PATIENT INSIGHTS

Australian perspectives on medicines access

A national snapshot of how Australians access medicines, and the factors shaping who gets treatment, when and at what cost.

PATIENTS AUSTRALIA

SANDOZ

Contents

Acknowledgement of support

Patients Australia acknowledges Sandoz Pty Ltd for funding and commissioning this research. This support has helped enable the development of this report and Patients Australia's ongoing efforts to elevate patient insights in national conversations about access to medicines.

The survey findings and patient insights reported in this document were analysed and reported by Patients Australia.

Disclaimer and Inherent Limitations

This report has been prepared as outlined in the section titled "About this Report". The findings in this report are based on data provided by patients who have received care in the Australian healthcare ecosystem. Any projection to the wider Australian community and patient experience is subject to the level of bias in the method of sample selection.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, the patients consulted as part of the process.

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Abbreviations

ABS – Australian Bureau of Statistics **PBS** – Pharmaceutical Benefits Scheme **TGA** – Therapeutic Goods Administration

Definitions

Biologic medicines
Biologic medicines are complex treatments derived from living cells, often used to treat conditions such as autoimmune disease, cancer and diabetes.

Biosimilar medicines
Biosimilar medicines are highly similar versions of an existing biologic medicine and are approved as equivalent in safety and effectiveness.

Generic medicines
Generic medicines contain the same active ingredient as a branded medicine and are considered equivalent in safety, quality and effectiveness.

Authority requirements
Rules that determine whether a patient is eligible to receive a medicine at the subsidised PBS price, based on specific clinical criteria.

Non-PBS medicines
Medicines that are not subsidised under the PBS and are typically paid for privately or accessed through alternative pathways.

Opening

Access to medicines is central to Australia's healthcare system. Medicines prevent illness, manage chronic conditions, and maintain quality of life. National data from the Australian Bureau of Statistics (2022) indicate almost seven in ten Australians are dispensed at least one Pharmaceutical Benefits Scheme (PBS) medicine over a six-month period, increasing to over eight in ten among those with chronic conditions. The PBS provides a strong foundation for subsidised access, but the pathway from prescription to treatment is shaped by listing criteria and subsidy decisions.

Even when a medicine appears on the PBS, subsidy may only extend to certain approved indications, meaning a patient with a different, unlisted condition receives no benefit. Access to even listed indications can be further constrained by step therapy requirements that mandate trials of alternative medicines before the preferred treatment is approved, regardless of the prescriber's clinical judgement. Compounding this, the journey from Therapeutic Goods Administration (TGA) approval to PBS listing can exceed twelve months, leaving patients and clinicians in a prolonged gap where a medicine is considered safe and effective yet remains financially out of reach for many.

For patients, navigating access to medicines begins long before a prescription is written. Through conversations with doctors, their own research, and lived experience of their condition, patients develop an understanding of what treatments exist, how they work, and whether better options might be available, sometimes looking beyond Australia to medicines approved or in use internationally when the latest therapies have not yet reached local markets. This knowledge, shaped by varying levels of health literacy, informs the questions they ask, the decisions they make, and the advocacy they undertake on their own behalf.

Yet understanding what is possible does not always translate into access. Patients must still navigate eligibility criteria, funding pathways, and the expectations of a health system that may not move at the same pace as their clinical need, coordinating across multiple providers and responding to shifts in cost, availability, or treatment requirements along the way. For some, this process is manageable. For others, it demands significant time, effort, and persistence, placing a burden on the very people whose energy is already consumed by managing their condition.

The decisions patients make about their medicines are rarely straightforward. Cost, perceived benefit, trust in their clinician, and confidence in the information available to them all weigh on how patients engage with treatment options. Those living with life-threatening or ongoing, chronic conditions tend to accumulate deeper experience of the system over time, yet this familiarity does not insulate them from the structural factors that shape access: whether a medicine is available in Australia, how it is priced, and the administrative requirements that must be satisfied before treatment can begin or continue.

These pressures are felt most acutely by patients who depend on specialised medicines, including biologic therapies and their biosimilar equivalents. For this group, the decisions are rarely just about whether a medicine is affordable or accessible in a general sense. They involve navigating eligibility criteria tied to specific conditions and treatment histories, understanding what switching from one medicine to another might mean for their health, and contending with the financial consequences of losing or never gaining subsidy. For patients whose conditions are serious and whose treatment options are limited, these are not administrative inconveniences. They are decisions with real clinical and personal consequences.

This edition of the Patient Insights Report examines how Australians experience access to medicines in practice. It explores patient awareness and understanding of PBS processes, experiences accessing subsidised and non-subsidised medicines, exposure to newer treatment options such as biologic and biosimilar medicines, and the impact of medicine shortages. It also considers the financial, practical and emotional implications of accessing medicines, and the factors that shape patient perceptions of fairness within the system.

The findings are based on a national survey of almost 4000 patients and carers, capturing a wide range of lived experiences across age groups, household income levels, geographic locations, and health conditions. Together, these insights provide a detailed picture of how medicines access is experienced across the Australian healthcare system today.

This report provides a patient-centred view of medicines access in Australia. It highlights the realities of navigating the system and identifies the areas that matter most to patients. These insights are intended to inform policy, practice, and ongoing efforts to ensure that access to medicines is equitable, timely, and responsive to patient needs.

About this report

This Patient Insights Report offers a timely snapshot of Australians' experiences accessing medicines and identifies the barriers people face when seeking affordable, timely and reliable treatment. It captures views from across the country on medicine affordability, PBS access, medicine shortages, biologic and biosimilar medicines, and perceptions of fairness in the medicines access system.

Together, these insights provide valuable evidence to inform policy, advocacy and patient-centred reform, ensuring that decisions about medicines access in Australia are guided by the needs, expectations and lived experiences of patients.

Research

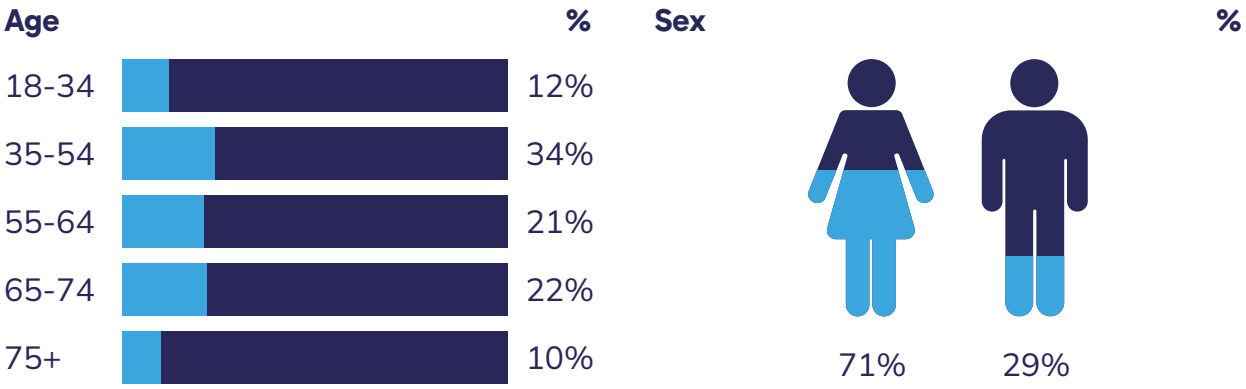
From 11 March to 29 March 2026, Australian adults were invited to participate in an online survey conducted by Patients Australia. Patients Australia designed the survey and analysed and processed the survey data, with a final sample of 3,996 responses included in the analysis and findings presented in this report. All figures are shown as percentages unless otherwise stated. Due to rounding to the nearest whole number, some totals may sum to 99% or 101%.

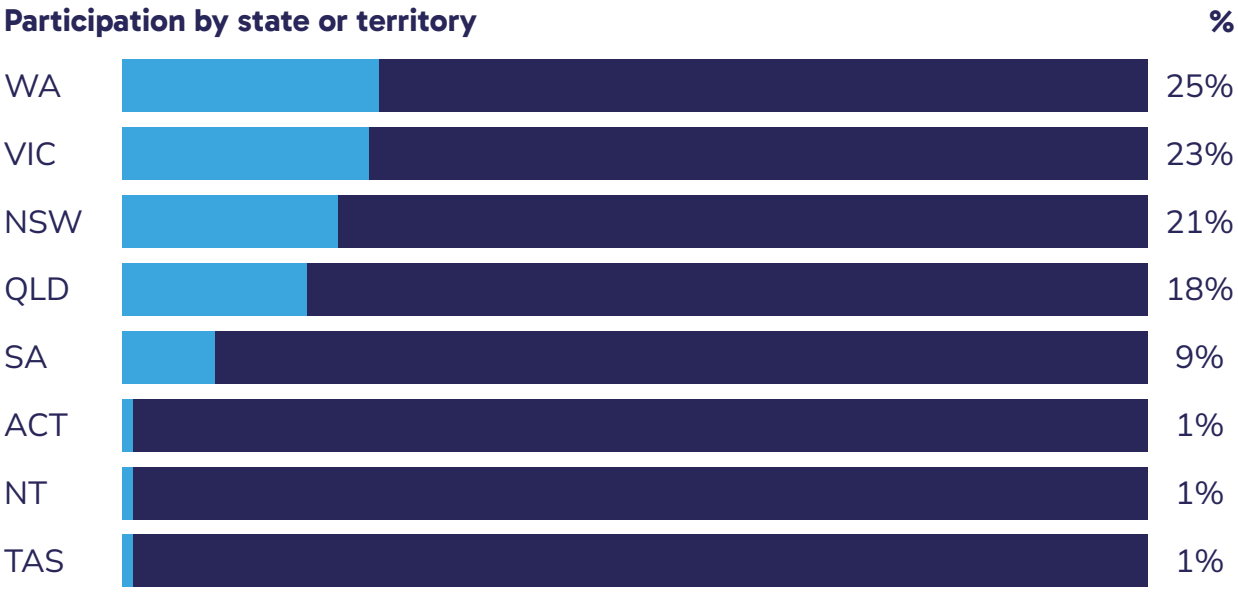
Data were weighted to improve alignment with the Australian adult population using 2021 Australian Census benchmarks for age, sex and metropolitan/non-metropolitan residence. All findings report weighted estimates.

In addition to descriptive results, multivariable regression models were used to examine which patient characteristics were independently associated with each outcome. These models adjust for age, sex, health status, household income, geographic location and prior exposure to biosimilar medicines simultaneously, allowing each factor to be assessed while holding the others constant. Throughout this report, findings described as holding "after adjustment" are drawn from these models. Where a difference seen in the raw data weakened or disappeared once other factors were accounted for, this is noted, because it changes how the finding should be understood.

Who took part?

A total of 3,996 patients and carers took part in the survey. The tables below describe the unweighted profile of respondents. All findings reported elsewhere use weighted estimates, adjusted to 2021 Census benchmarks for age, sex and metropolitan or non-metropolitan residence.

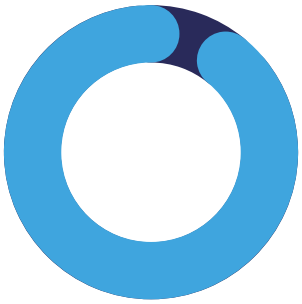




Location of primary residence

Metropolitan	70%
Non-metropolitan	30%

Aboriginal and/or Torres Strait Islander

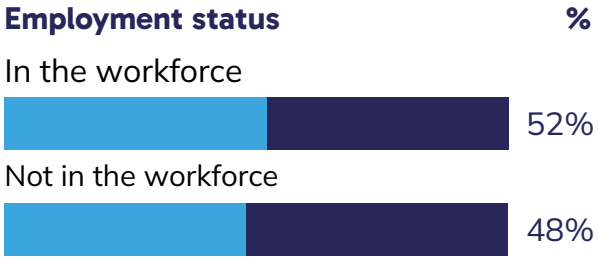


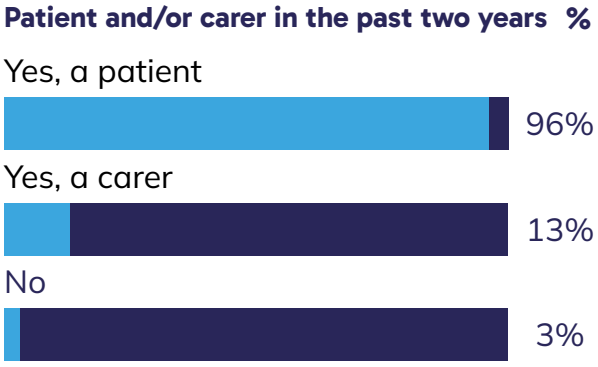
No	97%
Yes, Aboriginal and/or Torres Strait Islander	3%

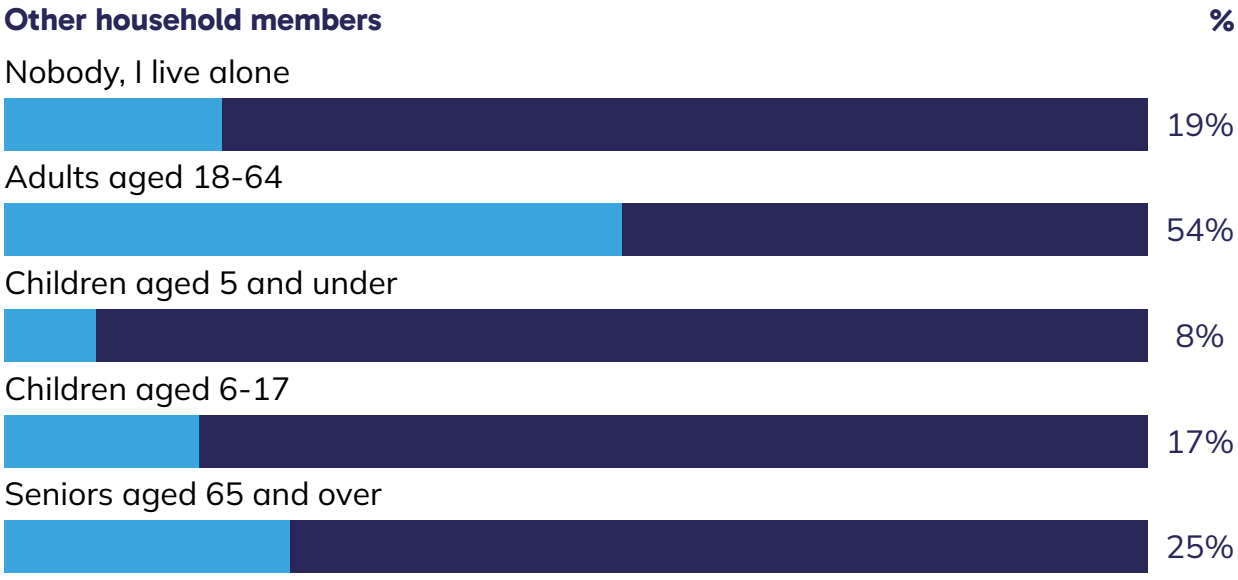
Highest level of education

Pre-university	65%
Bachelor and post graduate	35%


Annual household income
%
Nil income
7%
$1 - $25,999
16%
$26,000 - $64,999
25%
$65,000 - $90,999
15%
$91,000 - $129,999
15%
$130,000 - $181,999
11%
More than $182,000
10%


Employment status
%
In the workforce
52%
Not in the workforce
48%


Patient and/or carer in the past two years
%
Yes, a patient
96%
Yes, a carer
13%
No
3%


Other household members
%
Nobody, I live alone
19%
Adults aged 18-64
54%
Children aged 5 and under
8%
Children aged 6-17
17%
Seniors aged 65 and over
25%

Key findings

Patient and carer voice points to a medicines system that functions for many people but fails specific groups at identifiable points. Multivariable analysis, which accounts for age, sex, income, location and prior medicine exposure together, shows that the burden of access is not shared evenly: its consequences fall hardest on those with the least capacity to absorb them, particularly lower-income patients. Each of the findings below reveals where the system breaks down for patients, and where there is opportunity to improve access.

1. Most patients cannot navigate the PBS rules that govern their access

Only three in ten patients understood how PBS authority requirements affect their prescription, and almost three in ten knew nothing about them at all. These rules determine whether a medicine is accessed, yet the patients they affect are largely unaware of how they work. Understanding appeared to come from repeated exposure to the system, not from any deliberate effort to inform patients.

The opportunity: *Authority requirements are a hidden layer of the access pathway. Proactive, repeated plain-language explanation at the point of prescribing would let patients understand and question decisions that currently happen around them.*

2. Confidence to ask is the bottleneck, and it is unevenly distributed

Conversations with a doctor are a key way patients can close the knowledge gap on authority requirements, but only 58% felt confident initiating them. Crucially, confidence was not linked to managing illness once age was accounted for. After adjustment, only older age and prior exposure to complex medicines independently predicted confidence, meaning the patients newest to the system are both the least informed and the least equipped to ask.

The opportunity: *The information gap will not close on its own through clinical conversation initiated by patients, because the patients who most need to ask are the least likely to. Information needs to be offered proactively, not waited for.*

3. Biosimilar uptake fails at the prescriber's desk, not the patient's

The biosimilar pathway buckles at a single, identifiable point. Of patients offered a biosimilar, fewer than half (43%) were then prescribed one. But of those actually prescribed one, 89% went on to try it. The drop-off sits between being offered and being prescribed, not in patient follow-through. Once patients have a script, fulfilment is high; the offer is frequently failing to convert into a prescription.

The opportunity: *The lever is in the offer-to-prescription step. Targeting this step is where biosimilar uptake can realistically be improved. Further investigation into what occurs in these interactions is warranted, including how the offer is communicated, whether patients leave the consultation with unresolved questions about safety or equivalence, and what clinical, administrative or system factors influence whether an offer becomes a prescription.*

4. Patient comfort with biosimilar medicines is a closeable information gap

Patients were markedly less comfortable with a pharmacist offering a biosimilar (59% comfortable) than a generic (73%), and biosimilar medicines drew far more neutral, undecided responses. The single clearest predictor of comfort was prior exposure: after adjustment, patients who had encountered a biosimilar before were significantly more comfortable, while demographics barely mattered. Comfort grows with familiarity, and the decision to try one rests on clear reassurance about safety and effectiveness.

The opportunity: *Comfort is built by exposure and trusted explanation, both of which are within the system's control. Patients who tried biosimilar medicines overwhelmingly cited reassurance about safety and equivalence, not system savings, suggesting consistent clinical messaging on safety and effectiveness is the more effective lever.*

5. Support during medicine shortages is largely absent and depends on luck

Almost half of patients had struggled to get a medicine due to a shortage. When it happened, support was thin: only 14% were warned in advance by a pharmacist, 10% by a prescriber, and one in five received no support at all. The adjusted models found that patient characteristics barely predicted who got proactive help, which means the variation sits with the individual pharmacy or prescriber, not the patient. One in eight of those affected reported their health or symptoms worsened.

The opportunity: Government holds levers on the supply side, including stockholding requirements (which can have both positive and negative implications), supply-chain resilience, and the settings that affect whether companies keep supplying the Australian market. Alongside securing supply, the patient-facing response needs attention: shortage communication is currently insufficient, and defined responsibilities for advance notice and clear guidance on alternatives should be applied consistently

6. Unsubsidised medicines create a two-tier system that locks out lower-income patients

Around half of patients had needed a medicine not covered by the PBS, including 37% in the past year. Most paid out of pocket, but the response split sharply by income rather than by health. After adjustment, low-income patients were around twice as likely to delay starting treatment or switch to a less effective medicine because of cost. More than half of all those affected described the impact as moderately to extremely severe.

The opportunity: The clinical compromise is concentrated among those least able to pay, not those least in need. When a clinically appropriate medicine is not on the PBS, it remains available to those who can pay privately while being effectively out of reach for those who cannot. The same treatment is accessible or not according to means rather than clinical need, creating a two-tier system for the same drug. The lever sits upstream, in how quickly medicines move from TGA approval to PBS listing, and how readily clinically appropriate medicines can be listed in the first place.

7. The cost of access destabilises low-income households well beyond healthcare

When meeting access requirements created financial pressure, patients borrowed money, missed bill payments, applied for income support and drew on superannuation. These responses were driven overwhelmingly by income, not health status. After adjustment, low-income patients were more than ten times as likely as high-income patients to borrow from family or friends, and almost nine times as likely to apply for income support or draw on superannuation.

The opportunity: The financial consequences of medicine access spill into household stability and long-term savings. Reform should be measured by whether it reduces the need for patients to erode their savings, defer other obligations, or take on debt to stay on treatment.

8. Women are made to wait longer, pushed outside the PBS more often, and carry more of the strain

Women were 96% more likely than men to report having to wait for their condition to worsen before accessing a medicine, and 87% more likely to have needed a medicine not covered by the PBS in the past year. When access broke down, they carried more of the load: more likely to visit multiple pharmacies during a shortage, to report stress and emotional strain, and to delay their own healthcare to manage costs. They were also 43% less likely than men to regard the system as fair.

The opportunity: The pattern suggests women are held to a higher access threshold and more often pushed outside the PBS. The size and consistency of the gaps warrants further examination of whether the medicines more often required by women are less likely to be subsidised.

9. Patients have named where the system fails them

Asked what would most improve access, patients pointed to three concrete pressure points: the cost of co-payments and out-of-pocket expenses (40%), the wait to see a specialist (39%), and the delay between a medicine being approved and subsidised (28%). Priorities shifted by group, with older patients and those with multiple conditions placing faster PBS listing first, and rural patients twice as likely to flag regional support.

The opportunity: These priorities point to three areas patients value most: the affordability of medicines and consultations, timely access to specialists, and the time taken to list new medicines on the PBS following TGA approval. Each is a concrete area government can act on, and patient priorities offer a clear, evidence-based starting point for where that action would be felt most.

PBS Understanding and Confidence

Understanding of PBS authority varies, with confidence shaped by experience

PBS authority requirements are a set of rules that determine whether a patient is eligible to receive a particular medicine at the subsidised PBS price. For some medicines, a standard prescription is sufficient. For others, the prescriber must apply for approval, known as an authority, by demonstrating that the patient meets specific clinical criteria. These criteria may include having a particular diagnosis, having already tried other treatments, or being under the care of a specialist. Authority requirements are designed to ensure that subsidised medicines are used appropriately, but they also create a set of conditions that patients must satisfy, even when both the patient and their treating clinician believe the medicine in question is the most appropriate treatment from the outset.

Most respondents had limited understanding of these requirements. Only three in ten said they understood how authority requirements work and how they affect their prescription (30%), while a further 28% reported a basic understanding but found the details confusing. Around 14% had heard of authority requirements but did not understand them, while almost one third (29%) had no knowledge of them at all.

Table 1. *Which statement best reflects your understanding of PBS funding and authority requirements for medications?*

Response	%
I understand how PBS authority requirements work and how they affect my prescription	30%
I have a basic understanding but find the details confusing	28%
I have heard of PBS authority requirements but do not understand them	14%
I do not know what PBS authority requirements are	29%

Weighted percentages; n = 3,992. Totals may not sum to 100% due to rounding.

Understanding of PBS authority requirements was strongly shaped by age and by experience of the health system, and these patterns held even after accounting for one another and for income, sex and location. Older respondents were far more likely to understand the requirements: after adjustment, those aged 65 and over had more than six times the odds of understanding how authority requirements work compared with those aged 18-44. Experience of managing illness mattered just as much. After adjustment, respondents with more than one health condition had more than three times the odds of understanding the requirements compared with those with no health condition, and those who had been exposed to biosimilar medicines were also significantly more likely to understand them. Lower understanding was more common among middle-income respondents and those living outside metropolitan areas, again after adjustment. Taken together, this suggests that familiarity tends to build through repeated contact with the system rather than through broad public awareness, leaving those with less exposure at a persistent disadvantage.

While most respondents had limited understanding of PBS authority requirements, conversations with a doctor represent one pathway through which that gap could be addressed. However, not all patients feel equipped to initiate those conversations. Just over half of respondents felt very or somewhat confident asking their doctor about PBS authority requirements or eligibility for a specific medicine (58%), while 16% felt unconfident and 27% were neither confident nor unconfident. For those lacking confidence, this conversation is less likely to take place, and the gap in understanding is less likely to close through clinical interaction.

Table 2. *How confident do you feel asking your doctor about PBS authority requirements or eligibility for a specific medicine?*

Response	%
Very confident	34%
Somewhat confident	24%
Neither confident nor unconfident	27%
Somewhat unconfident	9%
Very unconfident	7%

Weighted percentages; n = 3,992. Totals may not sum to 100% due to rounding.

Confidence followed a different pattern to understanding. While understanding rose with the number of health conditions a person managed, confidence did not. In the raw data, those with health conditions appeared more confident, but after adjusting for age and other factors, having one or more health conditions was no longer significantly associated with greater confidence in asking a doctor about PBS requirements. Instead, confidence was driven almost entirely by age and by prior exposure to complex medicines. After adjustment, respondents aged 65 and over had four times the odds of reporting higher confidence compared with those aged 18-44, and those who had been exposed to biosimilar medicines were significantly more likely to feel confident, even after accounting for their age and health status. Apparent differences by income and location seen in the raw data also disappeared once age was taken into account, indicating that the confidence gap is fundamentally about experience and life stage rather than where someone lives or what they earn.

Together, these findings point to a system where knowledge of how medicines are accessed tends to accumulate through experience rather than baseline general awareness. For patients who are newer to the system, younger, or managing their first significant health need, the combination of limited understanding and lower confidence may mean that authority requirements operate as a poorly understood, potentially invisible, layer of the access pathway. They shape what is available and on what terms, but without sufficient awareness, understanding or confidence to ask, patients may not know what they are missing or how to navigate it.

PBS Access Requirements

PBS access requirements create unequal burden

For some medicines listed on the PBS, access is not automatic at the point of prescription. Patients may be required to meet additional requirements before subsidised treatment can begin or continue. These can include attending regular specialist appointments to maintain eligibility, completing ongoing pathology or blood testing, waiting for a defined period before access is approved, trying a different medicine first before the preferred treatment is subsidised, or in some cases, waiting for their condition to worsen before meeting the clinical threshold for access. These requirements are built into the PBS framework to support appropriate prescribing, but they also create a set of conditions that patients must satisfy, even when both the patient and their treating clinician believe the medicine in question is the most appropriate treatment from the outset.

Almost two thirds of respondents (64%) had not encountered any of these requirements before accessing a PBS-listed medicine. Among those who had, the most common were ongoing specialist appointments (17%) and regular blood testing (16%) to maintain eligibility, followed by waiting periods (11%), being required to try a different medicine first (10%), and waiting for their condition to worsen (8%).

Table 3. *Have you experienced any of the following before you were able to access a medication via PBS funding? (Select all that apply)*

Response	%
None of the above	64%
Attending regular specialist appointments to remain eligible	17%
Completing regular blood (pathology) testing to remain eligible	16%
Having to wait for a period of time	11%
Required to try a different medication first	10%
Waiting for medical condition to get worse	8%
Other	3%

Weighted percentages; n = 3,992. Respondents could select more than one option, so totals exceed 100%.

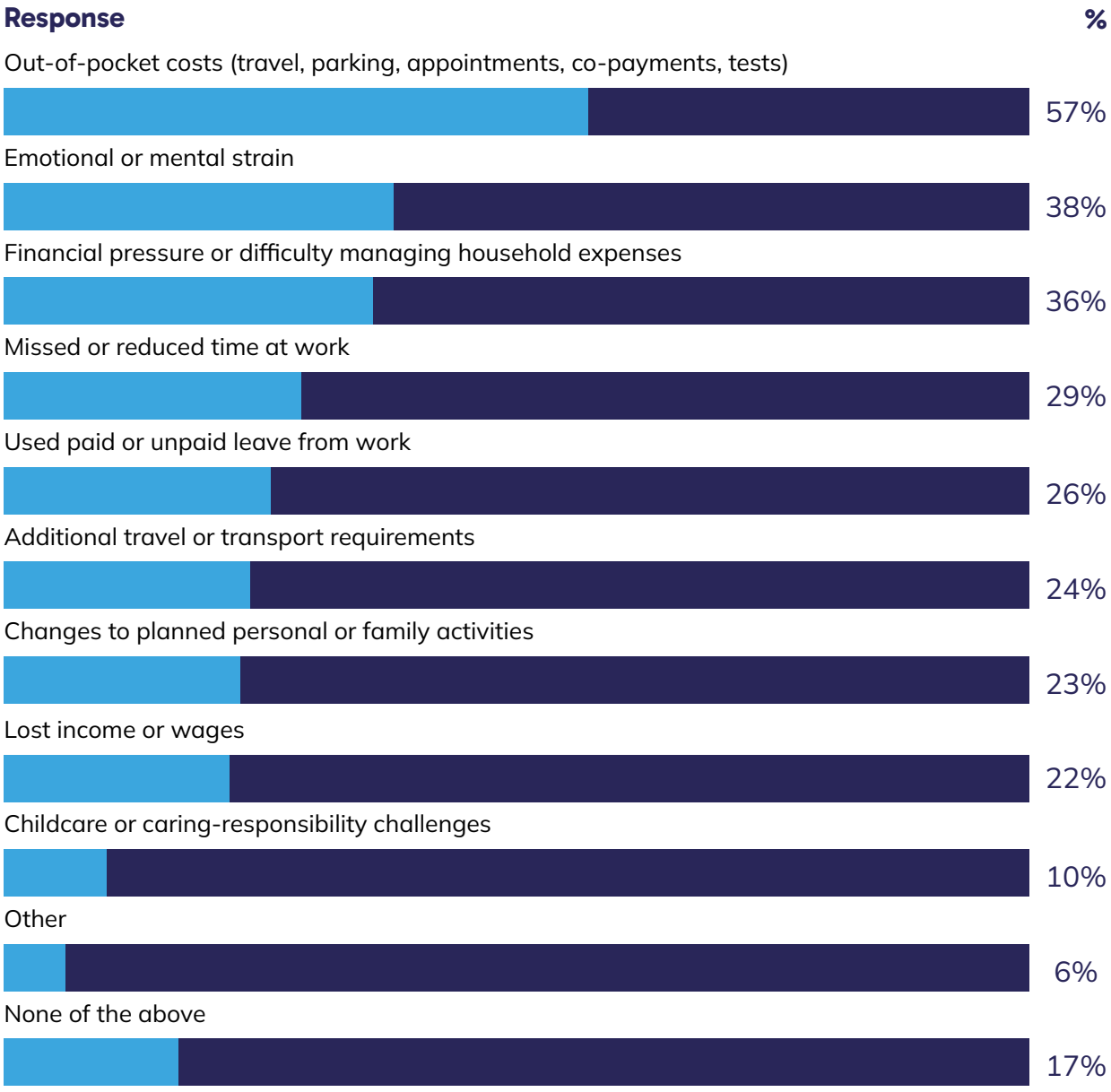
These requirements were concentrated among patients managing chronic and complex conditions. The likelihood of facing each requirement rose with the number of health conditions a person managed, and the increase was steepest for the more restrictive requirements. Patients managing more than one health condition were considerably more likely than those managing a single condition to report being required to try a different medicine first, to wait for their condition to worsen, and to attend ongoing specialist appointments to remain eligible.

Age also shaped exposure independently of health status. After adjustment, older respondents were consistently less likely to encounter most requirements: those aged 65 and over were 77% less likely to report waiting for their condition to worsen, 67% less likely to report trying a different medicine first, and 69% less likely to report waiting periods, compared with those aged 18-44. Prior exposure to biosimilar medicines was independently associated with two specific requirements, ongoing specialist appointments (around twice the odds) and regular

blood testing (82% higher odds), consistent with the monitoring regimes attached to these medicines. Sex was largely not associated with most requirements after adjustment, with one exception: women were almost twice as likely as men to report having to wait for their condition to worsen before gaining access, a difference that held after adjustment.

Meeting these requirements came at a cost. Among respondents who experienced PBS access requirements, the most common result was out-of-pocket spending on things like appointments, tests and travel (57%), followed by emotional or mental strain (38%) and financial pressure or difficulty managing household expenses (36%). Many also reported impacts on their work, including missed or reduced hours (29%), use of paid or unpaid leave (26%), and lost income or wages (22%).

Table 4. *As a result of the access requirements you experienced, did you experience any of the following? (Select all that apply)*



Weighted percentages; n = 1,457 (respondents who experienced at least one access requirement). Multiple responses permitted.

These costs were not borne evenly. After accounting for all other factors, respondents with more than one health condition were more than twice as likely to report out-of-pocket costs, and more than three times as likely to report both financial pressure and emotional strain, than those with no health condition. The same group most likely to face access requirements in the first place was therefore also the most likely to carry the financial and emotional weight of meeting them. Women were independently more likely to report emotional strain (around 60% higher odds after adjustment), even though they were not more likely than men to face most of the underlying requirements, pointing to a difference in how the burden is experienced rather than simply how often it occurs.

Where access requirements created lost income, out-of-pocket costs or financial pressure, respondents managed in ways that reached into the rest of their lives. More than half reduced spending in other areas (56%), around four in ten reduced healthcare use or delayed treatment (39%), and more than a third delayed or missed bill payments (37%) or borrowed money from friends or family (36%). The adjusted models show that income, not health status, was the dominant driver of these coping behaviours. Compared with high-income respondents, those on low incomes were more than ten times as likely to borrow money from family or friends, almost nine times as likely to apply for income support or draw on superannuation, and more than twice as likely to delay or miss bills, all after adjustment. The most financially destabilising responses to the cost of access were concentrated almost entirely among those with the least capacity to absorb them.

Table5. *Have you had to make any of the following changes to accommodate the lost income, out-of-pocket costs or financial pressures? (Select all that apply)*

Response	%
Reduce spending in other areas	56%
Reduce healthcare use or delay treatment	39%
Delay or miss bill payments	37%
Borrow money from friends or family	36%
Take extra shifts at work	21%
Apply for income support	18%
Take out a loan or increase existing debt	14%
Draw on superannuation	14%
Other	3%
None of the above	18%

Weighted percentages; n = 1,018 (respondents who reported lost income, out-of-pocket costs or financial pressure). Multiple responses permitted.

These findings show that the medicines access burden is distributed unevenly across the patient population. It can be expected that the requirements fall most often on patients managing chronic and complex conditions, as they are the patients who use the most medicines and have the most ongoing contact with the system. What should not be expected, in an equitable system, is that the financial consequences of meeting those requirements fall hardest on those with the least capacity to absorb them. For many patients the cost of access is not measured only in co-payments, but in time away from work, emotional strain, and trade-offs that reach into household budgets and long-term savings. Requirements meant to ensure medicines are used appropriately should not themselves become a barrier to treatment, particularly for the patients who face them most often and can least afford it.

Non-PBS Medicines

Non-PBS medicines expose affordability gaps

Not every medicine a patient needs is listed on the PBS. Some are not yet approved by the TGA for use in Australia, some are TGA approved and moving through the PBS assessment and listing process, some have been considered but are not listed, and others are listed but funded only for particular conditions, leaving patients who need them for a different indication to pay the full cost.

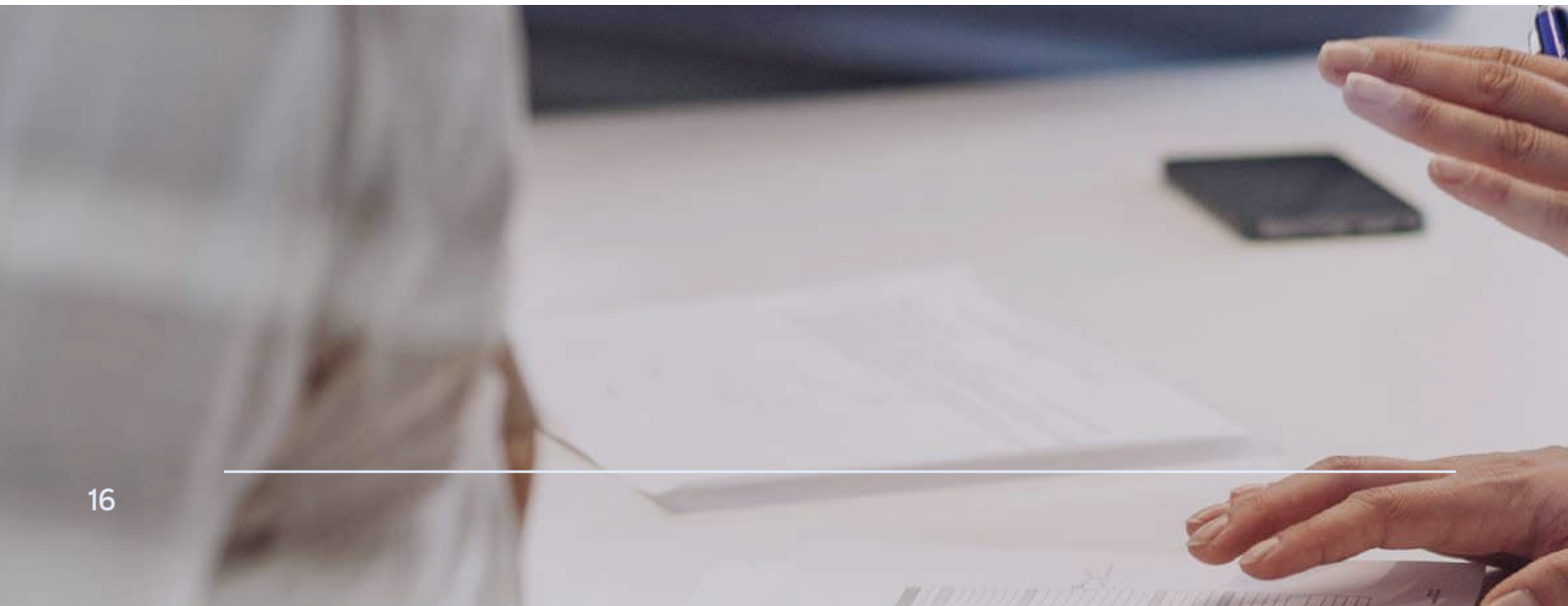
When a medicine sits outside the PBS, the patient either meets its price privately, without the subsidy that applies to listed medicines, or accesses it through alternative pathways such as a manufacturer's compassionate access program. For an inexpensive short course this may be a minor cost, but for ongoing treatment or a high-cost medicine it can place the treatment a clinician considers most appropriate beyond a patient's financial reach. This section examines how often patients encountered a medicine not covered by the PBS, what they did in response, and how heavily the cost fell.

Half of respondents (50%) reported that they or a family member had required a medicine not covered by the PBS at some point, including 37% who had done so in the past year and a further 13% earlier than that. A further 24% were unsure, leaving only 27% who said they had not encountered this situation. This suggests that non-PBS medicines are not a marginal issue for respondents. For many households, the medicine they need sits outside the main subsidy pathway.

Table 6. *Have you or a family member ever required a medicine that was not covered by the PBS?*

Response	%
Yes, in the past year	37%
Yes, more than a year ago but less than five years ago	9%
Yes, more than five years ago	4%
No	27%
Unsure	24%

Weighted percentages; n = 3,992. Totals may not sum to 100% due to rounding.



Recent need for a non-PBS medicine was strongly linked to managing illness, and this held firmly after adjustment. Compared with those with no health condition, respondents with one health condition were twice as likely, and those with more than one condition were around five times as likely, to have required a non-PBS medicine in the past year, after accounting for age, sex, income and other factors. Women were also independently more likely to report this need, at around 87% higher odds than men after adjustment, a sex difference that persisted across every time period examined. Age played a more limited role once other factors were controlled for, and income showed no consistent independent effect on whether a non-PBS medicine was needed. The most common response to needing a non-PBS medicine was to pay for it directly: 79% of those affected paid out of pocket. A substantial minority, however, changed or delayed their care because of cost, with 21% delaying treatment, 12% asking for a PBS-covered alternative, and 10% switching to a less effective or less preferred medicine.

Table 7. *Thinking about that experience, did any of the following occur as a result? (Select all that apply)*

Response	%
I paid out-of-pocket for the medicine	79%
I delayed starting treatment because of the cost	21%
I asked for an alternative medicine covered on the PBS	12%
I switched to a less effective or less preferred medicine	10%
Other	5%

Weighted percentages; n = 1,983 (respondents who needed a non-PBS medicine). Multiple responses permitted.

How people responded depended heavily on their circumstances. Paying out of pocket rose with age, with those aged 65 and over more than twice as likely as those aged 18-44 to absorb the cost directly after adjustment. The more concerning responses, delaying or compromising treatment, were concentrated among those with the least financial capacity. After adjustment, low-income respondents were twice as likely as high-income respondents to delay starting treatment because of cost, and twice as likely to switch to a less effective or less preferred medicine. Those managing more than one health condition were also more than twice as likely to delay treatment, independent of income. In other words, the people least able to afford an unsubsidised medicine, and those with the most at stake clinically, were the most likely to go without or settle for a lesser option.

The impact of needing a non-PBS medicine was frequently substantial. More than half of those affected described the impact on themselves or their family as moderately, very or extremely severe (53%). Severity was not evenly distributed. After adjustment, respondents with more than one health condition were twice as likely to report greater severity, low-income respondents were more than twice as likely, and middle-income respondents twice as likely, compared with high-income respondents. Women were also independently more likely to report greater severity, at around 30% higher odds than men. These are the same groups that were more likely to need a non-PBS medicine in the first place and more likely to compromise their treatment in response, compounding disadvantage at each stage of the pathway.

Table 8. *Overall, how severe was the impact on you or your family?*

Response	%
Extremely severe	9%
Very severe	14%
Moderately severe	30%
Slightly severe	25%
Not severe at all	23%

Weighted percentages; n = 3,992. Totals may not sum to 100% due to rounding.

Non-PBS medicines are a clear pressure point in medicine access. Some households can meet the cost directly. Others delay treatment, seek a subsidised alternative, or accept a less preferred medicine. The burden falls most heavily, and most consistently, on those managing multiple health conditions, those on lower incomes, and women.

For these patients, a medicine falling outside the PBS shapes not only their treatment but their household finances, and the same groups carry that cost at every stage: they are more likely to need an unsubsidised medicine, more likely to compromise their treatment because of it, and more likely to feel the impact severely.

Medicine Shortages

Medicines shortages disrupt continuity of care, and support is often reactive

The causes of medicine shortages sit largely outside the patient's control, and often outside Australia's. A problem in one part of the global supply chain, or demand surging, can leave Australian pharmacies unable to fill a prescription with little warning. For patients, the cause matters less than the effect: the medicine they rely on is not there when they need it. This section examines how often patients encountered a shortage, what it meant for their treatment, and what support they received when it happened.

Almost half of respondents (48%) had experienced difficulty getting a medicine at the pharmacy because of a shortage, and one third (33%) had experienced this in the past 12 months. Just over half (52%) said they had never had trouble accessing a medicine due to a shortage.

Table 9. *Have you ever had trouble getting a medicine because it was not available at the pharmacy due to a shortage?*

Response	%
Yes, many times in the last 12 months	7%
Yes, several times in the last 12 months	8%
Yes, once or twice in the last 12 months	18%
Yes, but not in the last 12 months	16%
No, never had trouble due to shortages	52%

Weighted percentages; n = 3,992. Totals may not sum to 100% due to rounding.

Respondents managing more health conditions reported shortages more often, though this may reflect their greater use of medicines and therefore more occasions on which a shortage could occur. More telling was the link to specialised medicines: respondents who had been exposed to a biosimilar were more than three times as likely to report experiencing shortages many times in the past year, after adjustment. Age and sex played smaller and less consistent roles, with middle-aged respondents and women somewhat more likely to report occasional shortages.

The most common consequence of a shortage was having to visit multiple pharmacies (42%), followed by stress or worry (34%), extra time or effort such as phone calls (28%), and missed doses (27%). Smaller proportions took a lower dose to make their medicine last longer (15%) or reported worsened health conditions or symptoms (13%).

Table 10. How did difficulty getting this medicine affect you or your family? (Select all that apply)

Response	%
Had to visit multiple pharmacies to get the medicine	42%
Caused stress or worry	34%
Took extra time or effort (e.g. phone calls)	28%
Missed one or more doses	27%
Caused confusion about what to do next	16%
Led to additional costs	16%
Took a lower dose to make medicine last	15%
Worsened health condition or symptoms longer	13%
Had little or no impact	17%
Other	5%

Weighted percentages; n = 1,913 (respondents who experienced a shortage). Multiple responses permitted.

When shortages occur, their clinical impact is greater for patients managing complex illness. Respondents with more than one health condition were five times as likely to report that a shortage worsened their health or symptoms, after adjustment. This group was also more likely to miss doses or take a lower dose to make a medicine last, and three times as likely to report stress or worry.

Almost half of those affected by a shortage (47%) described the impact as moderately, very or extremely severe.

After adjustment, respondents with more than one health condition were almost twice as likely to report greater severity, while low income respondents were more than twice as likely and middle-income respondents around 73% more likely than high-income respondents to do so. The financial cushion available to a household shaped how heavily a shortage landed, independent of how often it occurred.

Support during shortages was inconsistent. Around one in three respondents said their pharmacist gave

them information on next steps (32%), while 19% received clear guidance on alternative medicines and 24% needed to return to their prescriber to discuss options. Advance warning was uncommon, with only 14% informed in advance by a pharmacist and 10% by their prescriber. Notably, the adjusted models found very few patient characteristics predicted who received proactive support, suggesting that the quality of communication during a shortage depended more on the particular pharmacy or prescriber than on the patient. The main exceptions were that respondents with more than one health condition were more likely to need to return to their prescriber, and that those exposed to biosimilar medicines were more likely to receive clear guidance on alternatives, both after adjustment.

Table 11. *When your medicine was unavailable due to the shortage, which of the following occurred? (Select all that apply)*

Response	%
Pharmacist gave information on next steps to get my medicine	32%
I needed to return to my prescriber to discuss options	24%
Pharmacist gave clear guidance on alternative medicines	19%
Pharmacist informed me in advance	14%
Prescriber/doctor informed me in advance and provided guidance	10%
None of the above	20%
Other	7%

Weighted percentages; n = 1,913 (respondents who experienced a shortage). Multiple responses permitted.

Patients cannot prevent a shortage, and nor in most cases can their pharmacist or prescriber, because the immediate causes lie upstream in global supply. That makes shortages a problem to be managed on two fronts. On the supply side, government has levers that patients and clinicians do not, including stockholding requirements, supply chain resilience and the regulatory and pricing settings that influence whether companies continue to supply the Australian market. On the patient side, the survey points to a clear and more immediate gap: support during a shortage was not matched to need, with opportunity to improve provision of advance warning and advice and guidance on alternatives when a shortage does occur.

Biologic and Biosimilar Medicines

Biosimilar confidence depends on clinical reassurance

Biologic medicines are complex treatments derived from living cells, used for conditions such as autoimmune disease, cancer and diabetes. Biosimilar medicines are highly similar versions of an existing biologic, approved as equivalent in safety and effectiveness and typically offered to payer (government or PBS) at the lower cost to the originator medicine. Because these medicines are costly and clinically significant, the way patients experience being offered, prescribed or switched to them is an important part of the access picture.

Biologic medicines had been prescribed to 13% of respondents, and use was usually recent: 64% of those prescribed a biologic had used one in the past year. Prescription was concentrated among people managing health conditions, as expected given what biologics treat: respondents with one or more health conditions were more than four times as likely to have been prescribed one. Lower-income respondents were also more likely than high-income respondents to have been prescribed a biologic, after adjustment.

Table 12. *Biologic prescription and recency of use*

Response	%
Ever prescribed a biologic medicine	13%
Of those prescribed: used in the past year	64%
Of those prescribed: one to five years ago	28%
Of those prescribed: more than five years ago	9%

Weighted percentages; n = 1,913 (respondents who experienced a shortage). Multiple responses permitted.

Around one in ten respondents had been offered a biosimilar (11%), but fewer than half of those offered one went on to be prescribed it (43%). Once prescribed, however, almost all patients went on to try it (89%).

The drop-off sat between being offered and being prescribed, not in patient follow-through, locating the gap in whether an offer becomes a prescription rather than in patient willingness once it does.

Table 13. *The biosimilar pathway: offered, prescribed and tried*

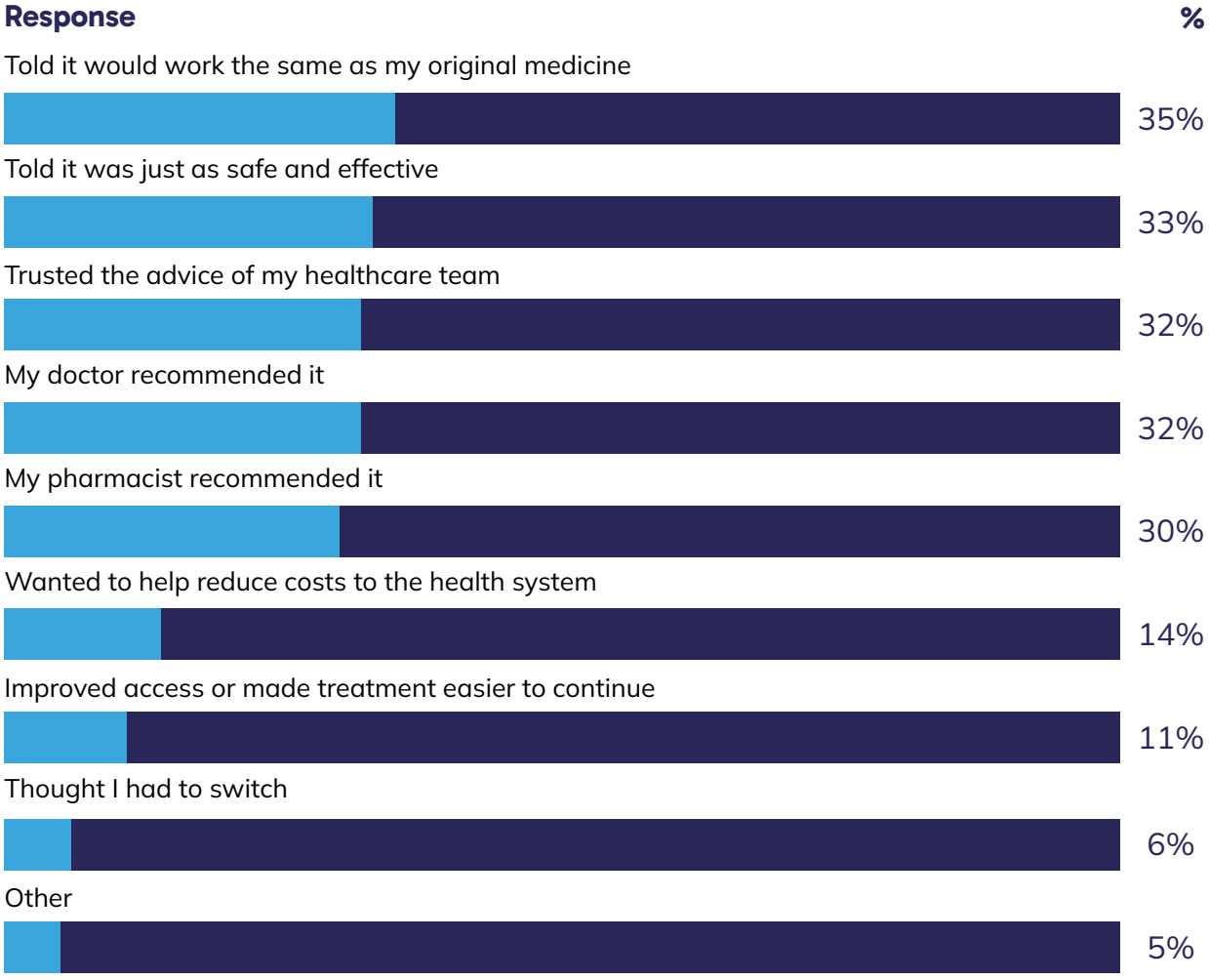
Stage	% of all respondents	Conditional rate
Offered a biosimilar	11%	–
Prescribed a biosimilar	5%	43% of those offered
Tried a biosimilar	4%	89% of those prescribed

Weighted percentages; base n = 3,992 for offered. Conditional rates are calculated within the preceding stage.

Two patterns in who was offered a biosimilar stood out after adjustment, beyond the expected link to managing a health condition. Low-income respondents were more likely to have been offered one than high-income respondents (around 93% higher odds), and among those offered a biosimilar, women were more likely than men to go on to be prescribed it (around 83% higher odds). At the final step, no measured characteristic predicted whether a patient who was prescribed a biosimilar went on to try it, consistent with the high uptake at that stage and reinforcing that the pathway narrows before prescription, not after.

For respondents who tried a biosimilar, the decision was most often linked to reassurance about safety and effectiveness and to trusted clinical advice. Around one third said they tried a biosimilar because they were told it would work the same as their original medicine (35%), were told it was just as safe and effective (33%), trusted the advice of their healthcare team (32%), or had their doctor recommend it (32%). Pharmacist recommendation was also common (30%). Far fewer cited reducing costs to the health system (14%) or improved access (11%). The adjusted models found few demographic patterns in these reasons, reinforcing that the decision to try a biosimilar rests on clinical reassurance and trust rather than on patient characteristics; the main exception was that patients in non-metropolitan areas were less likely to cite a doctor's recommendation as their reason, after adjustment.

Table 14. *Reasons for trying a biosimilar (Select all that apply)*



Weighted percentages; n = 163 (respondents who tried a biosimilar). Multiple responses permitted. Small base; interpret with caution.

Comfort with substitution was notably lower for biosimilar medicines than for generic medicines. Around three quarters of respondents said they would feel very or somewhat comfortable if a pharmacist offered a generic version of their medicine (73%), compared with 59% for biosimilar medicines. Biosimilar medicines also drew a larger neutral response (27% neither comfortable nor uncomfortable, compared with 18% for generics), indicating a sizeable group who may need clearer information before feeling at ease with substitution.

Table 15. *Comfort if a pharmacist offered a generic or a biosimilar medicine*

Comfort level	Generic	Biosimilar
Very comfortable	48%	31%
Somewhat comfortable	25%	28%
Neither comfortable nor uncomfortable	18%	27%
Somewhat uncomfortable	5%	8%
Very uncomfortable	4%	6%

Weighted percentages; n = 3,992. Columns may not sum to 100% due to rounding.

Prior exposure was the strongest driver of comfort with biosimilar medicines, with those who had encountered one before more comfortable than those who had not, whereas for generics prior exposure made no difference, potentially because generics are more widely familiar and trusted. Biosimilar medicines appear to be at an earlier stage of acceptance, where direct experience still shapes how patients feel.

After adjustment, people who had been exposed to a biosimilar were more comfortable with the idea of being offered one than people who had not. Comfort was also somewhat higher among respondents aged 45 to 64 than the youngest group, and lower among those on low incomes than those on high incomes.

The biosimilar findings point to a clear opportunity. Patients are willing: once a biosimilar was prescribed, almost all went on to take it, and their decision rested on reassurance that it was safe, effective and equivalent to their original medicine. The gains are to be found at two points. The first is the step between a biosimilar being offered and being prescribed, where uptake currently falls away and where understanding what happens in that interaction could make the difference. The second is patient comfort, which was lower for biosimilar medicines than for generics but grew with familiarity and with clear, trusted clinical advice. Both are addressable through the point of care: supporting consistent conversations about safety and equivalence when a biosimilar is raised, so that confidence keeps building. As with generics, comfort is likely to grow as biosimilar medicines become more familiar, and the foundation of patient willingness is already in place to build on.

System Fairness and Reform

Biosimilar confidence depends on clinical reassurance

Whether patients see the medicines system as fair captures their sense of whether the system works for people in their circumstances. Respondents were asked how fair they felt the system was for people like them and views on the fairness of the medicines access system were divided. Just over half of respondents (56%) felt the system was fair for people like them. Around one in five were neutral (22%), while almost one quarter (24%) felt the system was unfair.

Table 16. *When trying to access medicines, how fair do you feel the system is for people like you?*

Response	%
Very fair	27%
Somewhat fair	29%
Neither fair nor unfair	22%
Somewhat unfair	17%
Very unfair	7%

Weighted percentages; n = 3,992. Totals may not sum to 100% due to rounding.

The adjusted analysis shows that perceptions of fairness were shaped most strongly by health status, sex and age, independent of one another and of income and location. After adjustment, respondents with more than one health condition were 38% less likely to perceive the system as fair than those with no health condition, while no significant difference was found for those with a single condition, indicating that it is the cumulative experience of complex illness, rather than any illness, that erodes confidence in the system's fairness.

After adjustment, women rated the system as fair less often than men, a substantial and independent gap. Older respondents held more favourable views, with those aged 65 and over more likely than those aged 18-44 to see the system as fair. Income and location were not independently associated with perceived fairness once these other factors were accounted for.

Fairness, then, is not felt evenly, and the pattern is not random. The groups least likely to see the system as fair, those managing multiple conditions and women, are the same groups this report finds carrying the heaviest practical, financial and emotional burden across the access pathway. This suggests that how fair patients judge the system to be reflects what they have actually experienced of it, rather than general attitudes or awareness. Confidence in the system is therefore most likely to improve not through better messaging, but by easing the real burden on the patients who currently bear the most, so that their experience of access gives them less reason to consider it unfair.

Patients prioritise affordability and access

The findings so far describe how patients experience the medicines system as it is. This final section turns to what they want changed. Respondents were asked to identify the changes that would make the biggest difference to access, offering a direct, patient-defined agenda for reform and a clear sense of where effort would be felt most.

Affordability and timely access to care were the clear priorities. More affordable co-payments and out-of-pocket costs was the most frequently identified priority (40%), closely followed by better access to specialists and shorter wait times (39%). Faster PBS listing decisions for new medicines was the next most common priority (28%).

Table 17. *What changes would make the biggest difference to improving access to medicines? (Select up to three)*

Response	%
More affordable co-payments and out-of-pocket costs	40%
Better access to specialists and shorter wait times	39%
Faster PBS listing decisions for new medicines	28%
Clearer information about options and eligibility	22%
More rapid access to government funding for new medicines	21%
Broader access to government funding for new medicines	19%
More consistent supply and pharmacy availability	18%
Fewer administrative barriers (approvals, paperwork)	17%
Better support for rural and remote patients	15%
Greater use of biosimilar medicines where appropriate to reduce costs	13%
Greater use of biosimilar medicines where appropriate to reduce costs	12%

Weighted percentages; n = 3,992. Respondents could select up to three options, so totals exceed 100%.

These priorities point to two practical pressure points: the cost of accessing care and medicines, and the time it takes to reach the right treatment. While broadly consistent across groups, the order shifted in revealing ways. Younger adults most commonly prioritised affordability, while those aged 65 and over placed faster PBS listing decisions first, ahead of specialist access and out-of-pocket costs (42% of those aged 65 and over, compared with 19% of those aged 18-44). Respondents with multiple health conditions placed greater emphasis on access to new medicines, with 35% prioritising faster PBS listing decisions compared with 19% of those with no health condition, alongside higher priority on more rapid and broader government funding for new medicines.

Information and navigation were secondary but important. Around one in five respondents prioritised clearer information about options and eligibility (22%), more rapid access to government funding for new medicines (21%), and broader access to government funding (19%). Medicine supply and pharmacy availability were identified by 18%, and fewer administrative barriers by 15%. Regional needs were far more visible outside the major cities: better support for rural and remote patients was selected by 22% of non-metropolitan respondents, compared with 10% of metropolitan respondents, marking a distinct access concern for people outside major centres.

The priorities patients identified map directly onto the friction points described throughout this report: the cost of medicines and consultations, barriers to accessing specialists, the time between a medicine being approved and subsidised, the clarity of information available, and the reliability of supply. Taken together, they describe a system that patients want to be faster to move through, cheaper to participate in, and easier to understand.

System Fairness and Reform

Biosimilar confidence depends on clinical reassurance

The PBS remains a cornerstone of equitable access to medicines, but the findings show that barriers persist across several stages of the access pathway. These barriers are not felt uniformly. They fall most often on patients managing multiple health conditions and, when cost is involved, on those with lower incomes. Women report a heavier experience on several measures. Two themes run through the findings: the system relies on patients to understand it, ask the right questions and absorb cost without ensuring they are equipped to, and what a patient can do when access carries a cost is shaped by their income.

Patients prioritise affordability and access

Patients' understanding of PBS authority requirements is limited. Most respondents had little understanding of how these requirements affect access to their medicines or were unaware of them entirely. Understanding appeared to develop through repeated interaction with the health system, leaving those newest to the system least equipped to navigate it.

A conversation with a clinician is one way to close this gap, but confidence to have it was unevenly distributed. Only 58% of patients felt confident raising PBS eligibility or authority requirements, and confidence was not linked to the number of health conditions an individual lived with. Younger patients and those without prior exposure to biosimilar medicines were the least likely to initiate these conversations, so the patients who most needed to ask were among the least likely to.

An information gap that relies on patients to close it will not close for those who need it most. Plain-language information offered at the point of prescribing, rather than left for patients to seek out, would reach patients who currently navigate these decisions without understanding them.

PBS access requirements create burden for patients managing chronic and complex conditions

The burden of meeting PBS access requirements extends beyond administrative inconvenience. Patients who encountered requirements such as specialist reviews, pathology testing, waiting periods, or being required to try another medicine first frequently reported out-of-pocket costs, emotional strain, and disruption to work and family life.

These requirements support the appropriate use of subsidised medicines, but the cost of meeting them can itself become a barrier, contributing to financial hardship and, where access to the most appropriate treatment is delayed, potentially to poorer health outcomes.

The financial consequences fell unevenly. When meeting a requirement created financial pressure, low-income patients were far more likely than high-income patients to absorb it in ways that reached into household stability, including delaying or missing bill payments, borrowing money, and drawing on savings or superannuation. The requirements may be reasonable individually, but their cost is not borne equally, and it falls hardest on the households least able to carry it. decisions without understanding them.

Patients face difficult trade-offs when medicines fall outside PBS funding

Half of respondents had needed a medicine not covered by the PBS at some point. Most paid out of pocket, but those who could not afford to delayed treatment, sought a PBS-covered alternative, or accepted a less effective or less preferred medicine. These responses were concentrated among lower-income patients, who were around twice as likely as high-income patients to delay starting treatment or switch to a less effective medicine because of cost. More than half of all those affected described the impact as moderately to extremely severe.

When a clinically appropriate medicine is not subsidised, it remains available to patients who can pay privately and out of reach for those who cannot. Access turns on capacity to pay rather than clinical need, creating a two-tier outcome for the same medicine. This cannot be resolved by affordability support for individuals alone, because the barrier is whether and how quickly a medicine is listed. The time between TGA approval and PBS listing, and the readiness with which clinically appropriate medicines are listed, therefore shape how widely and how equally patients can access them.

Medicine shortages create preventable burdens for patients

Nearly half of respondents had experienced difficulty obtaining a medicine because of a shortage, often resulting in stress, missed doses, additional effort, and in some cases worsening symptoms. Support during a shortage was inconsistent: most patients received no warning, and too few received useful guidance.

The causes of shortages lie upstream. Government holds levers to alleviate medicines shortage burden, with respect to stockholding requirements, supply-chain resilience, and the settings that affect whether companies continue supplying the Australian market.

Biosimilar uptake is shaped by confidence, familiarity and the offer-to-prescription pathway

Patient willingness is not the obstacle to biosimilar use. Uptake among patients who were prescribed a biosimilar was high, with almost all going on to try it, and their decision rested on reassurance that it was safe, effective and equivalent to their original medicine rather than on cost.

There is a notable fall-off between a biosimilar being offered and being prescribed: fewer than half of patients offered one were then prescribed it. The survey cannot determine why so many offers do not lead to a prescription, but it points to that step as the place to look, including how the offer is communicated, whether patients leave with unresolved questions about safety or equivalence, and the clinical and system factors that influence whether an offer becomes a prescription.

Comfort with biosimilar medicines was consistently lower than comfort with generic medicines and was most strongly associated with prior exposure. Patients who had experience with biosimilar medicines were more comfortable with them, and trusted advice from healthcare professionals and reassurance about safety and effectiveness featured prominently in patients' decisions. Confidence in biosimilar medicines is built through experience and clear clinical communication, which suggests that equipping prescribers and pharmacists to provide consistent reassurance, particularly when a change is driven by funding or supply rather than patient choice, is a direct way to support uptake.

Women report a heavier experience that warrants examination

Women reported a heavier experience of the system than men on several measures, and in key cases this held after adjustment even where they were no more likely to face the underlying barrier. They were more likely to report needing a non-PBS medicine, to report emotional strain, to wait for their condition to worsen before becoming eligible for treatment, and to regard the system as unfair. The size and consistency of the pattern is reason to look further, both at why women report a heavier experience of the same barriers and at whether the medicines they more often need are less likely to be subsidised.

Patients prioritise affordability, timely care and faster access to new medicines

Patients identified clear priorities for reform: more affordable co-payments and out-of-pocket costs, better access to specialists, and faster PBS listing decisions for new medicines. These align closely with the barriers identified throughout the report and offer a patient-informed basis for policy. Improving medicines access is not only a matter of funding medicines, but of reducing the administrative, financial, informational and logistical barriers that stand between patients and the treatment they need.

Conclusion

Australia's medicines access system delivers substantial benefits to millions of people through the PBS and related programs. This report shows that gaps remain between the availability of medicines and patients' ability to access them in practice, and that these gaps are not randomly distributed.

The system works well for many patients but creates disproportionate difficulty for those managing complex illness, those on lower incomes, and, on several measures, women. Barriers arise at multiple points along the pathway: limited understanding of PBS processes, the requirements attached to access, delays in subsidy decisions, the cost of non-PBS medicines, shortages, and inconsistent support. Their consequences extend beyond healthcare into financial hardship, emotional strain, disrupted work, and compromised treatment decisions, and they fall most heavily on the patients with the least capacity to absorb them.

Equitable access requires more than making medicines available. It requires a system that is understandable, affordable, timely and responsive to patients' needs. The experiences captured in this report offer an evidence base for policymakers, clinicians and health system leaders working to ensure Australia's medicines framework delivers not only clinical effectiveness but fairness for all patients.

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Authors

Lisa Robins, Patients Australia, CEO
Gowri Rajaram, Patients Australia, Research Manager

Publisher

Patients Australia

Report design

Sandoz Pty Ltd

Email for general queries

hello@patients.org.au

Web

patients.org.au

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