White Paper

Bridging the Divide: Measuring the Impact of the Pharmaceutical Reform Agreements on Medicine Access

A data-driven analysis of how PRAs shape equity, access, and care integration across Australia

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Introduction

The Pharmaceutical Reform Agreements (PRAs) are bilateral agreements between the Commonwealth and relevant jurisdictions that facilitate the access of Pharmaceutical Benefits Scheme (PBS) medications for admitted patients on discharge, non-admitted patients and same day admitted patients in public hospitals.[2] Assessing disparities in the uptake and impact of PRAs is critical to understanding how policy differences across Australian states and territories influence equity of access, system efficiency and patient management pathways. The PRAs framework complements Australia's efforts to gradually integrate elements of value-based healthcare[1] with the key goal of enhancing provider and patient outcomes while improving equity of access.

Background and objectives

Using IQVIA's national data assets, this paper examines how PRAs participation influences medicine access across jurisdictions — revealing practical insights for improving equity and system efficiency.

Building on this perspective, the paper examines how the location of medicine dispensation — whether in hospital or community settings — varies between PRAs signatory and non-signatory regions. It explores these patterns across different channels, cost profiles, therapeutic areas, and geographic contexts, offering insights into how PRAs participation influences care integration.

Key jurisdictions that have signed PRAs include Queensland (QLD), Victoria (VIC), Tasmania (TAS), South Australia (SA) and Northern Territory (NT). These states and territories benefit from uniform pricing through nationally negotiated drug prices, supply security guarantees and cost recovery for government via confidential rebates.[2]

New South Wales (NSW) and Australian Capital Territory (ACT) are yet to sign on due to state specific considerations. In addition, Western Australia (WA) is currently not a signatory to the Hospital Reform component of the PRAs, hence, WA public hospitals do not routinely access PBS medications at commonwealth subsidised prices and face similar access challenges to NSW and ACT.

Data Source and methodology

To explore the impact of PRAs on dispensation pattern, we have leveraged 2 main IQVIA data sources:

IQVIA data sources

IQVIA's hospital PROFITs data which captures volume from wholesalers to individual hospital pharmacies, covering approximately 97% of volume dispensed in Australia.

IQVIA point of dispensing data, which captures prescription sales in over 4,000 community pharmacies. The number of packs dispensed in community pharmacies that can be linked back to a hospital doctor is reported in an aggregated manner in this report.

These sources allow for a comprehensive view of hospital-prescribed medicines, regardless of whether they are dispensed in hospital or community settings.

Molecule selection criteria

The analysis focuses on 153 molecules across 39 ATC3 classes that meet the following criteria:

- With over 50% of community volume linked back to a hospital with minimum 200 unit sold in 12 month period.
- Dispensed in both hospital and community settings.
- Excludes medicines requiring compounding (e.g., monoclonal antibodies, chemotherapy) due to incompatible unit measures.

Definitions and classifications

Anatomical Therapeutic Chemical (ATC) classification system

Developed by the World Health Organization (WHO) to categorise medicines. IQVIA used ATC level 3 to classify medicines based on organ or system they act on, therapeutic use and pharmacological subgroup.

Metropolitan vs. remote area

Australian Bureau of Statistics uses a classification system called the Australian Statistical Geography Standard (ASGS) to categorise areas as metropolitan (major cities), rural, and remote.[5]

High-cost drug

The PBS Safety Net threshold for general patients is $1,694.00 per year[6] updated on 1 January 2025. Monthly spending of $140 over 12 months would exceed the threshold, especially for chronic conditions, thus qualifying drugs as high-cost in terms of cumulative patient expenditure.

Discussion

Impact of PRAs on dispensation pattern

PRAs play an important role in the patient's journey, especially when they are transitioning from hospital to community care[2]. For the 153 molecules examined in this paper, over 50% of the hospital prescribed volume are dispensed inside the hospital pharmacies. This is 53% for PRAs jurisdictions and 50% for non-PRAs jurisdictions. However, we observed changes in dispensation patterns by cost of medicine, therapeutic area, and access of care by location. PRAs support integrated care and smoother transitions from hospital to community settings by enabling public hospitals to dispense a full month's supply of PBS-subsidised medicines. Patients pay only the standard co-payment, just as they would at a community pharmacy.

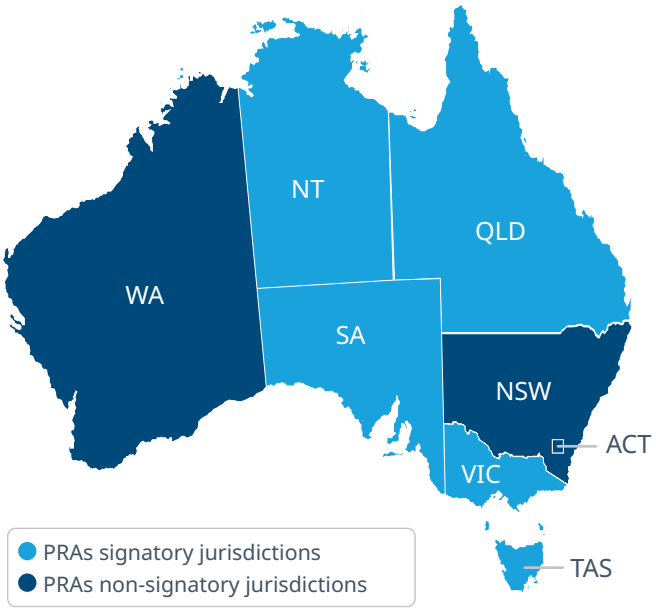
In contrast, hospitals in non-participating jurisdictions typically provide only a short-term supply (3–5 days), funded directly by the hospital. This approach often requires patients to take additional steps to access ongoing treatment through external providers, potentially disrupting continuity of care. We will explore the differences and similarities in this section.

Disparity in ATC classes dispensation patterns

Disparity in ATC classes dispensation patterns may reflect three key considerations:

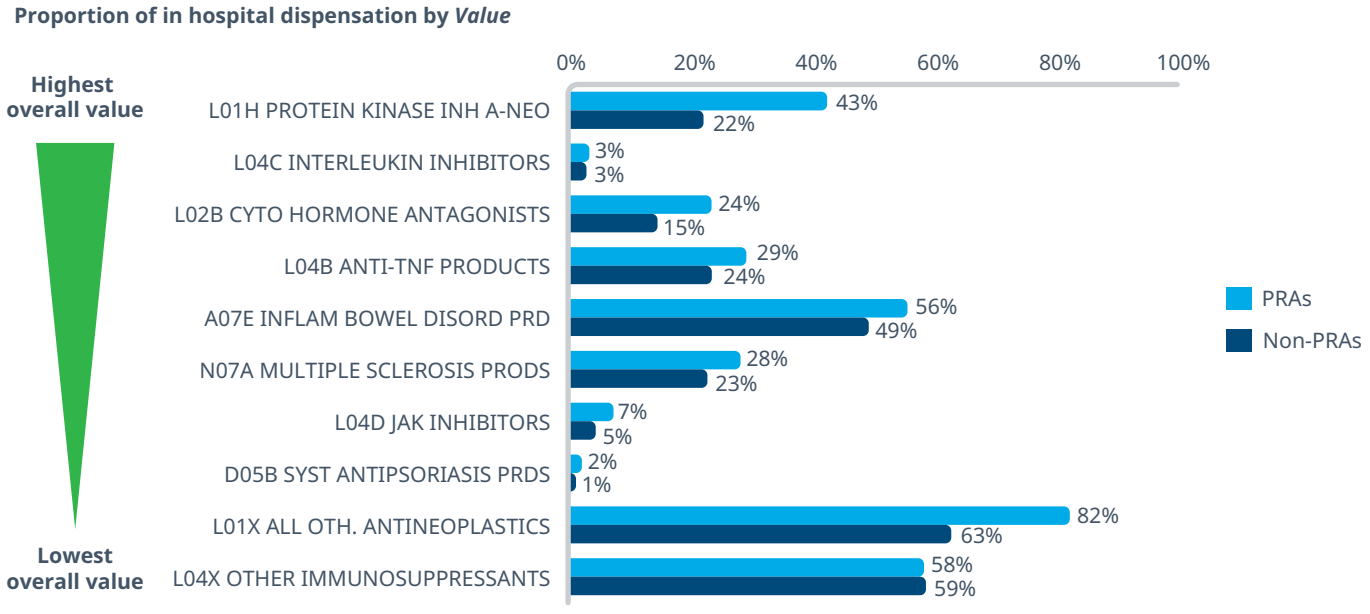
- Clinical practice in integration of patient care pathway.
- Logistic and infrastructure readiness.
- Cost and budgetary impact for state government.

Cancer treatments show significantly higher in-hospital dispensation in PRAs jurisdictions: Among the top 10 ATC3 classes by total value sold over a 12-months period, three high-cost cancer treatment categories — L01H Protein Kinase Inhibitors (antineoplastics), L02B Cytostatic Hormone Antagonists, and L01X Other Antineoplastics — showed notably higher rates of in-hospital dispensation in PRAs jurisdictions compared to non-PRAs jurisdictions. Specifically, these classes were dispensed 21%, 9%, and 19% more frequently in hospitals, respectively (see Figure 1). Immune-Mediated Inflammatory Diseases (IMIDs) — including rheumatoid arthritis, psoriasis, ulcerative colitis, Crohn's disease, and atopic dermatitis — are commonly treated with drugs from other top ATC3 classes by value, such as L04C, A07E, D05B, L04D, and L04X. Dispensation patterns for these therapies are more varied and often influenced by the location of specialists care. Indications managed by rheumatologists and dermatologists tend to show lower percentages of in-hospital dispensation, whereas gastroenterology-related indications (e.g., UC and Crohn's disease) show over 50% in-hospital dispensation, reflecting disease management pathways. PRAs jurisdictions, which benefit from access to nationally negotiated rebates and supply terms, can claim part of the cost from federal PBS



budgets, thereby removing the need to consider the impact on state budgets of the care provision decisions. Patients and providers would have more flexibility to choose optimal care pathways that best suit their individual situations. In contrast, non-PRAs jurisdictions, which are ineligible for national rebates and supply terms, may face higher net prices and tighter budget constraints. As a result, dispensation may shift to the community setting, relying on robust logistics and infrastructure to ensure that community pharmacies can deliver high-cost or cold-chain medicines to patients when needed.

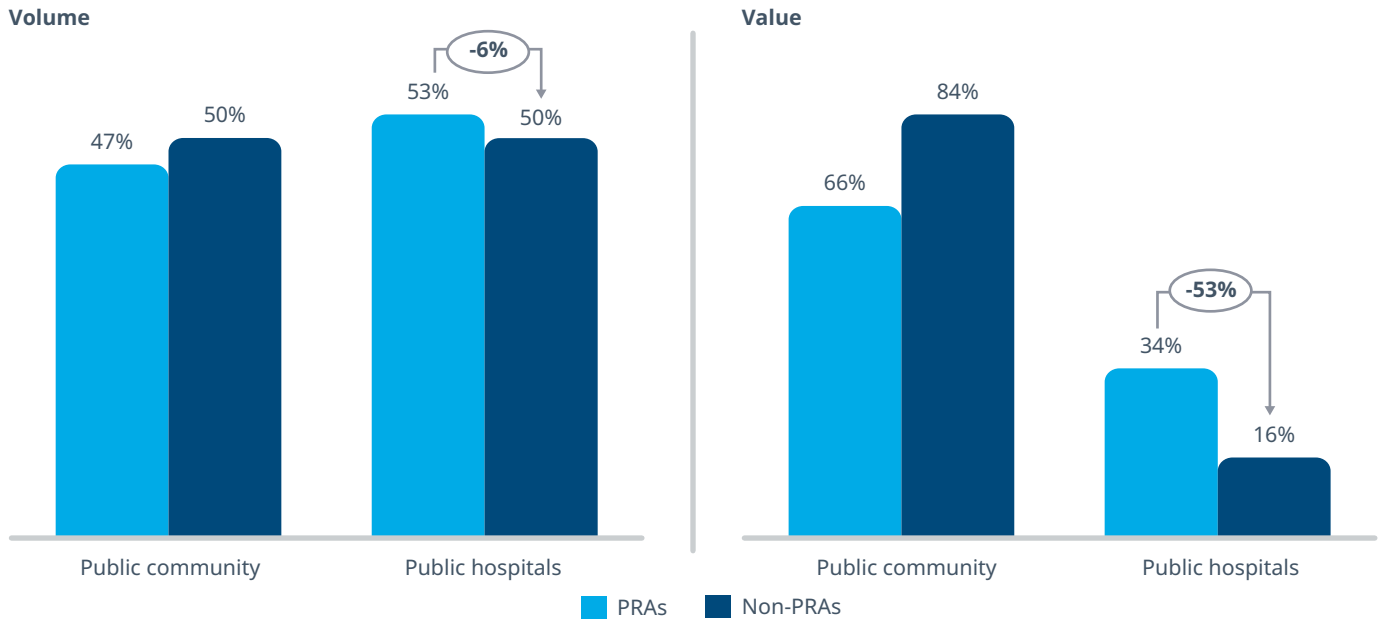
Figure 1: Top 10 ATC3 classes by value and proportion of in-hospital dispensation vs. community dispensations



Other considerations, such as **route of administration and PBS restrictions, may also influence the setting of care for patients**. Intravenous medicines are typically administered by clinicians in controlled environments, whereas oral drugs: such as Jakavi, Glivec, and Tagrisso (all part of the L01H class for cancer treatment), are more often dispensed in the community setting, where patient compliance and adherence are expected to be high. In non-PRAs signatory states, public hospitals can only supply PBS-reimbursed Section 100 Highly Specialised Drugs (HSD) to outpatients through hospital pharmacies.[4] This restriction may lead to fragmented care, where patients receive only initial treatment or are managed as inpatients.

Although one might attribute the disparity to hospital resourcing capacity, redirecting part of patient management to the community setting could help alleviate resourcing bottlenecks in the already constrained public hospital systems of non-PRAs jurisdictions. As shown in Figure 2, ~50% of total volume is still dispensed through public hospital pharmacies for both PRAs and non-PRAs jurisdictions (left chart), hence public hospitals in non-PRAs jurisdictions are still seeing similar volume of patients. However, the same 50% of volume represents only 16% of medicine cost in non-PRAs jurisdictions compared to 34% of medicine cost in PRAs jurisdictions (right chart) shifting 84% to community setting where medicine cost is funded by PBS.

Figure 2: Proportion of medicines dispensed in all hospitals and public hospital by PRAs status

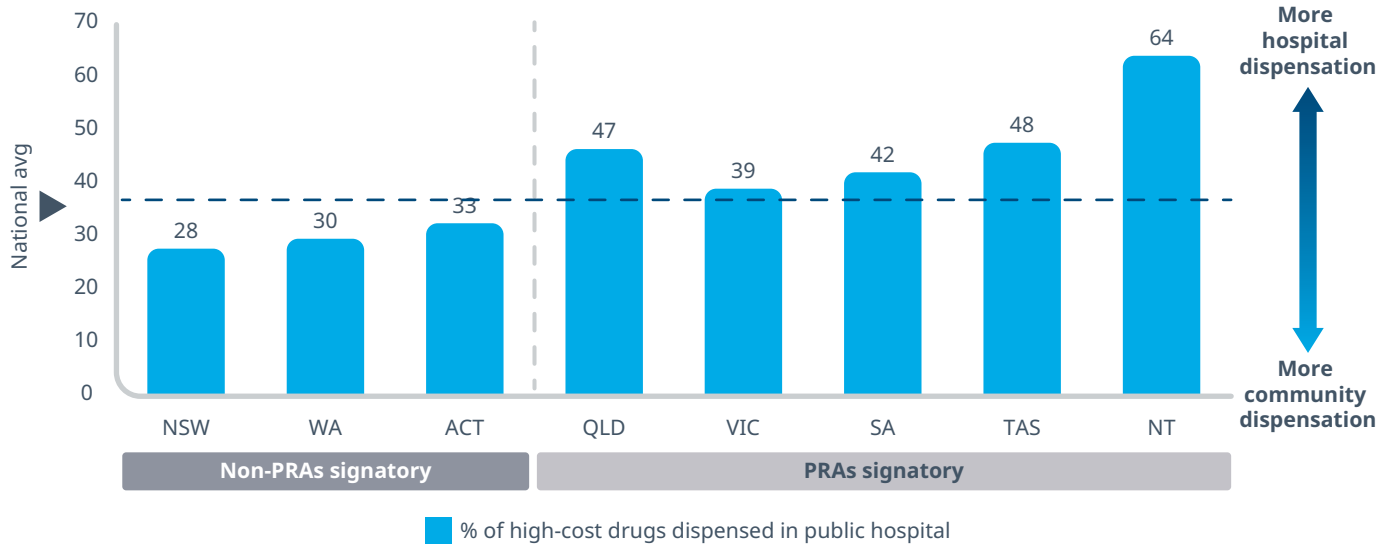


Deep dive on high-cost medicine dispensation in pubic hospitals

Zooming in on high-cost medicines (Figure 3), 28%–33% of hospital-prescribed scripts in non-PRAs jurisdictions are dispensed within public hospitals, whereas in PRAs jurisdictions, this figure ranges from 39% to 64%. These differences reflect varying benefits and trade-offs across states and territories, influenced by factors such as hospital and community resourcing challenges, the maturity of pharmacy networks, and supply chain efficiency.

For hospitals in PRAs jurisdictions, more complex inventory, additional rebate reconciliation and increased demand on hospital capacity may require forward workforce planning and IT system management to ensure sustainability. However, this can help to reduce community prescriber visits and provide better continuity of care for patients.

Figure 3: Proportion of high-cost drugs dispensed in public hospitals by state



Geographical and infrastructure influences

To further examine how PRAs influence the adjustment of care, we examined whether the availability of community care provision and specific patient needs across metro and remote areas have affected this process. We also compared dispensation patterns by population density, geographical sparsity, and hospital capacity — indicated by Australian Institute Health and Welfare (AIHW)'s number of hospital beds per 1,000 population — which varies across Australia.[3] The PRAs are designed to bridge disparities in access by enabling full PBS-subsidised dispensation in public hospitals, however adherence to this principle differs depending on access to care. In Figure 4, non-PRAs jurisdictions such as WA, with a higher in hospital dispensation in remote WA, may flag a need to implement PRAs-like policies which allow patients to access adequate care inside hospital with long supply of medicines. Similar patterns are seen due to difficulties in care access in community settings in remote SA and NT, with the proportion of hospital dispensation from hospital-prescribed medicines being 19% and 9% higher than national average respectively.

In TAS and QLD, remote patients are directed to community settings even though both states are PRAs jurisdictions — this may be due to capacity constraint and long waiting times indicated by lower number of hospital beds per 1,000 population.[3]

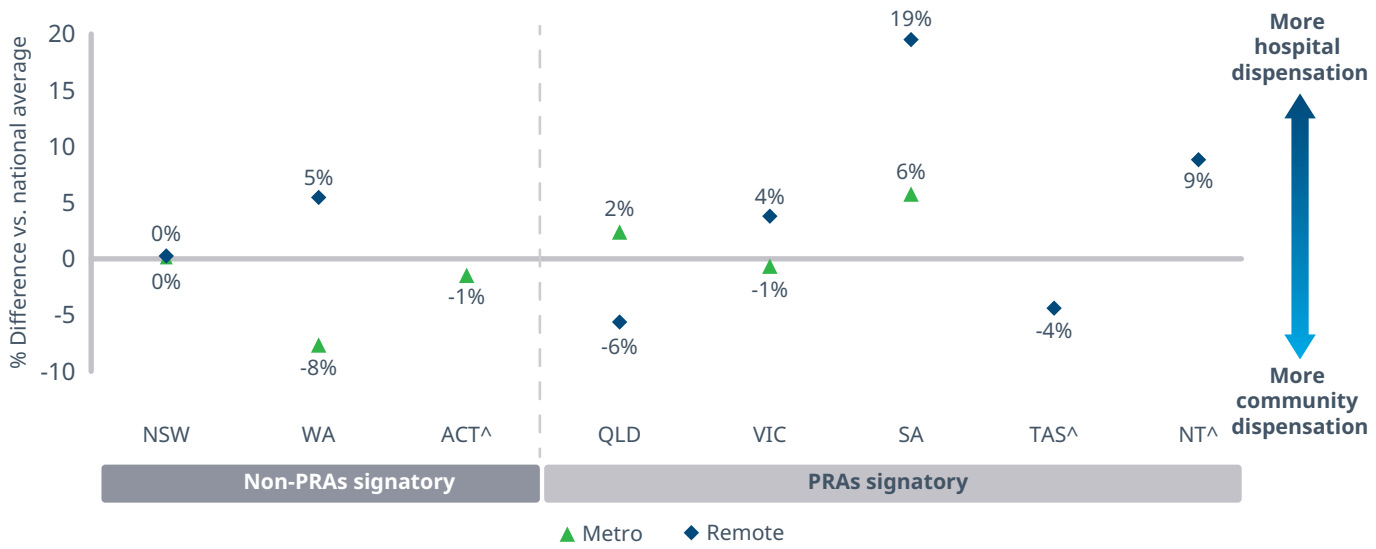
Conversely, VIC has a well-established public hospital network with a long-standing history of centralised health planning and integration. Ensuring long term sustainability of hospital-led care and integrated care models that bridge the gap between hospital and community care is a priority.

Signing onto the PRAs enhances and streamlines the process and shifts medicine cost to PBS budget.

NSW has the largest number of hospitals and pharmacies in Australia: with over 1,700 community pharmacies, 189 public and 109 private hospitals across the state. ACT and NSW Memorandum of Understanding for Regional Collaboration allows South-East NSW region and ACT patients to access health services across the borders. This extensive infrastructure supports equitable access and continuity of care across both metropolitan and remote regions. Given the scale and complexity of NSW's public hospital network, significant investment in IT systems, pharmacy resourcing, and workforce training across Local Health Districts may put more emphasis on healthcare policy autonomy and budgetary certainty over the nationally negotiated rebates and supply terms offered under the PRAs. The strong presence of primary care services and widespread pharmacy coverage provides ACT and NSW with alternative mechanisms to maintain continuity of care outside the PRAs framework. As part of the NHRA mid-term review recommendations, interim PRAs arrangements for NSW and ACT in the lead-up to a new Agreement could be progressed. If supported by those jurisdictions, this could enable tailored PRAs that balances integration of care with state policy and budgetary autonomy to deliver nationally consistent access to medicines across the care continuum.

Figure 4: Dispensation differences in public hospital by remoteness

% Dispensation difference in public hospital by remoteness



Available beds per 1,000 population[3]

	NSW	WA	ACT	QLD	VIC	SA	TAS	NT
Major cities	2.57	2.31	2.71	2.45	2.31	2.48	-	-
Remote	3.22	2.2	-	2.6	2.7	3.05	2.6	0

According to the ABS remoteness classification, NT and TAS are considered remote regions, while the entire ACT is classified as metropolitan.

Conclusion

In summary, the dispensation of medicines from public hospital prescribers reveals significant variation across states, driven by factors such as resourcing capacity, geographical challenges, and healthcare infrastructure. The Pharmaceutical Reform Agreements (PRAs) seek to improve equity in access by facilitating PBS-subsidised medicines in public hospitals, yet implementation is shaped by state specific circumstances — including the maturity of pharmacy networks and the balance between hospital and community capacity.

States like NSW, with robust networks and infrastructure, may choose alternative mechanisms to ensure continuity of care, while others leverage the PRAs to streamline medicine provision and shift costs. Ultimately, successful policy design and implementation must be adaptive, accounting for geographical nuances, capacity constraints, and the unique challenges faced by both metropolitan and remote populations to achieve equitable and sustainable access to medicines nationwide.

The PRAs offers a framework to improve equity, but success depends on collaboration and adaptive implementation.

Through its national data assets and analytical expertise, IQVIA works alongside stakeholders to uncover these patterns and support evidence-based decisions that advance equitable and sustainable access to medicines.

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