PULSE

PRIMARY CARE

Ballarat, Victoria

BENCHMARKED AGAINST NATIONAL AVERAGES · JULY 2026

THIS ISSUE'S LARGEST ESTIMATED TREATMENT GAP

An estimated 605K Australians with **COPD** may not be on PBS-listed therapy — about a **62.2%** gap against modelled disease burden.

BY AUSTRALIAN HEALTHCARE RESEARCH

Australian Healthcare Research analyses Commonwealth health data to surface treatment gaps and prescribing patterns at the local level. We put population-level evidence in the hands of clinicians, so more Australians can receive the care they need.

How to read this magazine

Each issue presents 14 chronic conditions with standardised metrics. The definitions below explain what each figure means and how to interpret it.

Prescribing vs national average

How local dispensing of a condition's main medicine group compares to the national average, shown as a percentage difference (e.g. −47% = about 47% fewer scripts per person than nationally; +12% = about 12% more). It is a crude population rate — not age-standardised — and is a comparison to the national average, not a judgement of prescribing or of care quality.

Estimated burden

The estimated total number of people living with the condition in this area, including those who may be undiagnosed. Estimates are age-standardised — meaning they account for the age structure of the local population rather than applying a flat national rate. Areas with older or higher-risk populations will show higher estimated burden than a flat national rate would suggest. Based on ABS NHS 2022 prevalence data, published under-diagnosis multipliers, and ABS Census 2021 LGA age structure.

Treatment gap

The estimated number of people with the condition who are not currently on PBS therapy, calculated against the age-standardised burden estimate for this area.

PPH rate

Potentially preventable hospitalisations per 100,000 residents — a population health indicator for hospitalisations associated with chronic conditions typically managed in primary care.

Care cascade

Shows the journey from estimated burden through to guideline-optimal treatment. Each stage represents a progressively smaller subset of patients receiving more complete care.

What's new on the PBS & TGA this quarter, methodology and a complete numbered reference list appear on the final six pages of this issue (pp. 32–37).

National Overview

Estimated disease burden, treatment rates and gaps across all 14 conditions — national figures based on ABS NHS 2022 prevalence data and PBS dispensing records. Turn to the page listed for each condition's full local spread.

CONDITION	EST. BURDEN	TREATMENT RATE	TREATMENT GAP	NATIONAL SCRIPT TREND (QOQ)	PAGE
Hypertension Cardiovascular	7.21M	84.1%	15.9%	▼ −8.1%	p. 4
Hypercholesterolaemia Cardiovascular	7.00M	74.3%	25.7%	▼ −4.6%	p. 6
Atrial Fibrillation Cardiovascular	1.03M	56.8%	43.2%	▼ −2.2%	p. 8
Heart Failure Cardiovascular	480K	26.1%†	73.9%†	▲ +8.6%	p. 10
Type 2 Diabetes Endocrine	1.40M	91%	9%	▲ +3.1%	p. 12
Chronic Kidney Disease Renal	3.00M	0.4%†	99.6%†	▲ +221.9%	p. 14
Depression & Anxiety Mental Health	5.71M	61.1%	38.9%	▲ +0.9%	p. 16
Migraine Neurology	4.90M	12%	88%	▲ +3%	p. 18
Asthma Respiratory	2.97M	41%	59%	▼ −0.2%	p. 20
COPD Respiratory	974K	37.8%	62.2%	▼ −4.9%	p. 22
GORD Gastro	2.44M	67.1%	32.9%	▼ −1.2%	p. 24
Osteoporosis Musculoskeletal	1.30M	47.9%	52.1%	▲ +3.2%	p. 26
Atopic Dermatitis Dermatology	2.81M	n/a‡	n/a‡	▲ +22.3%	p. 28
Psoriasis Dermatology	663K	n/a‡	n/a‡	▼ −3.6%	p. 30

Sources: ABS National Health Survey 2022 · PBS Date of Supply Jul 2021 – Jan 2026 · Under-diagnosis multipliers from published Australian epidemiological studies. All figures are national. Treatment gap = estimated burden − implied treated patients. QoQ = quarter-on-quarter change in national script volume (prior vs latest quarter in window). † Heart failure and chronic kidney disease show uptake of disease-specific advanced therapy plus the detection gap, not an all-therapy treatment rate — their foundational medicines are shared with other conditions (see Methodology). ‡ Atopic dermatitis and psoriasis are detection/referral spreads — no GP treatment rate or gap is computed (see Methodology).

CARDIOVASCULAR

Hypertension

REGULATORY WATCH 8 delisteds this quarter · 46 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

Approximately 1.4 million Australians with hypertension receive no pharmacotherapy, representing potentially preventable strokes, myocardial infarctions, and cardiovascular deaths[2]. An estimated 8.1 million Australians have hypertension based on ABS 2022 NHS objective blood pressure measurement (39% of adults); approximately 6.1 million are diagnosed, but only around 8.2 million scripts worth of treatment reaches the diagnosed population — a treatment gap of roughly 27% against true burden[123].

Generic ACE inhibitors and ARBs dominate the prescribing mix, led by perindopril (6.2 million scripts) and the sartans[1]. Single-pill combination formulations — dual-agent tablets such as Coveram (perindopril/amlodipine), Exforge (amlodipine/valsartan), Sevikar (olmesartan/amlodipine), and Twynsta (telmisartan/amlodipine), with triple-agent options including Sevikar HCT and Triveram — are proven to improve adherence and are now PBS-listed as initial therapy per updated Australian cardiovascular risk guidelines[4], yet remain a growing but still under-utilised prescribing strategy. The shift from monotherapy to fixed-dose combinations addresses the documented adherence failure that drives uncontrolled blood pressure in treated patients.

The highest-yield intervention targets remain undetected hypertension in at-risk populations and step-up to combination therapy in patients uncontrolled on monotherapy[23]. Uncontrolled hypertension is the leading modifiable risk factor for stroke in Australia.

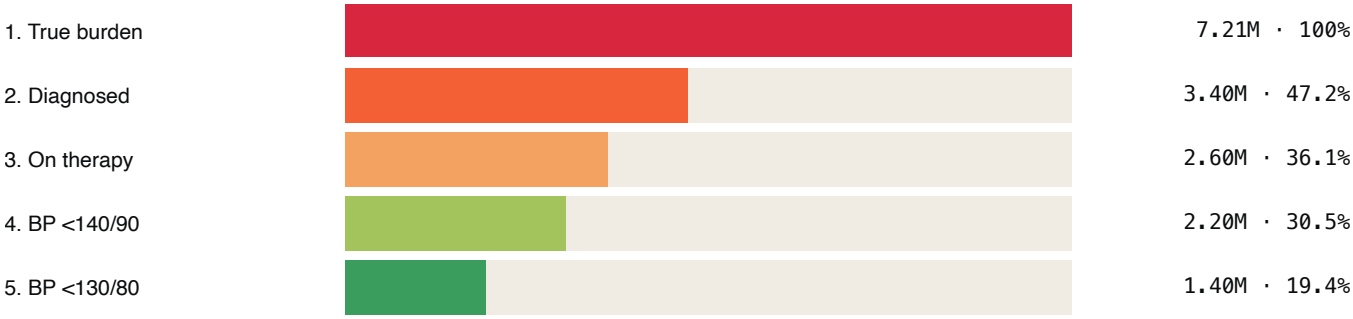
Note: ABS 2022 NHS self-reported prevalence is 23%; the 39% figure is from objective blood pressure measurement in the same survey and is the more accurate estimate of true population burden[2].

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS 2022[5] (objectively measured 39% of adults); AIHW[6].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. AIHW 2022: hypertension (high measured BP or on medication) 39% of adults (~7.2M) — base already captures undiagnosed + treated
4. Australian Cardiovascular Disease Risk Guidelines (2023)
5. ABS National Health Survey
6. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
7.21M	**84.1%**	**15.9%**	**56.6M**
27.2% population	6.06M treated	≈1.14M not on PBS therapy	$634M

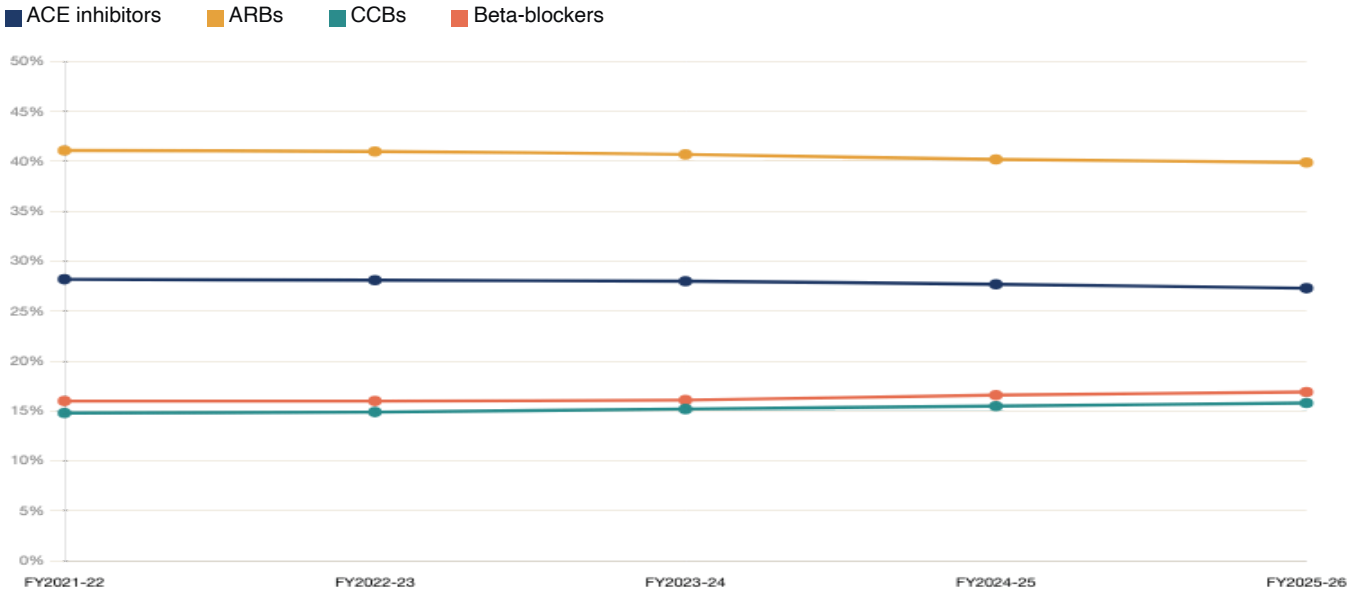
CARE CASCADE — % OF ESTIMATED BURDEN — 7.21M ESTIMATED PREVALENT



Stage 1 (estimated burden) uses the pipeline's ABS NHS 2022 prevalence estimate. Stages 2–5 are sourced from published Australian clinical studies.

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Ballarat · +15%

vs national average

national average

Ballarat · +15%

≈0

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the agents acting on the renin-angiotensin system — the main hypertension medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 15% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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CARDIOVASCULAR

Hypercholesterolaemia

REGULATORY WATCH 2 delisteds this quarter · 36 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

3.4 million Australians with high cholesterol — 39.7% of the true disease burden — receive no lipid-lowering therapy, representing potentially preventable myocardial infarction and stroke in a population where cardiovascular disease remains the leading cause of death[2,3]. Among the 8.6 million Australians with elevated LDL, only 5.2 million received PBS-dispensed therapy in 2024-25[1,2].

Statins dominate the prescribing landscape: rosuvastatin and atorvastatin account for 75% of the 36.4 million scripts dispensed[1]. But the critical gap sits at the top of the risk pyramid. When maximally tolerated statin therapy fails to reach LDL target, Australian cardiovascular risk guidelines[4] recommend adding ezetimibe (Ezetrol, or the fixed-dose combination Atozet) as the next step, then escalating to PCSK9 inhibitors — inclisiran (Leqvio), alirocumab (Praluent), and evolocumab (Repatha) — for very-high-risk patients. PCSK9 penetration remains below 1% of eligible patients, despite PBS listing since 2016[1].

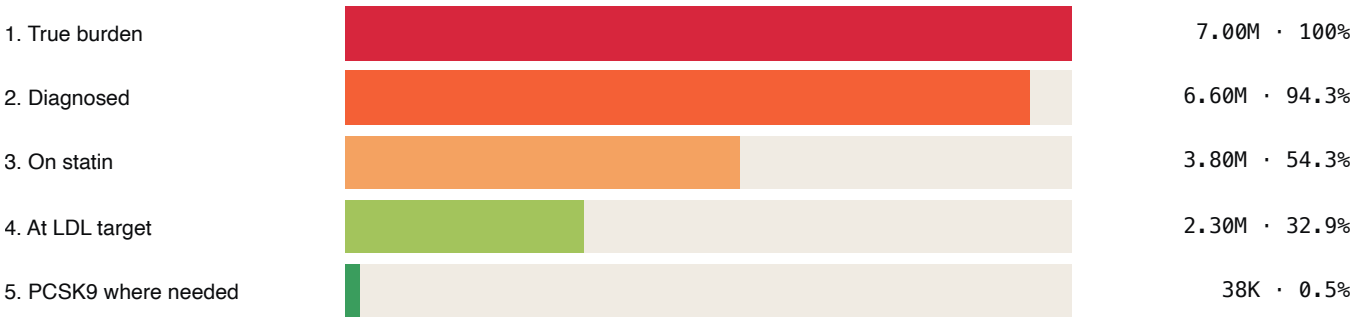
The prevention opportunity is two-fold: screening and detection in the 1.9 million undiagnosed cases, and guideline-concordant escalation in high-risk patients with residual LDL elevation despite statin therapy[2,3]. The latter group — post-ACS, familial hypercholesterolaemia, recurrent cardiovascular events — represents the highest-yield intervention cohort for stroke and MI prevention.

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS; AIHW[5].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. ABS NHMS 2022: measured high total cholesterol 30.2% of adults — base is a measured figure
4. Australian Cardiovascular Disease Risk Guidelines (2023)
5. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
7.00M	**74.3%**	**25.7%**	**36.4M**
26.4% population	5.20M treated	≈1.80M not on PBS therapy	$478M

CARE CASCADE — % OF ESTIMATED BURDEN — 7.00M ESTIMATED PREVALENT



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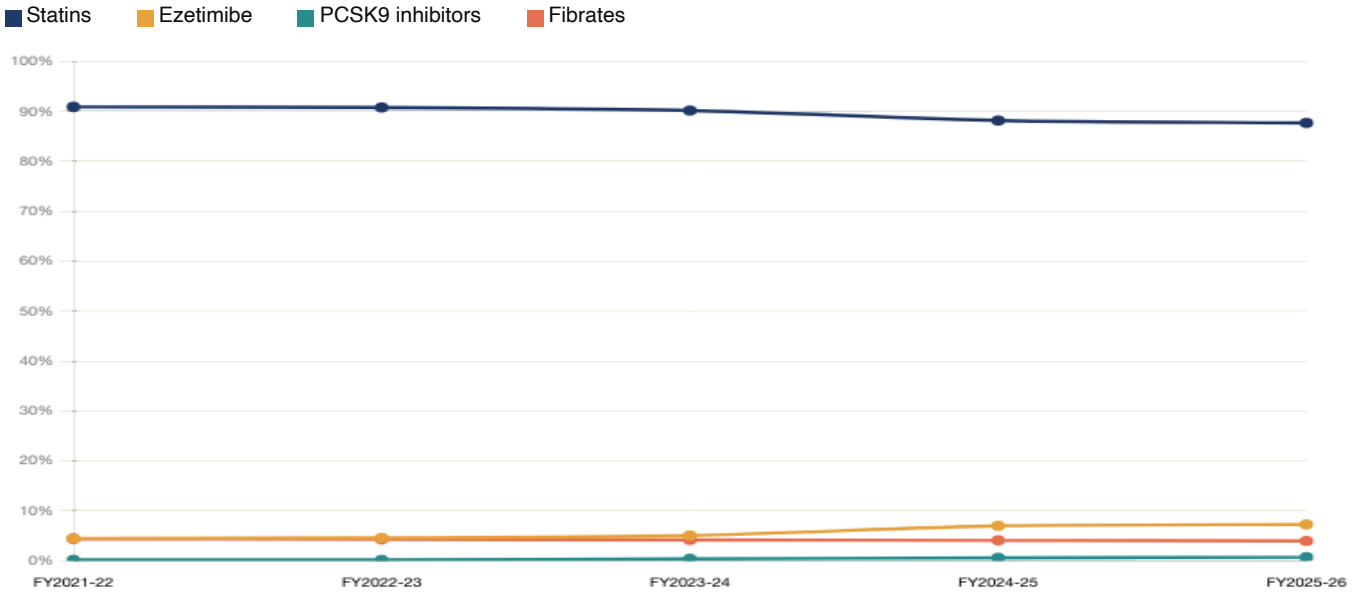
Stage patient counts are sourced from published Australian clinical studies and may differ from the estimated burden figure shown in the stat cards above, which uses ABS NHS 2022 prevalence scaled to current population.

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Ballarat · +12%

vs national average

national average

Ballarat · +12%

≈0

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the lipid modifying agents — the main hypercholesterolaemia medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 12% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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CARDIOVASCULAR

Atrial Fibrillation

REGULATORY WATCH 2 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

Nearly half a million Australians with atrial fibrillation remain undetected — approximately 473,000 cases based on European and AIHW[2] epidemiological estimates against NHS self-reported prevalence. Undetected AF carries substantial stroke risk without anticoagulation[34]. Paroxysmal and asymptomatic AF in older Australians with hypertension, heart failure, or CKD represents the primary detection gap[3].

Among diagnosed patients, prescribing has shifted decisively toward guideline-preferred therapy[13]. DOACs now account for 52% of anticoagulant dispensing — apixaban leads with 4.5 million scripts, rivaroxaban 2.5 million — while warfarin has declined to 750,000 scripts annually[1]. NHFA and CSANZ guidelines[5] recommend DOACs as preferred anticoagulation for most patients with non-valvular AF based on superior safety and adherence profiles. The branded DOAC market remains competitive across three factor-Xa inhibitors: Eliquis, Lixiana, and Xarelto.

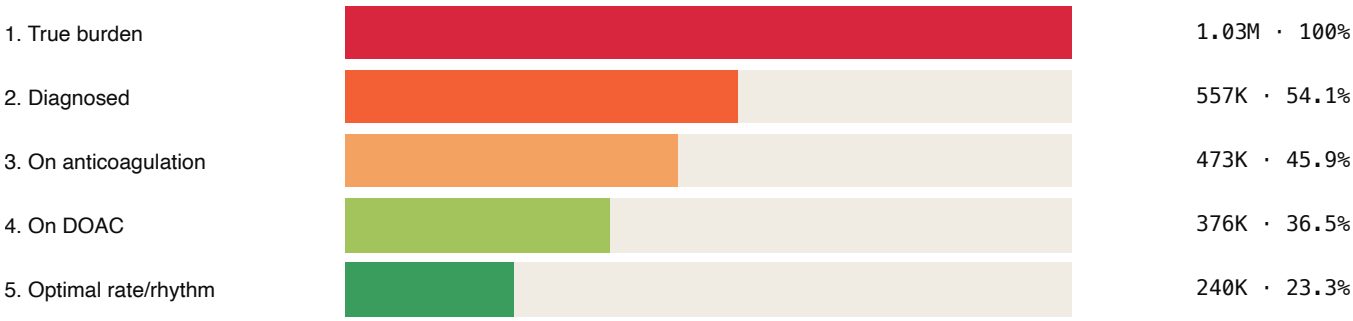
The clinical opportunity lies in case-finding, not treatment optimisation. Systematic pulse checks or single-lead ECG screening in at-risk patients aged 65-plus could detect paroxysmal AF before stroke events. Once diagnosed, anticoagulation rates approach 100%[3].

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS; AIHW[2].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. AIHW (Australian Institute of Health and Welfare)
3. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
4. True AF prevalence ~4% of adults (ESC 2024; AIHW CVD 2024) vs 2.1% self-report — paroxysmal/asymptomatic AF substantially under-detected (~1.03M incl undiagnosed)
5. National Heart Foundation of Australia / Cardiac Society of Australia and New Zealand AF Guidelines

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
1.03M	**56.8%**	**43.2%**	**13.3M**
2.1% population	585K treated	≈445K not on PBS therapy	$515M

CARE CASCADE — % OF ESTIMATED BURDEN — 1.03M ESTIMATED PREVALENT



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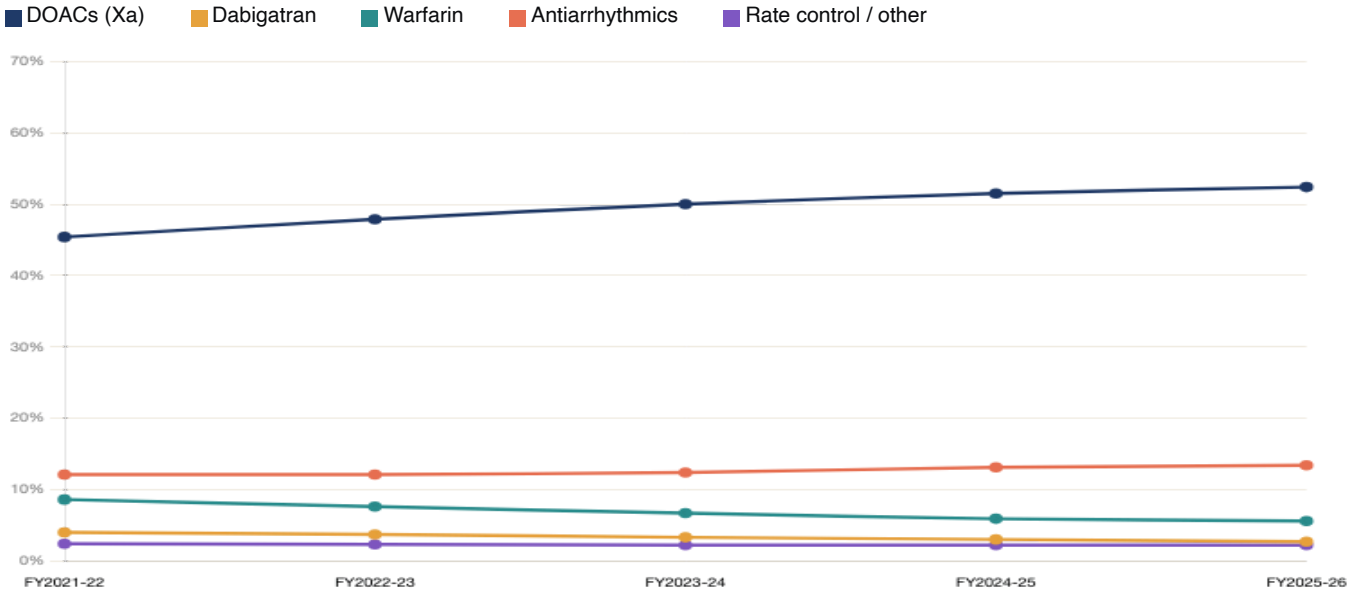
DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Ballarat · +17%

vs national average

national average

Ballarat · +17%

≈3,200

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the antithrombotic agents — the main atrial fibrillation medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 17% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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CARDIOVASCULAR

Heart Failure

Around 185,500 Australians are diagnosed with heart failure, but the true burden is closer to 371,000 — roughly half remain undiagnosed, with early HFpEF the largest hidden group[2][3]. Untreated or under-treated heart failure drives potentially preventable hospitalisations and premature death; it is one of the leading causes of avoidable admission in Australia.

Foundational "four-pillar" therapy — ACE inhibitors or ARBs, beta-blockers, mineralocorticoid antagonists and SGLT2 inhibitors — is shared with cardiovascular and diabetes prescribing and is counted under those conditions[1]. This spread instead tracks heart-failure-specific disease-modifying therapy, where the ARNI sacubitril/valsartan (Entresto) dominates (~88% of HF-specific scripts), alongside ivabradine and vericiguat[1]. NHFA/CSANZ guidelines position ARNI as a core disease-modifying agent for HFrEF.

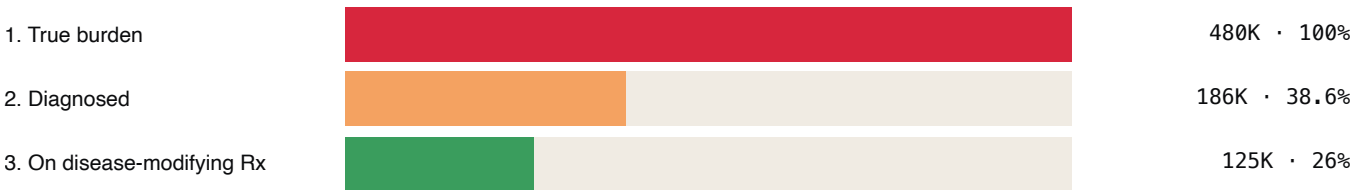
The opportunity is two-fold: detect undiagnosed HFpEF in breathless, comorbid older patients, and complete four-pillar therapy in diagnosed HFrEF, where SGLT2 inhibitor and ARNI uptake still lags guideline recommendations[2][3].

Data: PBS DoS Jul 2021–Jan 2026; AIHW[4] HSVD 2022–24; ABS NHS.

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. Heart Foundation: ~480,000 Australians with heart failure vs 0.7% self-report — multiplier derived to reach the Heart Foundation figure
4. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS	ON DISEASE-SPECIFIC THERAPY	DETECTION + ADVANCED-RX GAP	PBS SCRIPTS (12 MO)
480K	**26.1%**	**73.9%**	**1.00M**
0.7% population	125K on ARNI/ivabradine	foundational Rx counted elsewhere	$138M

CARE CASCADE — % OF ESTIMATED BURDEN — 480K ESTIMATED PREVALENT



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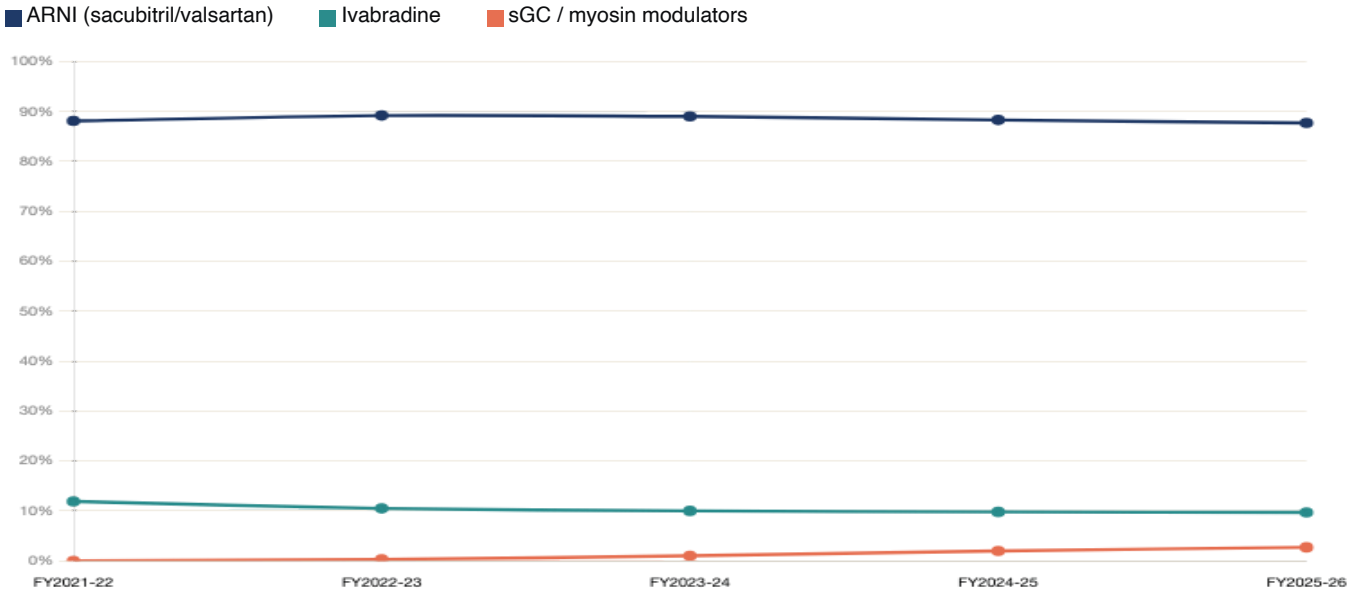
DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



TREATMENT CONTEXT

Guideline HFrEF therapy is **four foundational classes** — ARNI (or ACE/ARB), a beta-blocker, an MRA, and an **SGLT2 inhibitor** (dapagliflozin, empagliflozin). The chart tracks the HF-specific agents (ARNI, ivabradine, vericiguat); the shared classes are counted under cardiovascular and metabolic prescribing.

Ballarat · +8%

vs national average

national average

Ballarat · +8%

≈1,000

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the cardiac therapy — the main heart failure medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 8% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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ENDOCRINE

Type 2 Diabetes

REGULATORY WATCH 11 new listings this quarter · 8 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

Approximately 369,000 Australians living with type 2 diabetes receive no PBS-dispensed pharmacotherapy — representing potentially preventable cardiovascular events and hospitalisations, and renal-function decline[1,2]. The 71.5% true treatment rate (against estimated total burden including undiagnosed cases) masks a larger challenge: undetected disease in an estimated 562,000 Australians who remain undiagnosed[2,3].

Among treated patients, prescribing patterns are shifting toward guideline-concordant therapy[1]. SGLT2 inhibitors — dapagliflozin (Forxiga) and empagliflozin (Jardiance) — and GLP-1 receptor agonists — semaglutide (Ozempic) and dulaglutide (Trulicity) — now account for 34% of PBS scripts, reflecting RACGP and ADA guidance[4] recommending these agents first- or second-line for patients with established cardiovascular disease, heart failure, or chronic kidney disease. Metformin remains the foundation therapy at 27% of scripts, but the class mix indicates growing adoption of cardio-renal protective agents in high-risk subgroups[1].

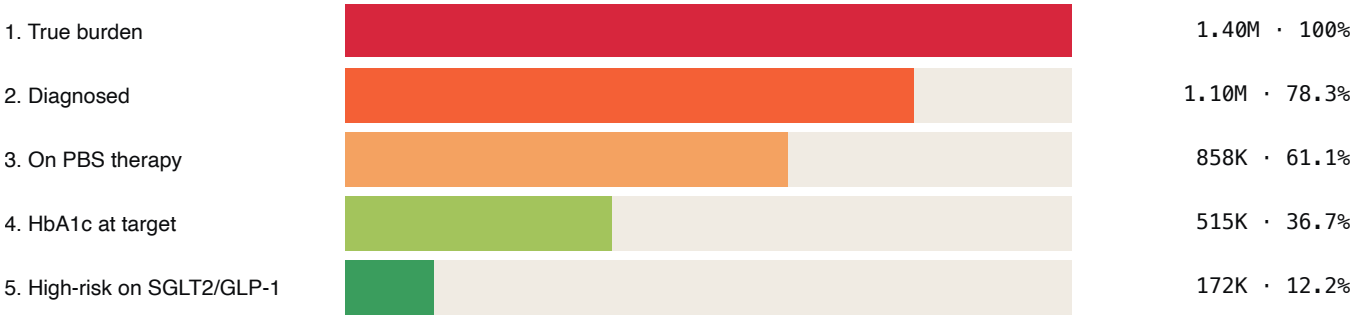
The primary clinical opportunity lies in two populations: undiagnosed Australians at elevated cardiovascular risk, and diagnosed patients with CVD, heart failure, or CKD not yet receiving SGLT2 inhibitor or GLP-1 RA therapy[2,3]. Prescribing momentum suggests accelerating guideline alignment in the diagnosed cohort[1,2].

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS; AIHW[5].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. ABS NHMS 2022: diabetes by HbA1c 6.4% of adults (only 0.9% newly diagnosed) — well-diagnosed
4. RACGP Management of Type 2 Diabetes (2024); ADA Standards of Care in Diabetes
5. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
1.40M	**91%**	**9%**	**22.4M**
5.3% population	1.28M treated	≈127K not on PBS therapy	$1.2B

CARE CASCADE — % OF ESTIMATED BURDEN — 1.40M ESTIMATED PREVALENT



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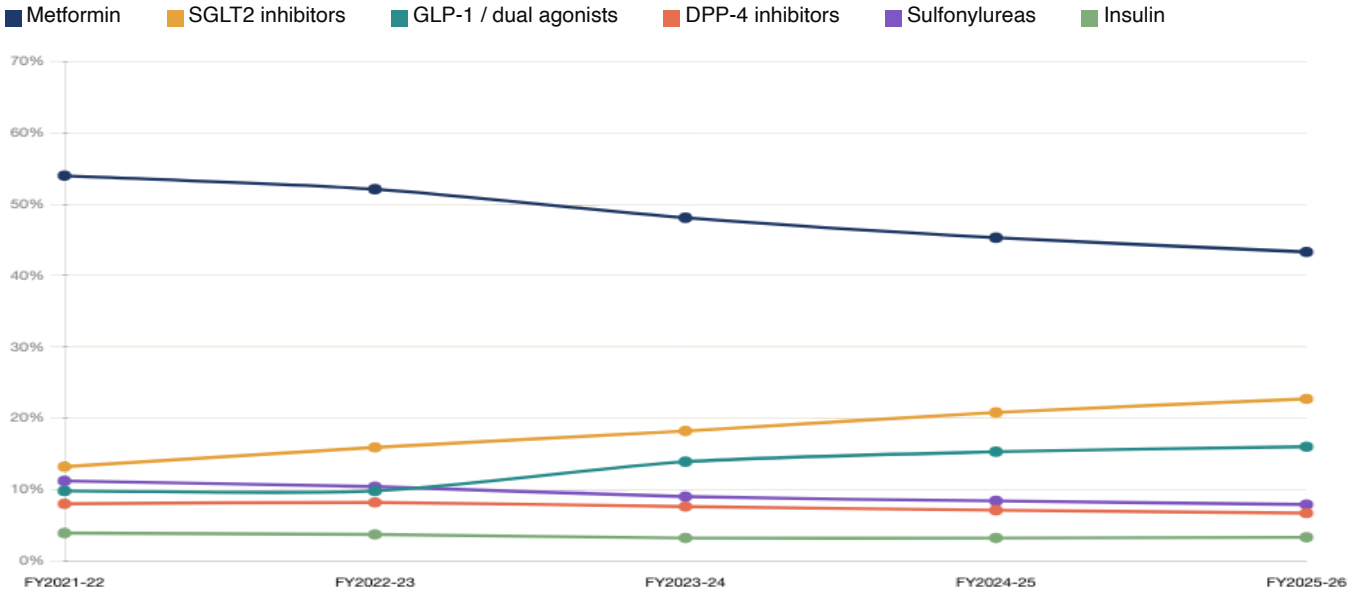
DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Ballarat · +5%

vs national average

national average

Ballarat · +5%

≈1,100

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the drugs used in diabetes — the main type 2 diabetes medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 5% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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RENAL

Chronic Kidney Disease

An estimated 14.2% of Australian adults have biomedical signs of chronic kidney disease, yet only about one in thirteen of them is aware of it — roughly 93% is undiagnosed[2][3]. This is the widest detection gap in this edition, and it matters because CKD is asymptomatic until late stages while silently multiplying cardiovascular and kidney-failure risk.

Foundational renoprotection — ACE inhibitors or ARBs plus SGLT2 inhibitors — is shared with hypertension and diabetes prescribing and is counted under those conditions[1]. The CKD-specific advance is finerenone (Kerendia), PBS-listed from 2025 for chronic kidney disease associated with type 2 diabetes with albuminuria, added on top of a maximally tolerated ACE inhibitor or ARB and an SGLT2 inhibitor per KDIGO and Kidney Health Australia guidance[1]. Uptake is early but growing.

The opportunity is detection: eGFR plus urine albumin-to-creatinine screening in every patient with diabetes or hypertension, then finerenone in eligible diabetic CKD.

Data: PBS DoS Jul 2021–Jan 2026; AIHW[4] CKD: Australian facts; ABS NHMS 2022–24.

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. ABS NHMS 2022-24: 14.2% of adults have CKD indicators (~3.0M) but only 7.4% self-report (~1.1% of population) — multiplier derived to reach the measured figure
4. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS

3.00M

1.1% population

ON DISEASE-SPECIFIC THERAPY

0.4%

12K on finerenone

DETECTION + ADVANCED-RX GAP

99.6%

foundational Rx counted elsewhere

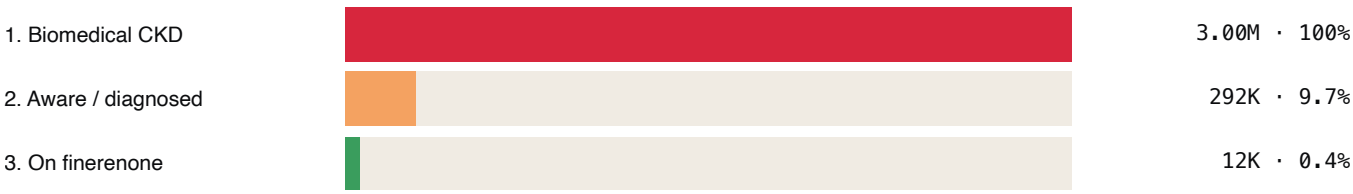
PBS SCRIPTS (12 MO)

86K

$6M

CARE CASCADE — % OF ESTIMATED BURDEN

3.00M ESTIMATED PREVALENT



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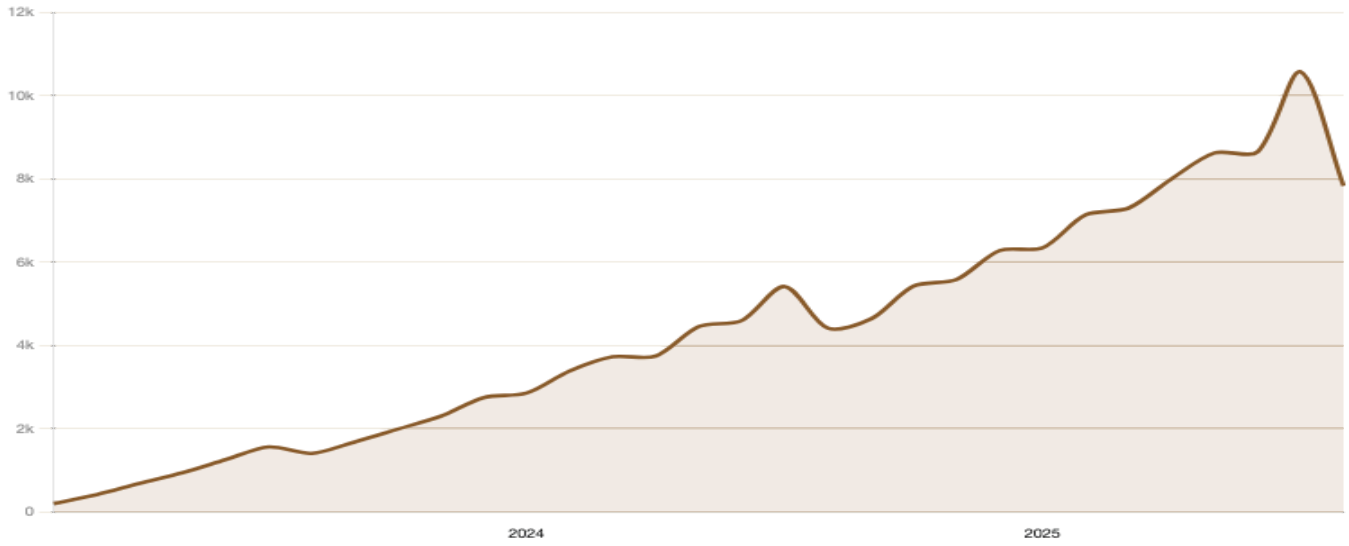
FINERENONE ADOPTION — MONTHLY PBS SCRIPTS 2021 → 2026

Finerenone (Kerendia) — scripts/month since PBS listing



TREATMENT CONTEXT

Foundational CKD therapy is an **SGLT2 inhibitor** (dapagliflozin, empagliflozin) plus an **ACE inhibitor or ARB**; **finerenone** is the newest add-on for type-2-diabetic CKD with albuminuria. The chart tracks finerenone because SGLT2i and ACE/ARB dispensing is counted under diabetes and hypertension to avoid double-counting.

Finerenone is the only CKD-specific PBS medicine (foundational ACE/ARB and SGLT2i are counted under hypertension and diabetes). Rather than a flat one-class mix, this tracks its monthly dispensing since PBS listing — a new-therapy adoption curve.

Local prescribing index: not published at LGA level for chronic kidney disease medicines, so the drug-class trend above is shown at the national level.

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MENTAL HEALTH

Depression & Anxiety

REGULATORY WATCH 14 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

Depression and anxiety affect an estimated 8.7 million Australians, yet only 4.1 million receive pharmacotherapy — a 53% treatment gap representing 4.6 million people not accessing medication that could reduce symptom burden, functional impairment, and downstream cardiovascular and metabolic risk. Under-diagnosis accounts for part of this gap: AIHW data[2] suggest only 59% of cases are clinically identified. Among diagnosed patients, 80% receive pharmacotherapy, but RANZCP guidelines[3] recommend combination therapy — both medication and structured psychological support — for optimal outcomes.

PBS dispensing is dominated by generic SSRIs and SNRIs[1]. Escitalopram and sertraline together account for 31% of scripts, with mirtazapine, venlafaxine and pregabalin rounding out the top five[1]. This pattern reflects guideline-concordant first-line prescribing, but PBS data capture only the pharmacological component[1]. MBS claims for mental health treatment plans (Item 2715) show parallel demand for psychological therapy, consistent with the RANZCP[3] combination-therapy recommendation.

The clinical opportunity lies in case-finding among the 41% of prevalent cases not yet diagnosed, particularly in primary care settings where depression and anxiety often present with somatic complaints[4]. Bridging the detection gap would enable earlier intervention and reduce the long-term disease burden in this highly prevalent condition.

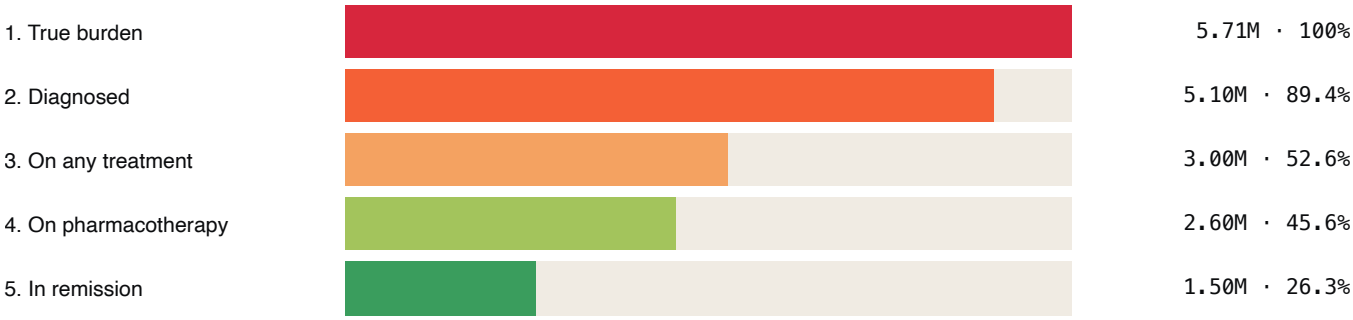
PBS data captures subsidised pharmacotherapy only; private antidepressant prescriptions (not Medicare-billed) are not quantified nationally and may represent an additional treatment stream, particularly for patients who prefer not to claim through Medicare[1].

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS; AIHW[2].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. AIHW (Australian Institute of Health and Welfare)
3. RANZCP Clinical Practice Guidelines (Royal Australian and New Zealand College of Psychiatrists)
4. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
5.71M	**61.1%**	**38.9%**	**41.0M**
19.4% population	3.49M treated	≈2.22M not on PBS therapy	$347M

CARE CASCADE — % OF ESTIMATED BURDEN 5.71M ESTIMATED PREVALENT

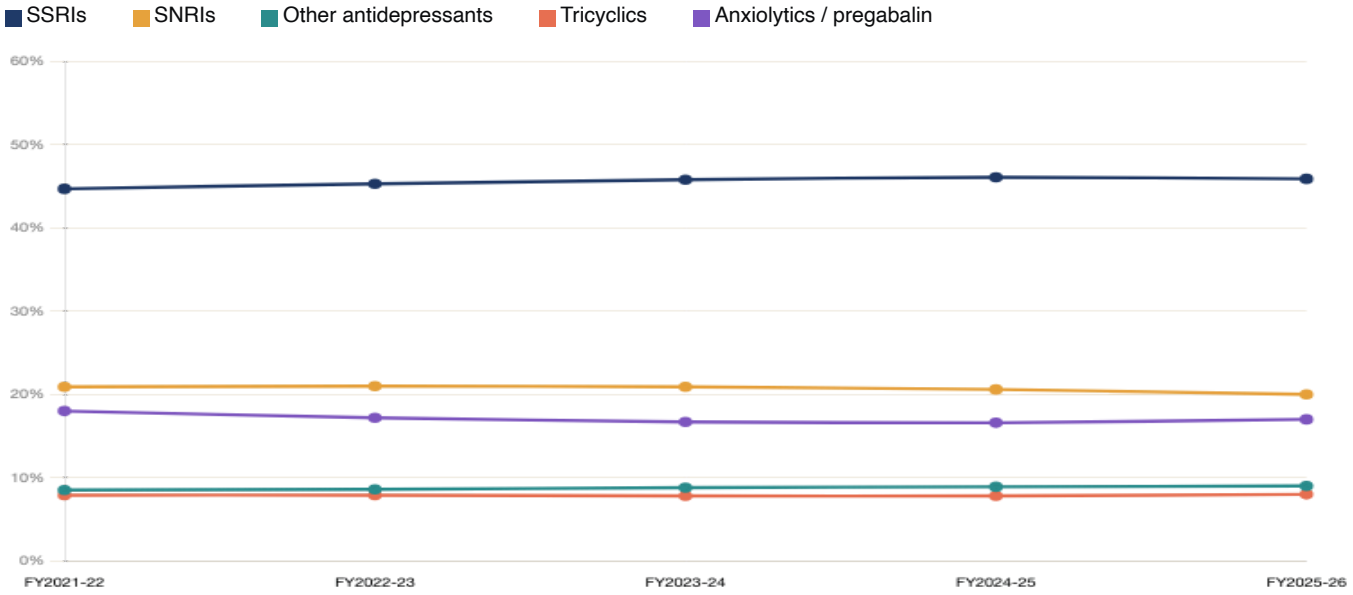


Stage 1 (estimated burden) uses the pipeline's ABS NHS 2022 prevalence estimate. Stages 2–5 are sourced from published Australian clinical studies.

Stage patient counts are sourced from published Australian clinical studies and may differ from the estimated burden figure shown in the stat cards above, which uses ABS NHS 2022 prevalence scaled to current population.

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Ballarat · +43%

vs national average

national average

Ballarat · +43%

≈0

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the psychoanaleptics — the main depression & anxiety medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 43% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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NEUROLOGY

Migraine

REGULATORY WATCH 7 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

About 6.2% of Australians report long-term migraine, but true prevalence is closer to 15% — migraine is the most under-diagnosed neurological condition, and among the largest causes of lost productivity in working-age adults[2][3]. The gap between those affected and those diagnosed and treated represents avoidable disability across millions of migraine days each year[2].

Acute prescribing is dominated by the triptans — rizatriptan, sumatriptan and eletriptan lead dispensing[1]. For prevention in chronic migraine (frequent headache days with inadequate response to oral prophylaxis), the CGRP monoclonal antibodies — fremanezumab (Ajovy) and galcanezumab (Emgality) — and the gepants are guideline-recommended per Australian and international headache guidance. Pizotifen remains a low-cost oral preventive option.

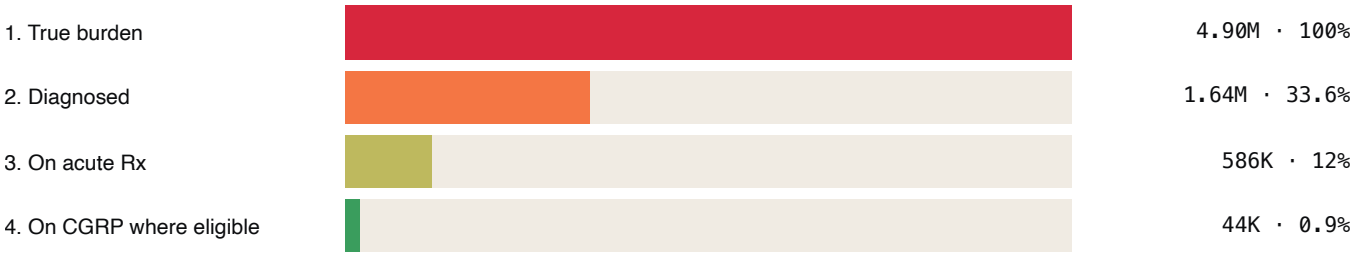
The opportunity is three-fold: diagnose the large undetected population, offer preventive therapy to the chronic-migraine group where it remains under-used, and identify medication-overuse headache from frequent acute-agent use[2][3].

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS 2022[4]; GBD; Deloitte Access Economics 2018.

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. Deloitte Access Economics 2018: 4.9M Australians experience migraine vs 6.2% self-report — multiplier derived to reach the epidemiological estimate
4. ABS National Health Survey

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
4.90M	**12%**	**88%**	**2.34M**
6.2% population	586K treated	≈4.31M not on PBS therapy	$173M

CARE CASCADE — % OF ESTIMATED BURDEN — 4.90M ESTIMATED PREVALENT

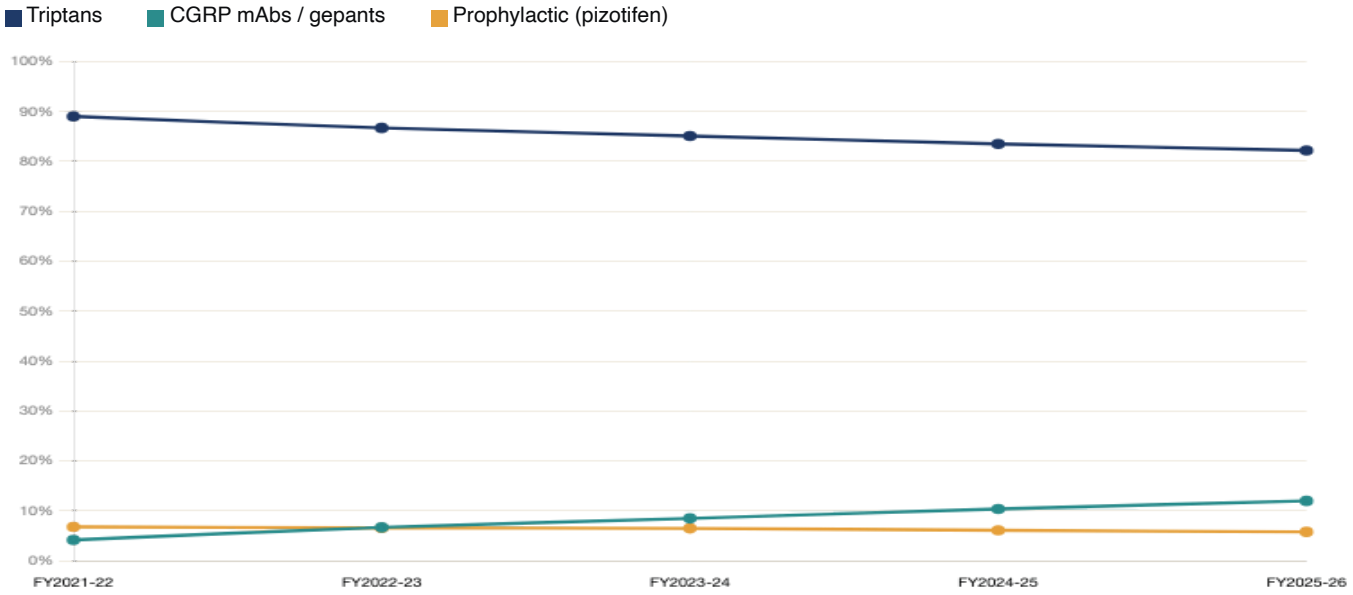


Stage 1 (estimated burden) uses the pipeline's ABS NHS 2022 prevalence estimate. Stages 2–5 are sourced from published Australian clinical studies.

Stage patient counts are sourced from published Australian clinical studies and may differ from the estimated burden figure shown in the stat cards above, which uses ABS NHS 2022 prevalence scaled to current population.

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Local prescribing index: not published at LGA level for migraine medicines, so the drug-class trend above is shown at the national level.

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RESPIRATORY

Asthma

REGULATORY WATCH 8 restriction changes this quarter · 9 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

Approximately 1.89 million Australians with asthma — 57.9% of the estimated disease burden — receive no PBS-dispensed pharmacotherapy, representing potentially preventable exacerbations, emergency presentations, and hospitalisations[1,3,4]. This gap includes mild intermittent cases for whom regular therapy is not recommended under GINA[2] Step 1; the gap among patients with persistent asthma needing preventer therapy is smaller. Among 1.37 million treated patients, salbutamol still accounts for a third of all scripts — despite GINA 2023[2] no longer endorsing SABA-only treatment and preferring as-needed low-dose ICS-formoterol as reliever from Step 1.

What the guidelines recommend, and where local prescribing sits: GINA[2]'s preferred pathway is ICS-formoterol as reliever (budesonide-formoterol is 18% of scripts) with maintenance ICS-LABA as control needs rise. For patients uncontrolled on medium-to-high-dose ICS-LABA, GINA[2] recommends stepping up by adding a long-acting muscarinic antagonist — fixed-dose triple therapy (ICS/LABA/LAMA). Triple-therapy scripts have climbed from negligible in 2021-22 to 6.6% of asthma prescribing in 2025-26, dispensed as Enerzair, Trelegy and Trimbow[1]. For severe, uncontrolled asthma with an eosinophilic or allergic phenotype, GINA[2] recommends add-on biologic therapy — Dupixent, Fasenra, Nucala and Tezspire — currently 3.8% of scripts.

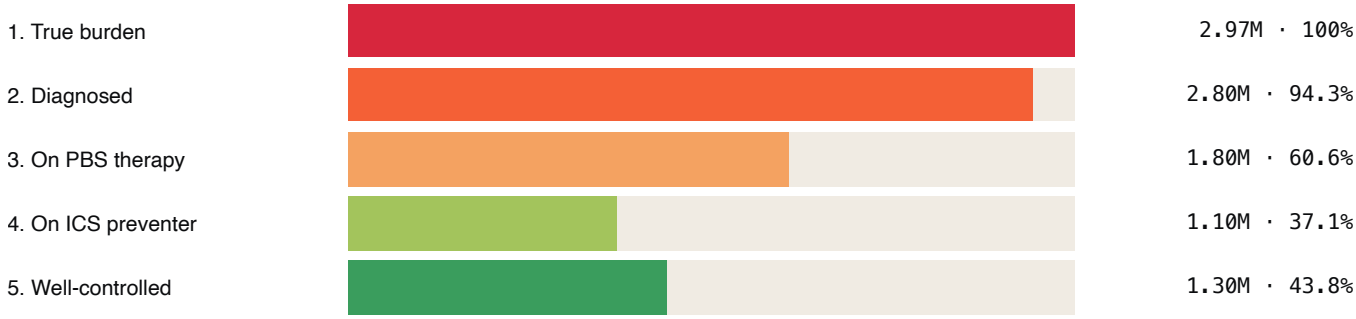
The clinical opportunities are threefold: shift SABA-monotherapy patients to ICS-containing reliever regimens; step up patients who remain uncontrolled on ICS-LABA to triple therapy per GINA[2], before or alongside specialist referral; and identify the severe eosinophilic sub-population eligible for biologics. The steady rise in triple-therapy uptake signals growing guideline-concordant step-up, while the persistent salbutamol volume marks the largest remaining gap to close.

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS; AIHW[5]; GINA 2023[2].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. GINA Global Strategy for Asthma Management and Prevention
3. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
4. ABS NHS 2022: asthma 10.8% self-report — well-diagnosed, symptom-driven
5. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
2.97M	**41%**	**59%**	**10.3M**
11.2% population	1.22M treated	≈1.75M not on PBS therapy	$618M

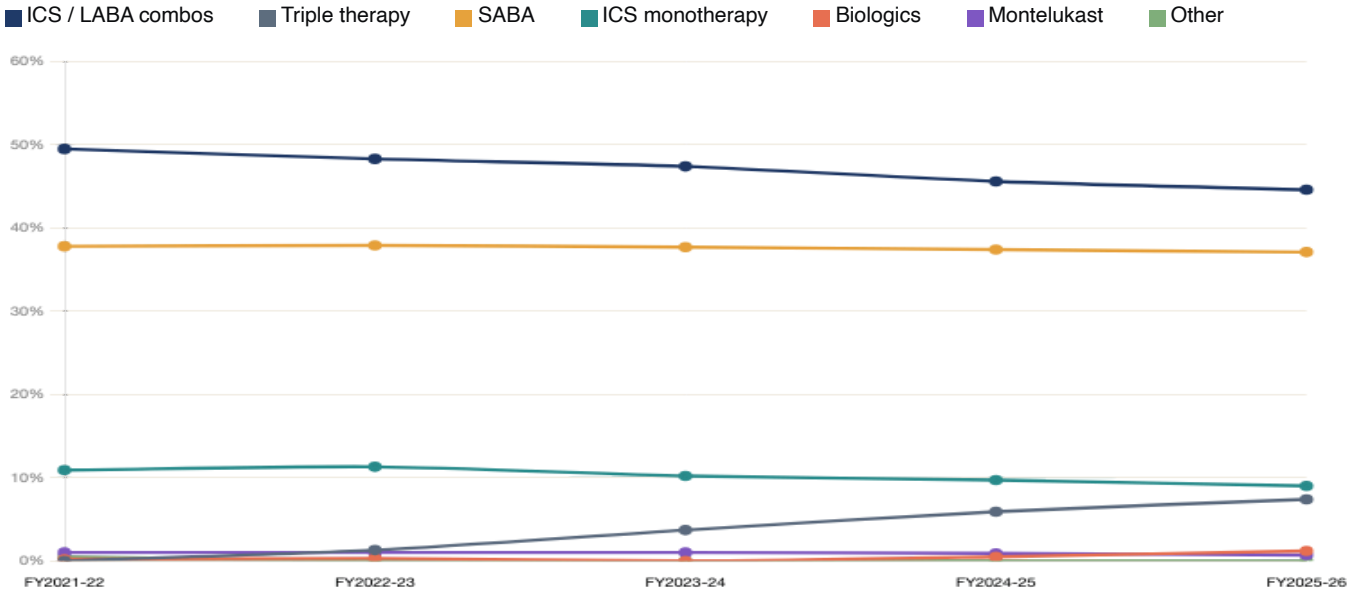
CARE CASCADE — % OF ESTIMATED BURDEN — 2.97M ESTIMATED PREVALENT



Stage 5 (1.3M) exceeds Stage 4 (1.1M) — patients with mild intermittent asthma can meet symptom control criteria on SABA alone without

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Ballarat · +36%

vs national average

national average

Ballarat · +36%

≈2,900

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the drugs for obstructive airway diseases — the main asthma medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 36% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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RESPIRATORY

COPD

REGULATORY WATCH 1 restriction change this quarter · 1 medicine in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

Of 1.3 million Australians living with COPD, only 473,000 receive maintenance pharmacotherapy — a 64% treatment gap representing potentially preventable exacerbations and hospitalisations[2]. Half of all cases remain undiagnosed, and among diagnosed patients, 44% have no recorded inhaled maintenance therapy despite guideline recommendations[23].

Triple-therapy combinations now account for around 40% of COPD prescribing — three competing brands (Breztri, Trelegy, Trimbow) collectively dispensed around 1.0 million COPD scripts in 2024-25[1]. GOLD and COPD-X guidelines[4] recommend triple therapy for high-risk patients with continued exacerbations on dual therapy, positioning these agents as the guideline-concordant escalation step. Long-acting monotherapy (tiotropium) remains the second-largest category at 26% of scripts[1]. An emerging option sits beyond the inhaler: dupilumab (Dupixent) gained TGA approval in February 2025 as an add-on for uncontrolled eosinophilic COPD, though it is not yet PBS-listed for this indication[1].

The primary prevention opportunity sits upstream: only two in five diagnosed patients have spirometry recorded, and half of prevalent cases remain undetected entirely[23]. For diagnosed high-risk patients already on dual therapy who continue to exacerbate, triple therapy represents the guideline-recommended step-up[2].

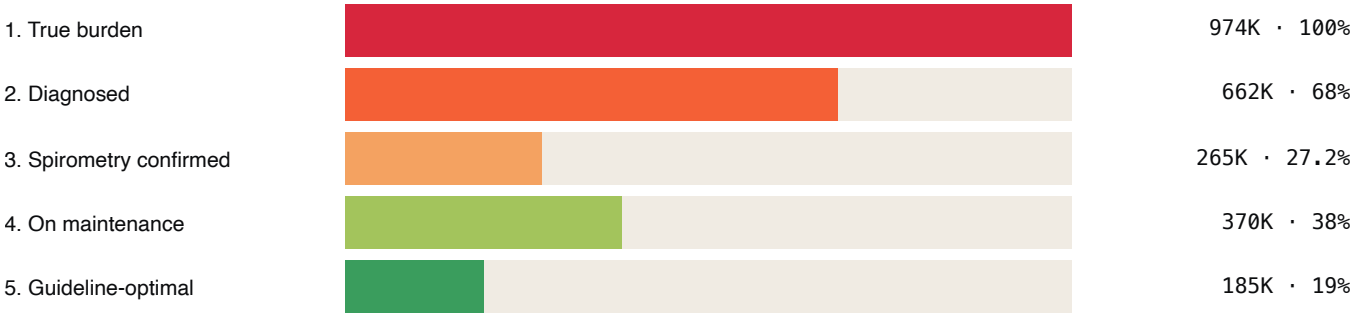
Population spirometry studies (BOLD Australia) suggest approximately 8% of adults aged 40 and over have COPD; only 2.5% self-report the diagnosis, indicating that roughly half of all COPD cases in Australia remain undetected and untreated[23].

Data: PBS DoS Jul 2021–Jan 2026; ABS NHS; AIHW[5]; CONQUEST Australia[6]; BOLD Australia; ACSQHC COPD Report 2025[7].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. BOLD Australia: spirometry-confirmed COPD 7.5% of adults 40+ vs 2.5% self-report — multiplier derived to reach the spirometry figure (~975K)
4. GOLD Global Strategy for COPD (2024); COPD-X Plan, Lung Foundation Australia
5. AIHW (Australian Institute of Health and Welfare)
6. CONQUEST Australia cohort, Lancet Respiratory Medicine 2025
7. ACSQHC COPD Highlights Report 2025

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
974K	**37.8%**	**62.2%**	**2.58M**
2.5% population	368K treated	≈605K not on PBS therapy	$165M

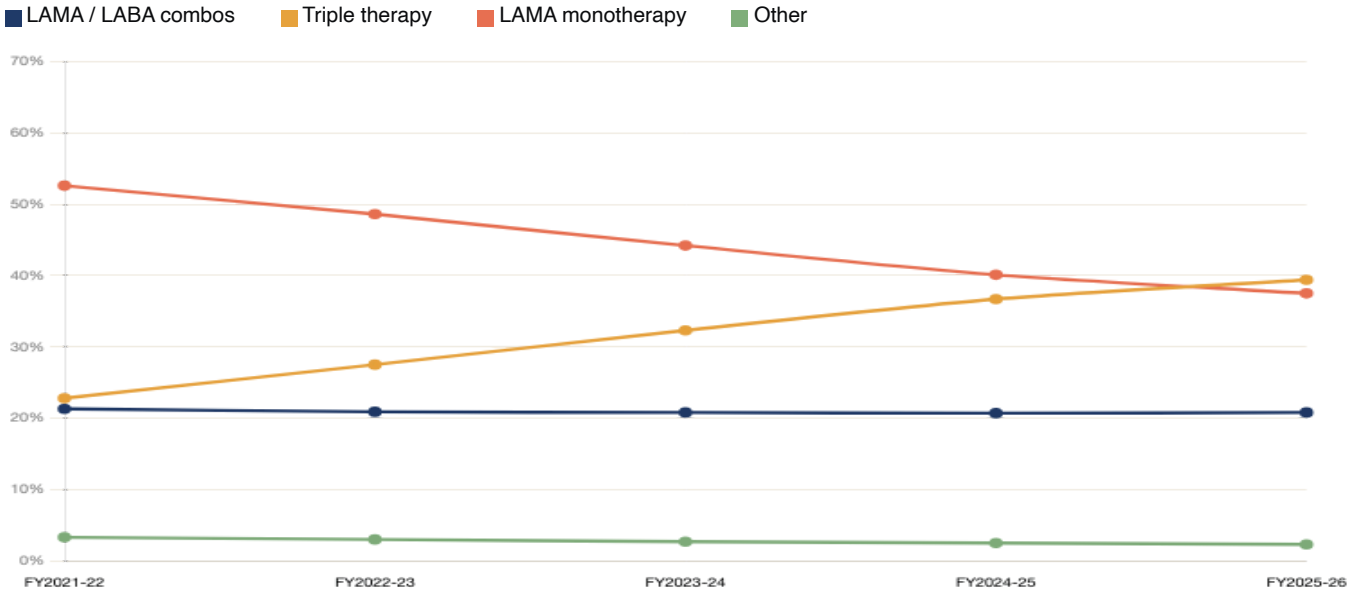
CARE CASCADE — % OF ESTIMATED BURDEN — 974K ESTIMATED PREVALENT



Stage 4 (370K) exceeds Stage 3 (265K) — reflects the documented Australian primary-care pattern of initiating maintenance inhalers without

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Ballarat · +36%

vs national average

national average

Ballarat · +36%

≈0

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the drugs for obstructive airway diseases — the main COPD medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 36% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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GASTRO

GORD

REGULATORY WATCH 6 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

More than 900,000 Australians estimated to have GORD but not currently on PPI therapy — but the larger clinical opportunity is deprescribing. PBS data show 2.4 million Australians dispensed acid-suppression therapy in 2024-25, with PPIs accounting for 94% of scripts[1]. Most patients continue therapy indefinitely without step-down review.

RACGP guidelines[2] recommend PPI cessation or dose reduction after 4-8 weeks of initial therapy unless there is an ongoing indication such as Barrett's oesophagus or continued NSAID use. Pantoprazole and esomeprazole dominate dispensing (78% combined), but duration of use — not agent choice — is the primary quality gap[1]. Long-term PPI use without indication is associated with fracture risk, enteric infection, and micronutrient deficiency.

The clinical opportunity is medication review in patients on maintenance PPI therapy without documented high-risk features. Symptom-driven step-down or cessation after 4-8 weeks aligns with guideline recommendations and reduces unnecessary exposure. The deprescribing conversation — not initiation — is where GORD management now needs focus.

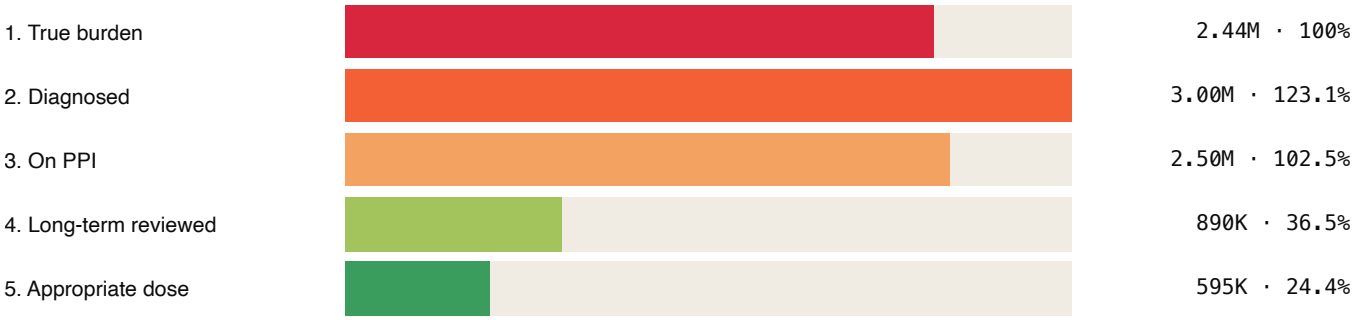
Data: PBS DoS Jul 2021–Jan 2026; ABS NHS; AIHW[3].

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. RACGP guidelines (Royal Australian College of General Practitioners)
3. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
2.44M	**67.1%**	**32.9%**	**24.0M**
9.2% population	1.63M treated	≈803K not on PBS therapy	$218M

CARE CASCADE — % OF ESTIMATED BURDEN

2.44M ESTIMATED PREVALENT

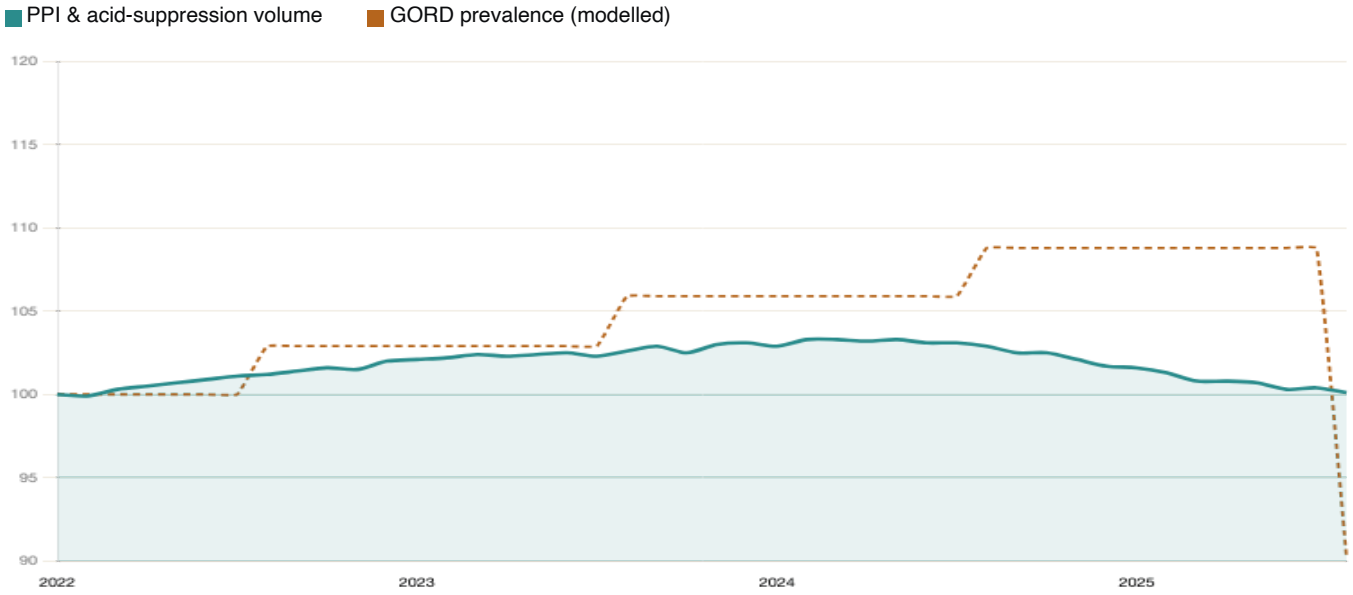


Stage 1 (estimated burden) uses the pipeline's ABS NHS 2022 prevalence estimate. Stages 2–5 are sourced from published Australian clinical studies.

Stage patient counts are sourced from published Australian clinical studies and may differ from the estimated burden figure shown in the stat cards above, which uses ABS NHS 2022 prevalence scaled to current population.

PPI VOLUME VS PREVALENCE — INDEXED, 2022 = 100

2021 → 2026



The teal line is total PPI dispensing volume; the dashed line is GORD prevalence. Prevalence keeps rising while dispensing stays flat — so PPI use *per person* is falling. For GORD that is the deprescribing signal guidelines encourage (long-term PPIs should be reviewed), not under-treatment.

Ballarat · +40%

vs national average

national average

Ballarat · +40%

≈1,150

est. not yet on PBS therapy

This is not intended to imply under- or over-prescribing — it is a comparison to the national average.

Reading this: the figure compares local dispensing of the drugs for acid related disorders — the main GORD medicine group — as scripts per 1,000 residents against the national average. Ballarat is about 40% more scripts per person than nationally. It is a *crude* population rate — not age-standardised — so part of any difference reflects the local age and risk profile, not prescribing behaviour alone. It measures dispensing volume at medicine-group level (not the individual drug classes above).

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MUSCULOSKELETAL

Osteoporosis

REGULATORY WATCH 2 medicines in shortage (alternatives exist) — see "New on the PBS & TGA this quarter", p. 32.

Around 1.8 million Australians are estimated to have osteoporosis, but only about half are diagnosed — the condition is typically silent until a minimal-trauma fracture[2]. Each untreated hip fracture carries substantial mortality and loss of independence, making the treatment gap a driver of potentially preventable disability and death.

Prescribing is led by denosumab (Prolia), which accounts for just over half of anti-osteoporosis scripts, followed by the oral and intravenous bisphosphonates — alendronate, risedronate and zoledronic acid[1]. For very-high-risk patients and those after a recent fracture, guidelines (RACGP[3]; Healthy Bones Australia) recommend anabolic therapy — romosozumab (Evenity) or teriparatide — before an antiresorptive. SERMs such as raloxifene retain a niche role.

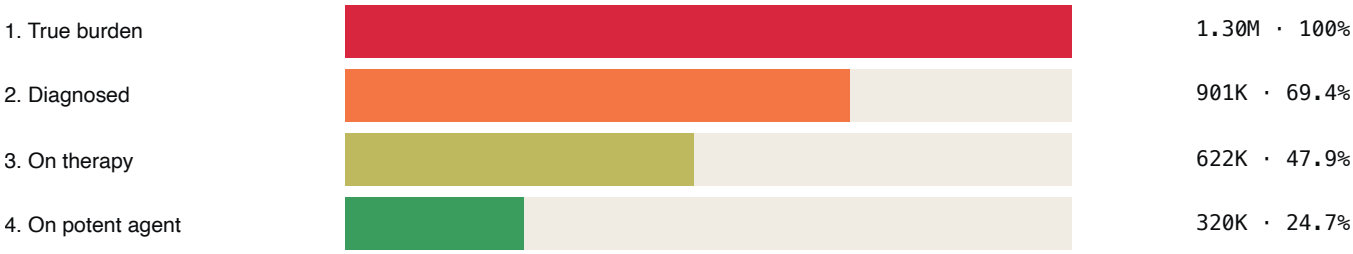
The highest-yield opportunity is secondary prevention: most patients presenting with a minimal-trauma fracture leave hospital without bone-protective therapy or a DEXA referral. Systematic post-fracture care and DEXA screening from age 50 close the largest part of the gap.

Data: PBS DoS Jul 2021–Jan 2026; AIHW[4] osteoporosis 2022; ABS NHS.

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates
3. RACGP guidelines (Royal Australian College of General Practitioners)
4. AIHW (Australian Institute of Health and Welfare)

ESTIMATED PREVALENT PATIENTS	TREATMENT RATE (ESTIMATED BURDEN)	EST. GAP (VS MODELLED BURDEN)	PBS SCRIPTS (12 MO)
1.30M	**47.9%**	**52.1%**	**2.49M**
3.4% population	622K treated	≈676K not on PBS therapy	$435M

CARE CASCADE — % OF ESTIMATED BURDEN — 1.30M ESTIMATED PREVALENT



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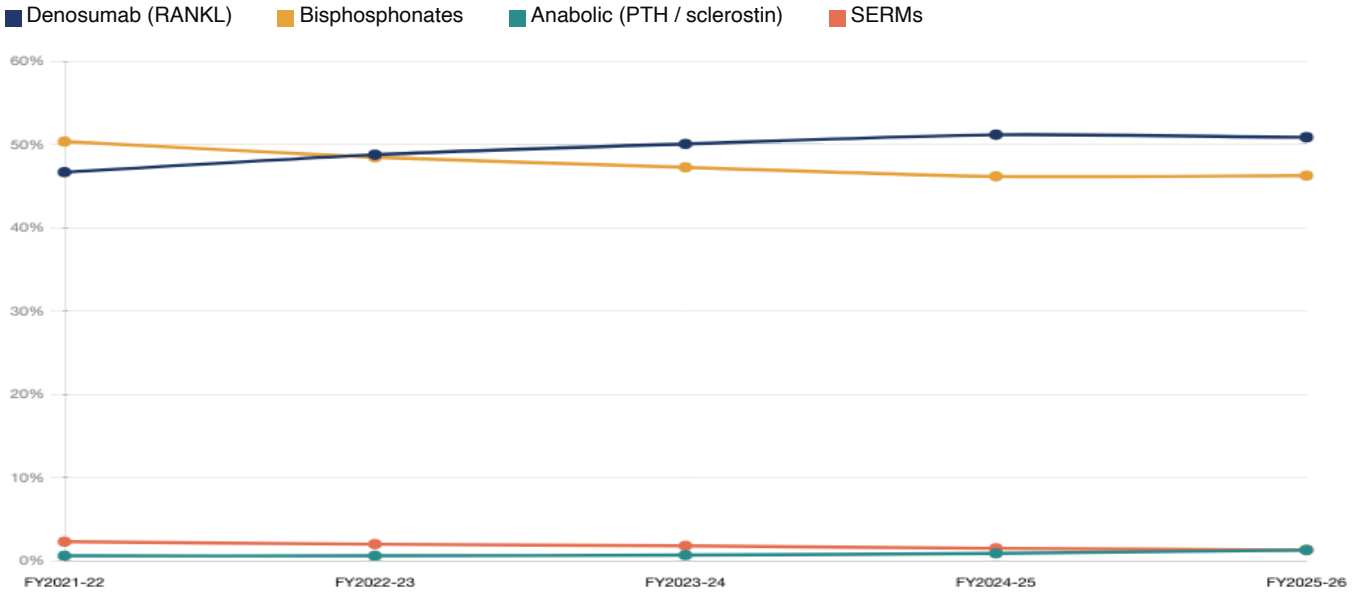
DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



Local prescribing index: not published at LGA level for osteoporosis medicines, so the drug-class trend above is shown at the national level. Estimated untreated in Ballarat: ≈2,800.

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DERMATOLOGY

Atopic Dermatitis

Atopic dermatitis affects an estimated 16.4% of Australians — up to 2.8 million people — one of the most common inflammatory skin conditions in general practice. This spread carries no computed treatment gap: the PBS's AD-defining biologic, dupilumab, is dermatologist- or immunologist-initiated, so a GP treatment rate calculated from PBS dispensing would describe specialist prescribing, not GP under-treatment[1].

PBS dispensing over five years shows dupilumab's share of the AD basket rising from 40% in FY2021-22 to 58% in FY2025-26, while pimecrolimus — the topical calcineurin inhibitor GPs can initiate directly for steroid-sparing maintenance — fell from 60% to 42% of scripts[1]. AD-attributable PBS cost reached roughly $470 million in the past 12 months, dupilumab-dominated, with scripts up 22% year-on-year — wider biologic-eligible referral, not a shift in GP-level topical prescribing[1].

The GP opportunity is recognition and topical optimisation: emollients plus a topical corticosteroid, stepping up to pimecrolimus for sensitive sites or steroid-sparing maintenance, then timely referral once control fails or disease reaches a moderate-severe threshold.

Data: PBS DoS Jul 2021–Jan 2026; Su JC et al., Australasian Journal of Dermatology 2025; MedicineInsight[2], Australasian Journal of Dermatology 2020.

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. MedicineInsight (NPS MedicineWise general practice dataset)

ESTIMATED PREVALENT PATIENTS	LEADING PBS THERAPY SHARE	PBS SCRIPTS (12 MO)	SCRIPT VOLUME, YEAR-ON-YEAR
2.81M	58.8%	460K	+22.3%
10.6% population	Dupilumab	$470M	FY2024–25 vs FY2023–24

DETECTION & REFERRAL PATHWAY — NO COMPUTED TREATMENT GAP

2.81M ESTIMATED PREVALENT

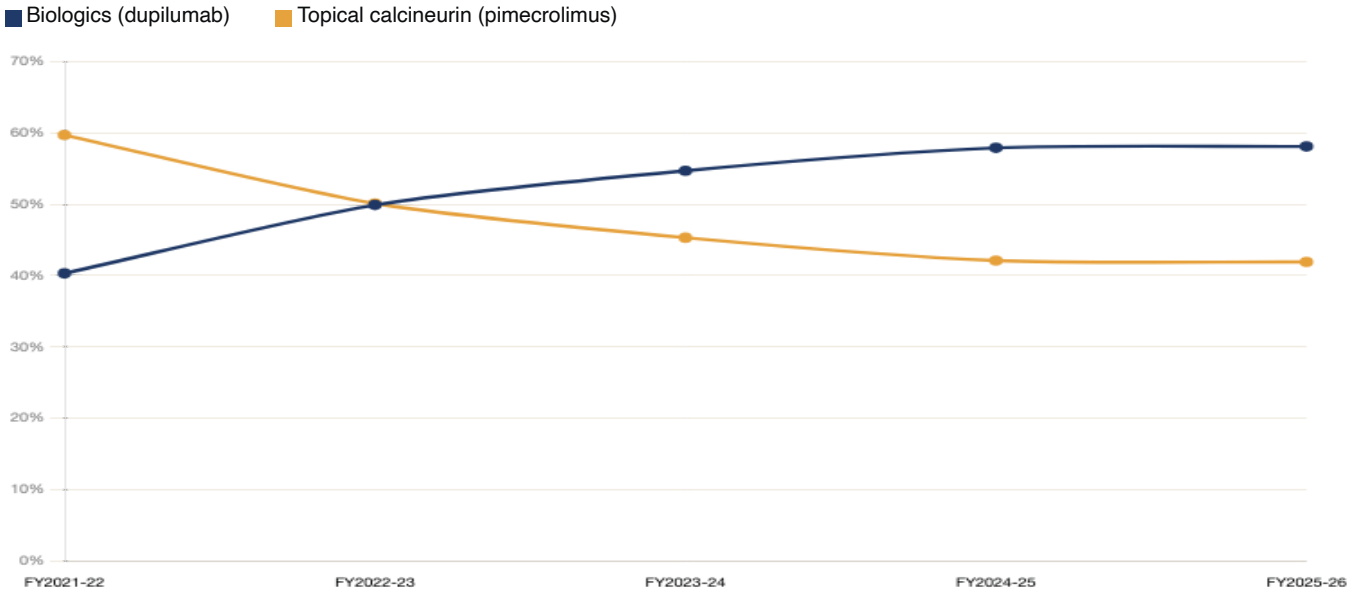
1. **Recognition**
   Chronic relapsing eczematous dermatitis in a typical flexural/extensor distribution, confirmed on history and exam.
2. **Topical optimisation**
   Emollients plus topical corticosteroid; step up to topical calcineurin inhibitor (pimecrolimus) for sensitive sites or steroid-sparing maintenance — the GP-owned layer of this basket.
3. **Referral threshold**
   Inadequate control on optimised topical therapy, or moderate–severe disease by validated severity scoring — refer to dermatology or immunology.
4. **Specialist biologic pathway**
   Dermatologist/immunologist-initiated dupilumab under PBS Authority for eligible moderate–severe disease — specialist-initiated, not GP-prescribed.

> *"estimated current prevalence of 16.4%, or up to 2.8 million Australians"*
> — Su JC et al., Australasian Journal of Dermatology 2025;66(8):e544–e552

This spread reports detection and referral, not a treatment gap: dupilumab is dermatologist/immunologist-initiated, so a GP treatment rate computed from PBS dispensing would describe specialist prescribing, not GP under-treatment.

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



TREATMENT CONTEXT

This chart is **GP-relevant PBS volume only** — dupilumab (dermatology listing) and the GP-owned topical calcineurin inhibitor pimecrolimus. Dupilumab here is **dermatologist/immunologist-initiated** under PBS Authority, not GP-prescribed; it is shown because it is the AD-defining on-patent volume, not as a GP treatment-rate signal. JAK inhibitors (upadacitinib, baricitinib, tofacitinib) are excluded — they are pan-indication (chiefly RA/PsA) and not AD-isolable at PBS item level.

Local prescribing index: not published at LGA level for atopic dermatitis medicines, so the drug-class trend above is shown at the national level.

ABOUT THE PUBLISHER

Australian Healthcare Research

Australian Healthcare Research analyses Commonwealth health data to surface treatment gaps and prescribing patterns at the local level. We put population-level evidence in the hands of clinicians, so more Australians can receive the care they need.

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DERMATOLOGY

Psoriasis

Between 2.3% and 6.6% of Australians have psoriasis; this issue anchors the prevalence card at the conservative end of that range — 2.5%, about 662,500 people[2]. Like atopic dermatitis, this is a detection/referral spread: the commercial core of psoriasis therapy — IL-17/23 and TNF-inhibitor biologics — is deliberately excluded from the PBS basket shown, since it spans psoriasis, psoriatic arthritis, axial spondyloarthritis and inflammatory bowel disease with no verified psoriasis-only split[1].

What GPs actually prescribe is topical calcipotriol plus betamethasone dipropionate — 90.5% of psoriasis-basket scripts in the past 12 months — and oral acitretin at 9.3%, with PUVA phototherapy a small remainder[1]. That mix has stayed essentially flat across five PBS years: a stable, guideline-first-line GP segment, not the disease's growth story, which sits with the specialist biologic layer off this chart[1]. Basket scripts eased 3.6% year-on-year, consistent with a mature first-line segment[1].

The GP opportunity is recognition — well-demarcated, silvery-scaled plaques, with a low threshold to screen for psoriatic arthritis — topical optimisation, and timely referral to dermatology, with rheumatology where indicated, once disease is moderate-severe or refractory.

Data: PBS DoS Jul 2021–Jan 2026; Kovitwanichkanont T et al., Medical Journal of Australia 2020.

1. PBS Date of Supply (Jul 2021 – Jan 2026); PBS item-drug map (Services Australia)
2. ABS National Health Survey 2022; AIHW chronic disease prevalence estimates

ESTIMATED PREVALENT PATIENTS	LEADING PBS THERAPY SHARE	PBS SCRIPTS (12 MO)	SCRIPT VOLUME, YEAR-ON-YEAR
663K	**90.5%**	**333K**	**-3.6%**
2.5% population	Calcipotriol + Betamethasone Dipropionate	$25M	FY2024–25 vs FY2023–24

DETECTION & REFERRAL PATHWAY — NO COMPUTED TREATMENT GAP

663K ESTIMATED PREVALENT

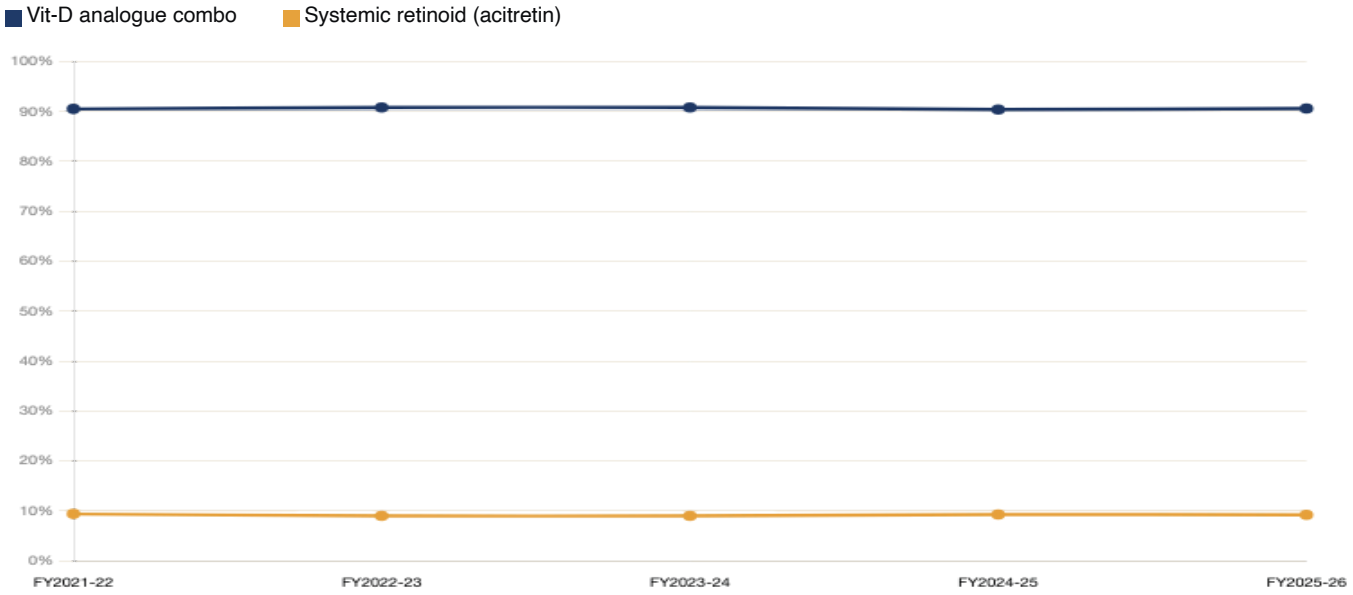
1. **Recognition**
   Well-demarcated erythematous plaques with silvery scale, typically extensor surfaces and scalp; screen for psoriatic arthritis.
2. **Topical optimisation**
   Calcipotriol + betamethasone dipropionate combination first-line; oral acitretin or PUVA phototherapy for more extensive disease — the GP-prescribable layer of this basket.
3. **Referral threshold**
   Moderate–severe or treatment-refractory disease, or signs of psoriatic arthritis — refer to dermatology (± rheumatology).
4. **Specialist biologic pathway**
   IL-17/23 and TNF-inhibitor biologics are dermatologist-initiated and PBS-Authority-restricted — excluded from the PBS volume on this spread (see caveat, facing page).

> *"Between 2.3% and 6.6% of the Australian population have psoriasis"*
> — Kovitwanichkanont T et al., Medical Journal of Australia 2020

This spread reports detection and referral, not a treatment gap: the specialist-led IL-17/23/TNF biologic layer sits outside the PBS volume shown, so a GP treatment rate computed from it would understate true psoriasis therapy.

DRUG CLASS SHARE — 5-YEAR TREND

FY2021-22 → FY2025-26



TREATMENT CONTEXT

The commercial centre of psoriasis therapy sits off this chart. IL-17/23 biologics (secukinumab, ixekizumab, guselkumab, risankizumab, tildrakizumab, ustekinumab, bimekizumab) and TNF inhibitors (adalimumab, etanercept and others) are dermatologist-initiated, PBS-Authority-restricted, and **excluded from this basket** because they span psoriasis, psoriatic arthritis, axial spondyloarthritis and IBD with no verified psoriasis-only split — including them without that split would double-count against a future rheumatology/gastro basket. What the chart shows is the GP-prescribable layer only: the topical vitamin-D/corticosteroid combination and oral acitretin.

Local prescribing index: not published at LGA level for psoriasis medicines, so the drug-class trend above is shown at the national level.

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New on the PBS & TGA this quarter

AUTO-GENERATED — FACTUAL LISTING CHANGES ONLY

Every entry below is a factual PBS record for this issue's tracked conditions — A–Z within class, no commentary. Generated automatically from the PBS Summary of Changes (as at 2026-07). Not a promotional or clinical-guidance page. TGA ARTG registrations and current shortages continue overleaf.

PBS SCHEDULE CHANGES — NEW LISTINGS, DELISTINGS, RESTRICTION CHANGES

Hypertension (8)

DELISTED **PERINDOPRIL** 3050M

DELISTED **PERINDOPRIL** 13404L

DELISTED **PERINDOPRIL** 3051N

DELISTED **PERINDOPRIL** 13371R

DELISTED **PERINDOPRIL** 8704D

DELISTED **PERINDOPRIL** 13372T

+2 more — full list in output/regulatory/pbs_changes.json

Hypercholesterolaemia (2)

DELISTED **EZETIMIBE + SIMVASTATIN** 9483D

DELISTED **EZETIMIBE + SIMVASTATIN** 13385L

Type 2 Diabetes (11)

NEW LISTING **INSULIN DEGLUDEC** 15393E

NEW LISTING **SITAGLIPTIN + METFORMIN** 9449H

NEW LISTING **SITAGLIPTIN + METFORMIN** 13994M

NEW LISTING **SITAGLIPTIN + METFORMIN** 9450J

NEW LISTING **SITAGLIPTIN + METFORMIN** 14064F

NEW LISTING **SITAGLIPTIN + METFORMIN** 10090C

+5 more — full list in output/regulatory/pbs_changes.json

Asthma (8)

RESTRICTION CHANGE **BENRALIZUMAB** 11997K

RESTRICTION CHANGE **BENRALIZUMAB** 11994G

RESTRICTION CHANGE **DUPILUMAB** 12313C

RESTRICTION CHANGE **DUPILUMAB** 12310X

RESTRICTION CHANGE **DUPILUMAB** 12309W

RESTRICTION CHANGE **DUPILUMAB** 12293B

+2 more — full list in output/regulatory/pbs_changes.json

COPD (1)

RESTRICTION CHANGE **GLYCOPYRRONIUM** 15337F

New on the PBS & TGA this quarter — continued

TGA ARTG NEW REGISTRATIONS

TGA ARTG's public search moved to a Microsoft Dynamics 365 Power Pages portal (compliance.health.gov.au/artg) that requires a live, cookie-authenticated browser session for search and CSV export. There is no stable unauthenticated bulk endpoint or scheduled extract to fetch programmatically (the legacy ARTGWebService.svc JSON endpoint referenced in older TGA docs has been retired and now 404s). This pipeline does not carry a headless-browser dependency, so ARTG new-registration data cannot currently be automated. Manual fallback: run the portal's Active Ingredient / Product Name search for the quarter in question and export to CSV by hand; this fetcher's disease-tagging logic (basket.match_baskets) is ready to consume that export once available.

COMING TO THE PBS — RECOMMENDED, AWAITING LISTING

Medicines with a positive PBAC recommendation touching this issue's conditions that have not yet appeared in a PBS Schedule — the forward pipeline. Factual record of PBAC outcomes; listing timing and final restrictions are matters for the PBS.

MEDICINE	PBAC-RECOMMENDED INDICATION	RECOMMENDED	CONDITION SPREAD
DUPILUMAB (Dupixent)	Chronic obstructive pulmonary disease (COPD)	Mar 2026	Asthma
MEPOLIZUMAB (Nucala)	Chronic obstructive pulmonary disease (COPD)	Mar 2026	Asthma
NEMOLIZUMAB (Nemluvio)	Atopic dermatitis	Mar 2026	Atopic Dermatitis
CALCIPOTRIOL WITH BETAMETHASONE (Actobet)	Chronic stable plaque type psoriasis vulgaris	Nov 2025	Psoriasis
CALCIPOTRIOL WITH (Wynzora)	Chronic stable plaque type psoriasis vulgaris	Jul 2025	Psoriasis

Typical waits across all drugs in the measured window (medians): TGA registration → PBAC positive recommendation **9 mo** (n=51) · PBAC recommendation → PBS listing **5 mo** (n=33) · end-to-end **15 mo** (n=14). Method & caveats: output/regulatory/pipeline.json.

CURRENTLY IN SHORTAGE (TGA) — PBS-LISTED ALTERNATIVES

"Alternatives exist" checks whether this issue's own disease basket contains other PBS-listed same-class agents not currently reported short — a factual same-class lookup, not a substitution recommendation. As at 2026-07-10.

CONDITION	MEDICINES IN SHORTAGE	ALTERNATIVES EXIST
Hypertension	CADUET 10/80 amlodipine (as besilate) a…; DICARZ carvedilol 6.25 mg tablet bliste… +44 more	Yes
Hypercholesterolaemia	CADUET 10/80 amlodipine (as besilate) a…; APO-ATORVASTATIN atorvastatin (as calci… +34 more	Yes
Atrial Fibrillation	RIVAROXABAN SANDOZ rivaroxaban 10 mg fi…; RIVAROXABAN SANDOZ rivaroxaban 15 mg fi…	Yes
Type 2 Diabetes	METFORMIN SANDOZ metformin hydrochlorid…; METFORMIN SANDOZ metformin hydrochlorid… +6 more	Yes
Depression & Anxiety	ENLAFAX-XR venlafaxine 75mg modified re…; ENLAFAX-XR venlafaxine 150mg modified r… +12 more	Yes
Migraine	PHARMACOR SUMATRIPTAN 50 sumatriptan su…; SUMATRAN sumatriptan (as succinate) 50 … +5 more	Yes
Asthma	SALBUTAMOL CIPLA salbutamol 2.5mg/2.5mL…; SALBUTAMOL CIPLA salbutamol 5mg/2.5mL (… +7 more	Yes
COPD	DUORESP SPIROMAX budesonide / formotero…	Yes
GORD	ZOPRAL lansoprazole 15 mg enteric capsu…; ZOPRAL lansoprazole 30 mg enteric capsu… +4 more	Yes
Osteoporosis	APO-ALENDRONATE alendronate sodium trih…; EVISTA raloxifene hydrochloride 60mg ta…	Yes

Full shortage list and same-class alternative basis for each condition: output/regulatory/tga_shortages.json.

References

NUMBERED CITATIONS — VANCOUVER STYLE

1. ABS National Health Survey 2022; AIHW chronic-disease prevalence estimates
2. PBS Date of Supply (Jul 2021 – Jan 2026) + PBS item-drug map
3. AIHW 2022: hypertension (high measured BP or on medication) 39% of adults (~7.2M) — base already captures undiagnosed + treated
4. ABS NHMS 2022: measured high total cholesterol 30.2% of adults — base is a measured figure
5. True AF prevalence ~4% of adults (ESC 2024; AIHW CVD 2024) vs 2.1% self-report — paroxysmal/asymptomatic AF substantially under-detected (~1.03M incl undiagnosed)
6. Heart Foundation: ~480,000 Australians with heart failure vs 0.7% self-report — multiplier derived to reach the Heart Foundation figure
7. ABS NHMS 2022: diabetes by HbA1c 6.4% of adults (only 0.9% newly diagnosed) — well-diagnosed
8. ABS NHMS 2022-24: 14.2% of adults have CKD indicators (~3.0M) but only 7.4% self-report (~1.1% of population) — multiplier derived to reach the measured figure
9. ABS National Study of Mental Health and Wellbeing 2020-22: any 12-month mental disorder ~21.5% (~5.7M)
10. Deloitte Access Economics 2018: 4.9M Australians experience migraine vs 6.2% self-report — multiplier derived to reach the epidemiological estimate
11. ABS NHS 2022: asthma 10.8% self-report — well-diagnosed, symptom-driven
12. BOLD Australia: spirometry-confirmed COPD 7.5% of adults 40+ vs 2.5% self-report — multiplier derived to reach the spirometry figure (~975K)
13. RACGP/AIHW BEACH: GP-diagnosed GORD 9.2% of population — base is a diagnosed figure
14. AIHW/Geelong Osteoporosis Study: BMD-measured osteoporosis (~1.3M) vs 3.4% self-report — multiplier derived to reach the DEXA-measured figure
15. Su et al. AJD 2025: current AD prevalence 16.4% / up to 2.8M Australians — prevalence_pct (10.6%) is already count-anchored to the 2.8M target, so no further multiplier (detection/referral frame)
16. MJA 2020 (Kovitwanichkanont et al.): 2.3-6.6% of Australians have psoriasis — prevalence_pct (2.5%, ~662K) is a conservative point in the sourced range; base already a prevalence figure (detection/referral frame)

Methodology

EDITORIAL INDEPENDENCE & FUNDING

The data does not depend on the advertising. Every figure in Pulse is drawn from published Commonwealth and public sources (ABS, AIHW, PBS/Services Australia, AIHW MyHospitals and, for immunisation, the AIR and NCIRS) and is referenced. Editorial content is prepared independently of any advertiser; advertising is sold and laid out separately and does **not** influence which conditions are covered, how figures are calculated, or what the numbers say. A brand advertising alongside a condition has no input into that condition's data or narrative.

Pulse presents **population-level estimates for education**, not clinical directives. Treatment-gap and prescribing figures are modelled indicators, not audits of any practice or clinician, and do not constitute advice about an individual patient. Prescribing decisions remain a matter for the treating clinician and the patient.

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TREATMENT RATE

Treated-patient estimates are derived from PBS dispensing volumes (Services Australia, latest 12 months), normalised for condition-specific dispensing frequency and for the 60-day dispensing reform staged in from September 2023 (most chronic-disease medicines; insulin and anticoagulants only partially eligible). This converts dispensing into an implied number of patients on therapy.

Treatment rate is reported against two denominators: the diagnosed population (ABS NHS prevalence with ABS population data) and total estimated burden, which additionally accounts for undiagnosed cases using under-diagnosis factors from published Australian epidemiological literature. The headline rate on each spread uses estimated burden.

CARE CASCADE

Each cascade descends from estimated population burden (Stage 1) through diagnosis, diagnostic confirmation where relevant (spirometry for COPD, HbA1c for diabetes, LDL screening for hypercholesterolaemia), maintenance therapy, and guideline-optimal therapy. Stages can invert when primary-care patterns deviate from guideline order — for example, the COPD chart shows more patients on maintenance inhalers than have spirometric confirmation, a documented Australian primary-care pattern (ACSQHC 2025).

Cascade stages use red→amber→green colour-coding to indicate the distance from optimal therapy. Red bars represent the largest unmet-need populations.

Atopic dermatitis and psoriasis do not carry a care cascade — both are detection/referral spreads, not treatment-gap spreads (see Prescribing mix, below), and show a recognition → referral pathway panel instead.

PRESCRIBING MIX

Drug-class share is computed independently for each fiscal year from per-item PBS dispensing. For respiratory conditions — where many products are fixed-dose combinations — products are mapped to guideline drug classes (COPD-X / GOLD and GINA) using an internal classification of PBS items by indication. Where a product's class cannot be attributed from dispensing alone, the affected bucket is flagged on the chart.

Heart failure and chronic kidney disease are reported differently. Their foundational therapies (ACE inhibitors/ARBs, beta-blockers, mineralocorticoid antagonists, SGLT2 inhibitors) are shared across cardiovascular and metabolic prescribing and are counted under those conditions. To avoid double-counting, these two spreads track only the disease-specific advanced agents — ARNI, ivabradine and vericiguat for heart failure; finerenone for CKD — so their rates reflect uptake of guideline-specific therapy, and the leading metric is the detection gap, not an all-therapy treatment rate. These agents are indicated for specific phenotypes — ARNI and ivabradine for heart failure with reduced ejection fraction (HFrEF), and finerenone for CKD associated with type 2 diabetes and albuminuria — and several are Authority-listed or specialist- initiated. Figures are a population signal, not a prescribing recommendation for any individual patient.

Atopic dermatitis and psoriasis (added this edition) are also detection/referral spreads with no computed treatment rate or gap: AD's basket is dominated by the specialist-initiated biologic dupilumab, and psoriasis's on-patent IL-17/23/TNF biologic layer is deliberately excluded (cross-indication, no verified psoriasis-only split) to avoid double-counting a future rheumatology/gastroenterology basket. Both show a sourced prevalence figure and measured PBS class-mix instead of a gap.

AGE-STANDARDISED BURDEN ESTIMATES

LGA-level burden estimates are age-standardised: national age-specific prevalence (ABS NHS 2022) is combined with each area's local age structure (ABS Census 2021) so estimates reflect local demographic risk rather than a flat national rate. Older or more disadvantaged populations therefore show higher estimated burden than a flat rate would suggest. Published under-diagnosis factors are applied on top of the age-standardised estimate.

Data sources

DATA SOURCES BY CONDITION

CONDITION	PREVALENCE	DISPENSING	UNDER-DIAGNOSIS	HOSPITALISATIONS
Hypertension	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	AIHW 2022: hypertension (high measured BP or on medication) 39% of adults (~7.2M) — base already captures undiagnosed + treated	—
Hypercholesterolaemia	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	ABS NHMS 2022: measured high total cholesterol 30.2% of adults — base is a measured figure	—
Atrial Fibrillation	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	True AF prevalence ~4% of adults (ESC 2024; AIHW CVD 2024) vs 2.1% self-report — paroxysmal/asymptomatic AF substantially under-detected (~1.03M incl undiagnosed)	—
Heart Failure	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	Heart Foundation: ~480,000 Australians with heart failure vs 0.7% self-report — multiplier derived to reach the Heart Foundation figure	—
Type 2 Diabetes	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	ABS NHMS 2022: diabetes by HbA1c 6.4% of adults (only 0.9% newly diagnosed) — well-diagnosed	—
Chronic Kidney Disease	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	ABS NHMS 2022-24: 14.2% of adults have CKD indicators (~3.0M) but only 7.4% self-report (~1.1% of population) — multiplier derived to reach the measured figure	—
Depression & Anxiety	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	ABS National Study of Mental Health and Wellbeing 2020-22: any 12-month mental disorder ~21.5% (~5.7M)	—
Migraine	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	Deloitte Access Economics 2018: 4.9M Australians experience migraine vs 6.2% self-report — multiplier derived to reach the epidemiological estimate	—
Asthma	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	ABS NHS 2022: asthma 10.8% self-report — well-diagnosed, symptom-driven	—
COPD	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	BOLD Australia: spirometry-confirmed COPD 7.5% of adults 40+ vs 2.5% self-report — multiplier derived to reach the spirometry figure (~975K)	—
GORD	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	RACGP/AIHW BEACH: GP-diagnosed GORD 9.2% of population — base is a diagnosed figure	—
Osteoporosis	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	AIHW/Geelong Osteoporosis Study: BMD-measured osteoporosis (~1.3M) vs 3.4% self-report — multiplier derived to reach the DEXA-measured figure	—
Atopic Dermatitis	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	Su et al. AJD 2025: current AD prevalence 16.4% / up to 2.8M Australians — prevalence_pct (10.6%) is already count-anchored to the 2.8M target, so no further multiplier (detection/referral frame)	—
Psoriasis	ABS NHS 2022; AIHW estimates	PBS DoS Jul 2021 – Jan 2026	MJA 2020 (Kovitwanichkanont et al.): 2.3-6.6% of Australians have psoriasis — prevalence_pct (2.5%, ~662K) is a conservative point in the sourced range; base already a prevalence figure (detection/referral frame)	—

Glossary & disclosure

GLOSSARY

Estimated burden
Estimated number of people living with the condition in the selected area, including undiagnosed cases. LGA-level estimates are age-standardised to local population age structure (ABS Census 2021 and ABS NHS 2022) with published under-diagnosis factors applied.

Treatment rate
The implied share of patients on PBS therapy, reported against either the diagnosed population or total estimated burden. The headline figure on each spread uses estimated burden.

Care cascade
Stepwise drop-off from estimated population burden to guideline-optimal therapy. Each stage's percentage is the share of estimated burden remaining at that step.

Prescribing rate index
Local dispensing intensity for the medicine group (AIHW LGA dispensing data), indexed to the national average (=100). Values above 100 indicate higher local script intensity, below 100 lower.

PPH
Potentially preventable hospitalisation — admission whose cause is amenable to outpatient management. National rates per 100,000 population from AIHW.

LHN
Local Hospital Network — the public-hospital service catchment used by AIHW MyHospitals. LGA→LHN mapping uses a curated table where the geography is unambiguous; otherwise reports the state average across LHNs.

60-day dispensing
PBS reform from September 2023 allowing 60-day supplies for many chronic-disease medicines — roughly halving annual script counts at unchanged patient numbers. Average-scripts-per-patient assumptions reflect post-reform values.

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Treatment-gap and prescribing data for your LGA, benchmarked against national averages — Commonwealth health data in the hands of clinicians.

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