

Childhood vaccinations: Pharmacists fill a gap, but what's the cost for GPs?

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The expansion of vaccination services to include younger children at community pharmacies represents a significant shift in public health strategy. This move aims to bolster vaccination rates, particularly for routine childhood immunisations, by leveraging an accessible healthcare workforce.

KEY TAKEAWAYS

- **The Pivot:** Pharmacists will now be authorised to vaccinate children under 5, expanding their scope beyond older age groups.
- **The Data:** The primary goal is to improve vaccination uptake, especially for routine childhood immunisations, where rates have stagnated or declined in some regions.
- **The Action:** GPs should prepare for a shift in patient flow and consider how to integrate pharmacy vaccination records into existing patient care pathways.

Childhood vaccination rates across Europe have faced persistent challenges, with some regions reporting declines in uptake for critical immunisations like MMR and DTaP. This trend creates pockets of vulnerability, increasing the risk of preventable disease outbreaks. The existing infrastructure, primarily reliant on general practice and dedicated vaccination clinics, struggles to meet demand in certain areas, leading to missed appointments and delayed schedules.

Governments and public health bodies have explored various strategies to address these gaps, including extended clinic hours and mobile vaccination units. Expanding the role of community pharmacists, who are often the most accessible healthcare professionals, has emerged as a pragmatic solution to improve coverage. Pharmacists already administer a significant proportion of seasonal influenza and COVID-19 vaccines to adults and older children, demonstrating their capacity and reach within the community.

The Policy Shift and Its Implications

New regulatory frameworks will permit a broader range of pharmacists to administer routine childhood vaccinations to children under 5 years of age. This change builds on previous expansions that allowed pharmacists to vaccinate school-aged children and adults. The specific vaccines covered will align with national immunisation schedules, including those for measles, mumps, rubella (MMR), diphtheria, tetanus, pertussis (DTaP), polio, and *Haemophilus influenzae* type b (Hib).

Pharmacists undertaking this expanded role must complete additional specialised training focused on paediatric immunisation, including age-appropriate administration techniques, recognition and management of adverse reactions in young children, and communication strategies for parents. This training ensures competency and adherence to

safety protocols, which are paramount when vaccinating vulnerable populations. The curriculum typically includes both theoretical components and practical assessments, often requiring supervised practice before independent administration.

The primary objective of this policy is to increase overall vaccination coverage. By offering more convenient access points, public health officials anticipate a reduction in missed appointments and an improvement in the timeliness of immunisations. Parents often find pharmacy hours more flexible than traditional GP surgery appointments, particularly for those with demanding work schedules or limited transport options. This convenience factor is expected to remove some of the logistical barriers that contribute to under-vaccination.

But, the integration of pharmacy-administered vaccinations into existing primary care records presents a logistical challenge. Accurate and timely sharing of immunisation data is critical for maintaining comprehensive patient records and avoiding duplicate vaccinations or missed doses. National digital health systems will need robust mechanisms to ensure seamless data flow between pharmacies and GP practices. Without this, GPs will struggle to maintain an accurate overview of their patients' immunisation status, potentially compromising care coordination.

The impact on general practice workload is another consideration. While some may argue that this offloads a portion of the vaccination burden from GPs, it also introduces a new layer of administrative oversight. GPs will still be responsible for overall patient care, including managing complex vaccination schedules for children with underlying health conditions or those requiring catch-up immunisations. The expectation is that pharmacists will handle routine, uncomplicated cases, allowing GPs to focus on more complex clinical presentations.

Concerns have also been raised regarding the potential for fragmentation of care. The traditional model of childhood immunisation within general practice allows for opportunistic health checks and discussions about other aspects of child development during vaccination visits. Pharmacists, while clinically trained, may not have the same scope for these broader health assessments. This means GPs must remain vigilant in ensuring that these holistic care opportunities are not lost, perhaps by encouraging parents to maintain regular well-child visits even if vaccinations occur elsewhere.

The success of this initiative hinges on public trust and effective communication. Parents must be confident in the ability of pharmacists to safely and effectively vaccinate their young children. Public health campaigns will be essential to inform parents about the expanded service and to reassure them about the training and competency of pharmacy staff. Clear guidance on when to use pharmacy services versus GP services will also be necessary to avoid confusion and ensure appropriate care pathways.

The policy does not address the underlying causes of vaccine hesitancy, which often involve complex socio-economic factors and misinformation. While increased access may help those facing logistical barriers, it will not necessarily sway individuals who are fundamentally distrustful of vaccines or the healthcare system. Addressing hesitancy requires targeted, community-level interventions and ongoing dialogue, which extend beyond the scope of a simple access expansion.

CLINICAL IMPLICATIONS

The shift to allow pharmacists to vaccinate children under 5 is a pragmatic response to persistent vaccination rate shortfalls. For general practitioners, this means a potential reduction in routine immunisation appointments, freeing up some capacity. But, it also necessitates a robust system for data exchange; without

immediate, reliable updates from pharmacies, patient records will become fragmented, and that is a clinical liability.

The convenience factor for parents is undeniable, and it will likely improve uptake in busy urban areas.

However, the comprehensive health check that often accompanies a GP-administered vaccination visit for a young child is not easily replicated in a pharmacy setting. GPs will need to reinforce the importance of regular well-child visits, irrespective of where vaccinations are administered, to ensure holistic developmental monitoring continues.

This policy also places a significant responsibility on the pharmacy sector to ensure consistent training, cold chain management, and adverse event reporting. Any misstep could erode public confidence, not just in pharmacy services, but in the broader vaccination program. The success of this expansion hinges on meticulous execution and seamless integration with existing primary care infrastructure.

Ultimately, this is an access play, not a solution to vaccine hesitancy. While it removes logistical barriers, it does not address the deeper concerns some parents hold. GPs will continue to be the primary source of trusted information for these families, and their role in advocating for vaccination remains unchanged, regardless of who administers the jab.

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