists*¹⁸ in New South Wales found some pharmacists questioned the appropriateness of charging for consultations that did not result in treatment.

The separation of prescribing and dispensing exists to manage this pressure, and the UK's Royal College of Pharmacy clearly states that the two functions should remain separate to protect patient safety.¹⁹ Consolidating them into a single retail transaction removes a key safeguard at exactly the process point where the claims data shows it matters most: with drugs of dependence sought by patients who can present at the next pharmacy if declined.

Pharmacists also play an oversight role in medication safety that depends entirely on this separation. Every day they review and monitor the medicines doctors prescribe, educate patients and at times prescribers, and intervene by contacting the prescriber when something is not right. That is the system's independent check on every prescription, and its value lies precisely in its independence. No practitioner can be the independent check on their own prescription, and a colleague in the same business, with the same interest in the sale, is not an independent check either. A model in which the prescriber and the dispenser are the same removes this safeguard for every script written under it.

4. Implications for pharmacist prescribers

Pharmacists are medicines experts, and they frequently detect prescribing errors and act as the independent check on which prescribing safety depends. The claims experience describes the medico-legal environment pharmacist prescribers will inherit. Claims against doctors occurred even when robust record keeping, extensive diagnostic and patient management training, published standards, peer support and indemnity sat behind them, built over decades of prescribing practice. Practitioners new to prescribing will carry the same risk with considerably less mature frameworks, evidence and indemnity experience behind them.

The burden of refusal transfers too. Pharmacist prescribers will face the same dissatisfied patients when declining drugs of dependence and other medications including antibiotics, across a retail counter, in a business that benefits from supply. Avant's experience is that claims and regulatory processes exact a heavy toll even when the practitioner is vindicated.

The University of Newcastle's final evaluation of the NSW pharmacist trials for the management of uncomplicated urinary tract infections found 90 per cent of cases resulted in patients taking the antibiotic prescribed, while only 7.3 per cent were referred to a GP or emergency department. These findings must be considered in the context of growing antimicrobial resistance and Australia's high levels of antibiotic use, highlighting the need for cautious, evidence-based prescribing practices and robust antimicrobial stewardship.²⁰

On 10 September 2026, the NSW Government announced a new trial which will allow pharmacists to expand their scope to include wound care, chronic disease management, and ear infections.²¹

17. Queensland University of Technology, UTIPP-Q Service Evaluation Report (2023), cited above.

18. University of Newcastle, NSW Government Sponsored Trial: Resupply of Oral Contraception by Community Pharmacist Final Report (2026), cited above.

19. Royal Pharmaceutical Society (2026), cited above.

20. University of Newcastle, Management of uncomplicated urinary tract infections by community pharmacists: Evaluation of PATH-UTI (2026), cited above.

21. NSW Premier, NSW Health Minister (2026), cited above.

5. The evidence gap

International experience is frequently cited as settling the safety question. It does not. In the UK, the most mature comparator, prescribing pharmacists work predominantly in general practices and hospitals. These practice settings have shared records and National Health Service (NHS) clinical governance. According to the Nuffield Trust (2026), pharmacists in general practice are the most likely to be active prescribers and those in community pharmacy the least.²² A 2024 UK-wide survey found 71 per cent of general practice pharmacists were prescribers compared with 14 per cent in community pharmacy,²³ and according to NHS England (2025) most community pharmacists who hold the qualification do not use it.²⁴ The evidence supports collaborative, integrated pharmacist prescribing. It provides little data about autonomous prescribing in standalone retail settings.

According to the Sax Institute's 2026 Evidence Check, conducted by the University of Sydney, five years of international research on community-setting pharmacist prescribing yielded 18 eligible studies. One was a randomised trial and the rest were lower-level evidence, with safety outcomes reported in only two. The reviewers concluded the available evidence was too weak for reliable conclusions on clinical effectiveness, safety or health system impact.²⁵

Australia's own record is weaker still. The same review found that all jurisdictions have implemented programs, yet only Queensland and Victoria have published evaluations, covering a fraction of the roughly twenty conditions now in routine practice, and only after implementation. Of the pilots reviewed, two had ethics approval and one was registered on a trials registry. The Queensland UTI evaluation was graded level IV evidence with a high risk of bias. It reported antibiotics supplied in 96.6 per cent of consultations, no microbiological confirmation and 71 per cent of patients lost to follow-up. The Victorian evaluation reported no clinical or safety outcomes at all.²⁶ These findings reflect program design and evaluation choices, not the pharmacists who practised within them. The safety of any prescribing model is determined by the design and evaluation of the models' outcomes. At present not enough evidence has been gathered to support major changes to established practice. It should also be noted, NSW has also completed final evaluations in April 2026 of pharmacy prescribing trials covering uncomplicated UTIs, dermatology and resupply of oral contraception which were not subject to the Sax Institute's analysis.



22. Nuffield Trust. Independent prescribing in the UK: workforce ambitions and implementation challenges. London: Nuffield Trust; 2026. <https://www.nuffieldtrust.org.uk/research/independent-prescribing-in-the-uk-workforce-ambitions-and-implementation-challenges>

23. The Pharmaceutical Journal. Prescribing in community pharmacy: will it fail or flourish? London: Royal Pharmaceutical Society; 2024. <https://pharmaceutical-journal.com/article/feature/prescribing-in-community-pharmacy-will-it-fail-or-flourish>

24. NHS England. Community Pharmacy Workforce Survey 2024. London: NHS England; 2025.

25. Raghunandan R et al, Sax Institute Evidence Check (2026), cited above.

26. Raghunandan R et al, Sax Institute Evidence Check (2026), cited above.

6. The way forward

In June 2026, Avant called for a nationally consistent prescribing framework. On 4 September 2026, State, Territory and Federal Health Ministers agreed to update the Australian Health Ministers' Advisory Council (AHMAC) Guidance for National Boards on scheduled medicines under section 14 of the National Law, noted the benefits of expanding scope of practice for equity of access for communities, and agreed to develop for consideration a National Decision-Making Framework to promote national consistency in prescribing scope of practice.²⁷ Avant welcomes this decision from the Health Ministers Meeting.

Based on our extensive experience in assessing prescribing-related risks, including those outlined in this report, Avant believes federal, state and territory governments, in developing this framework, need to include a number of important considerations.

1. Sequence the Framework before further expansion.

Health Ministers should agree that there be no further extension of autonomous prescribing, with no new conditions, medicines or settings, until the National Decision-Making Framework is in place and implemented. Decisions made while the Framework is being developed would pre-empt the national consistency Ministers have agreed to pursue. Existing authorisations continue unchanged, so no patient loses access to current services.

2. Task the Australian Commission on Safety and Quality in Health Care to set and test the criteria.

The Commonwealth should task the Commission to establish national prescribing criteria, including processes in relation to misdiagnosis and delayed diagnosis, antimicrobial stewardship, adverse events and unplanned escalation of care, to independently evaluate existing programs against those criteria and to publish the results in full. This implements the independent, evidence-based scope mechanism recommended by the Commonwealth's own Scope of Practice Review.²⁸ Pharmacist training should also be updated to reflect these requirements with appropriate minimal clinical supervision and competencies.

3. Draw on medico-legal claims experience in building the Framework. Insights should be sought from medical indemnity providers and others who see prescribing at the point it goes wrong. Claims and complaints data reveals where prescribing risk materialises, which medicines and patient groups it concentrates in, and which safeguards fail. Avant's dataset of more than 2,600 medication-related matters, the analysis behind this commentary, is available to inform that work.

4. Apply a diagnostic-risk test to medicine in scope.

Where there is a reasonable likelihood that safe use of a medicine depends on assessment and diagnosis by a doctor, that medicine should not be available for

autonomous pharmacy prescribing. The evidence in this commentary illustrates where that test would be relevant. Medicines for asthma and COPD depend on a diagnosis that guidelines require to be confirmed by spirometry, yet reassessment studies found one in three adults diagnosed with asthma did not have the condition, and misdiagnosis of COPD is common, with alternative explanations including heart failure and lung cancer.²⁹ Initiation of antihypertensive and lipid-lowering therapy rests on structured cardiovascular risk assessment and pathology. Psychotropic medicines require psychiatric assessment, and Avant's claims data shows patients with psychiatric conditions account for almost 30 per cent of prescribing claims.³⁰ There are existing arrangements where pharmacists have access to emergency dispensing arrangements to ensure patients can access their essential regular medications during emergencies.

5. Keep Schedule 8 medicines and drugs of dependence outside autonomous community-setting pharmacy prescribing. The claims evidence is unambiguous.

Schedule 8 medicines featured in more than a third of prescribing claims, led by opioids, and the claims arising from clinically sound refusals concentrate in drugs of dependence.³¹ These medicines demand the strongest safeguards the system has, not the newest prescribing pathway.

6. Require monitoring and records to be operational before authorisation. Real-time prescription monitoring should be reviewed, confirmed as fit for purpose and operational, before any prescribing authority is exercised. More than half of medication errors occur at transitions of care, and every prescriber added without connected information adds transitions.³²

7. Decouple consultation remuneration from supply of a medicine. The evaluation of Queensland's UTI pilot found around half of participating pharmacists found it difficult to charge the consultation fee when they did not supply an antibiotic.³³ A framework that pays for the consultation regardless of the outcome protects the decision not to prescribe and protects the prescriber who makes it.

8. All consultations must include documentation and a comprehensive clinical record in line with Ahpra's shared code of conduct. Ahpra's shared code of conduct states registered practitioners must maintain accurate, contemporaneous and objective records sufficient to support continuity of care. For prescribing pharmacists this must go beyond and be separate to the dispensing record. Appropriate record keeping is critical for quality control processes and to allow for an audit trail to assess whether the prescribing service is being delivered safely and consistently.

27. Health Ministers' Meeting. Communiqué, 4 September 2026.

28. Cormack M. Unleashing the Potential of our Health Workforce. Scope of Practice Review Final Report. Canberra: Australian Government Department of Health and Aged Care; 2024. <https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report>

29. Aaron SD et al, JAMA (2017), and Woolcock Institute of Medical Research, both cited above.

30. Avant Mutual Group, Medico-legal risks in prescribing (2026), cited above.

31. Avant Mutual Group, Medico-legal risks in prescribing (2026), cited above.

32. Australian Commission on Safety and Quality in Health Care (2025), cited above.

33. Queensland University of Technology, UTIPP-Q Service Evaluation Report (2023), cited above.

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