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Research Letter

Medication Use by Indigenous and Non-Indigenous Australians After a Pharmaceutical Co-Payment Subsidy

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Introduction

Through self-determination, community-led service models support healthy communities and promote equitable access to health care for Aboriginal and Torres Strait Islander peoples (hereafter Indigenous Australians). Yet, structural barriers contribute to poorer health outcomes among Indigenous Australians, including a life expectancy over 8 years shorter than the general population (eAppendix in Supplement 1).[1,2] Chronic conditions, especially cardiovascular disease and diabetes, are major contributors to this gap.[2] Effective management requires long-term adherence to medications for blood pressure, cholesterol, and blood glucose control. However, out-of-pocket (OOP) costs can limit access to essential treatments.

In 2010, the Australian government implemented the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-Payment Program initially for Indigenous Australians with chronic disease or risk factors and, in 2020, to nearly all Indigenous Australians.[3] The policy reduced prescription co-payments from A$33.30 to A$5.40 for general patients (in 2024, A$1.44 = US$1.00). Indigenous Australians with concessional status (pensioners, low-income individuals, and welfare recipients) had co-payments waived entirely.

Prior studies using administrative data from older adults in New South Wales and patients with cardiovascular disease in Queensland found that the policy was associated with increased medication use and decreased OOP spending.[4,5] National-level data on long-term trends are lacking. This cohort study examined CTG uptake among Indigenous Australians and medication use and OOP spending among Indigenous and non-Indigenous Australians between January 2012 and December 2022.

Methods

We used the Person-Level Integrated Data Asset, which links demographic, health care, and taxation data for the Australian population.[6] The sample included all Indigenous Australians aged 15 years or older and a 5% random sample of non-Indigenous Australians in the 2011 census, linked to prescription data from 2012 to 2022. The University of Melbourne Human Research Ethics Committee approved the study, with waiver of informed consent because deidentified data were used. The study followed the STROBE reporting guideline.

We measured CTG registration using a binary indicator and examined uptake over time and across states and territories. We compared mean annual per-person prescription medication use and OOP spending (in A$) for Indigenous and non-Indigenous Australians with and without adjustment for age, sex, and concession status (eMethods in Supplement 1). Analyses were conducted in 2025, using Stata/MP, version 18.0.

Results

The study population included 249 199 Indigenous (median age, 35 years; 55% female; 45% male; 46% concessional) and 671 087 non-Indigenous (median age, 45 years; 52% female; 48% male;

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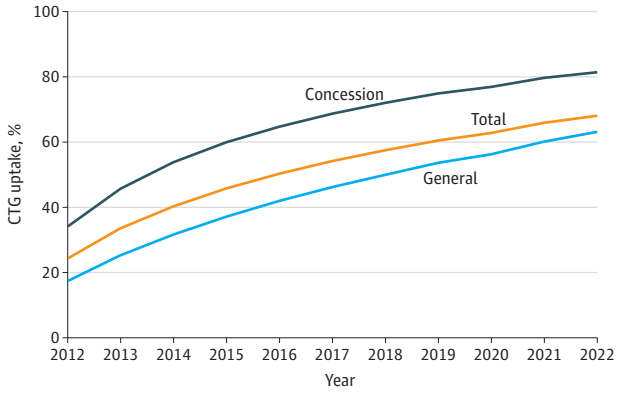
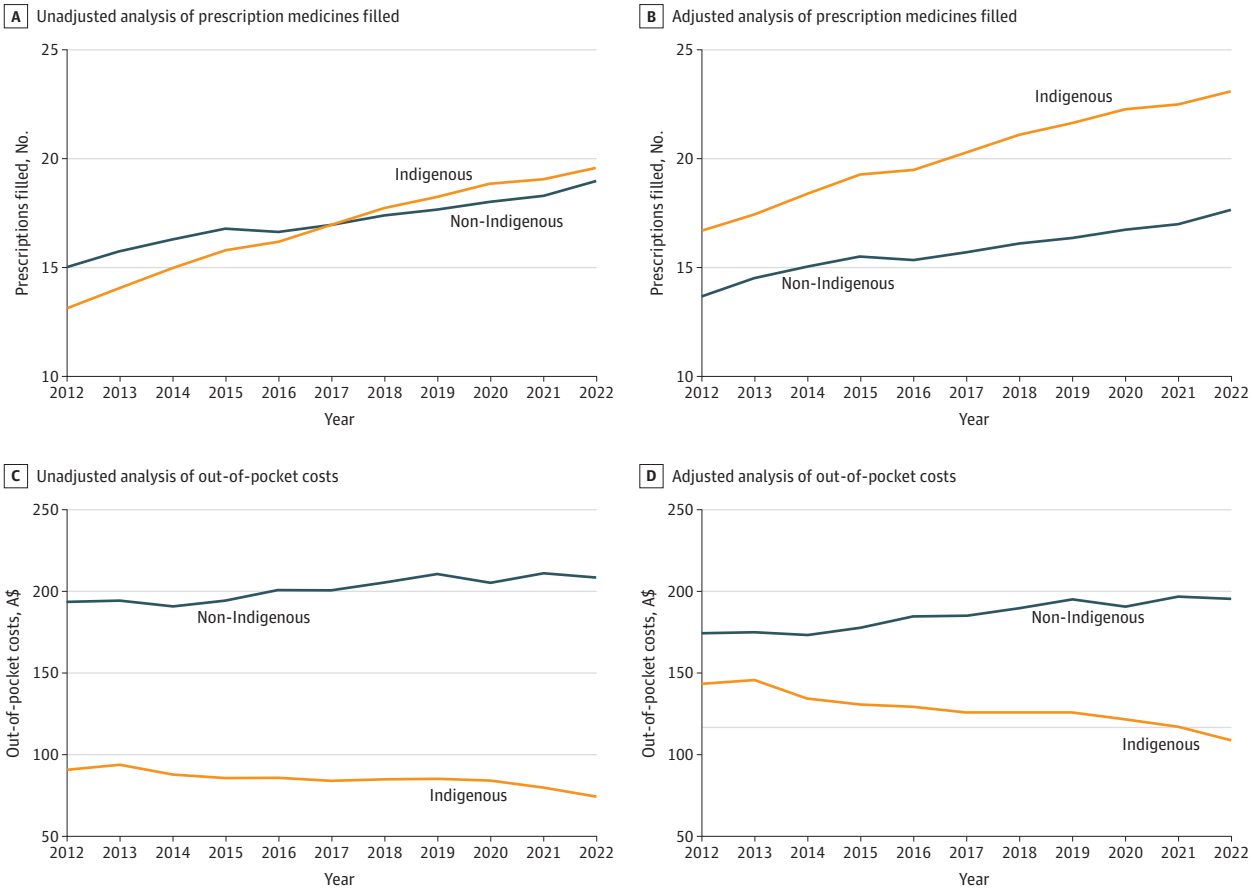
51% concessional) Australians. CTG registration among Indigenous Australians increased from 24.4% in 2012 to 68.0% in 2022, with higher uptake among concessional patients (**Figure 1**). Uptake in 2022 varied across regions, with lower rates in Northern Territory (46.2%), Tasmania (49.4%), and

Figure 1. Line Graph of Share of Indigenous Australians Who Registered With the Closing the Gap (CTG) Pharmaceutical Benefits Scheme Co-Payment Program Over Time, by Concessional Status



The denominator for general and concessional individuals was based on the first observed concessional status. The denominator for total individuals included all Indigenous Australians in the sample for each year.

Figure 2. Line Graphs of Temporal Trends in Prescription Medicine Use and Out-Of-Pocket Spending



All outcomes were the mean per person per year for Indigenous and non-Indigenous Australians. Adjusted analyses controlled for age group (5-year ranges starting with 15-19 years and ending with 70-74 years and ≥75 years), sex, and concession card status; 95% CIs are not shown. Out-of-pocket costs are presented in 2024 A$ (in 2024, A$1.44 = US$1.00). Prescription medications were those subsidized through the Pharmaceutical Benefits Scheme (PBS). Data for quarter 1 of 2012 were imputed within the total for 2012, as co-payment prescriptions were not captured in the PBS dataset before April 2012.

Canberra (55.9%) and higher rates in Queensland (73.0%), South Australia (72.0%), and New South Wales (71.5%). Adjusted mean annual prescription medication use increased from 16.7 (95% CI, 16.6-16.8) prescriptions in 2012 to 23.1 (95% CI, 23.0-23.2) prescriptions in 2022 among Indigenous Australians and from 13.7 (95% CI, 13.6-13.7) to 17.6 (95% CI, 17.6-17.7) prescriptions among non-Indigenous Australians (**Figure 2**A and B). The adjusted difference in use between groups increased from 3.0 (95% CI, 2.9-3.1) to 5.4 (95% CI, 5.3-5.5) prescriptions, from 2012 to 2022, respectively. Annual OOP spending among Indigenous Australians declined from $143.61 (95% CI, $142.88-$144.34) in 2012 to $109.04 (95% CI, $108.03-$110.05) in 2022 (change, −$34.57; 95% CI, −$35.73 to −$33.40) and increased among non-Indigenous Australians from $173.95 (95% CI, $173.52-$174.38) to $195.45 (95% CI, $194.84-$196.05) (change, $21.50; 95% CI, $20.75-$22.14) (Figure 2C and D).

Discussion

This national study found increased prescription medication use and reduced OOP spending among Indigenous Australians, compared with non-Indigenous Australians, following CTG implementation. CTG uptake increased markedly from 2012 to 2022, with 68.0% of Indigenous Australians registered by 2022. The 2020 expansion of eligibility may have contributed to these trends. These results suggest modest progress in reducing inequities in access. Limitations include the absence of prepolicy data, limited clinical information, and the influence of concurrent health promotion initiatives.

ARTICLE INFORMATION

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SUPPLEMENT 1.

eMethods.

eAppendix. Acknowledgment

SUPPLEMENT 2.

Data Sharing Statement