

Measuring uptake of 60-day prescribing

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Peter Breadon and Wendy Hu

What is 60-day prescribing?

In 2023, the federal government introduced 60-day prescribing. This allows doctors to write prescriptions for a 60-day supply of eligible drugs. Previously, the maximum amount a doctor could prescribe was a 30-day supply.

The Pharmaceutical Benefits Advisory Committee recommended the drugs suitable for 60-day dispensing. About 300 drugs for chronic health conditions (such as cardiovascular disease, diabetes, and asthma) have been added to the eligibility list in three stages, on 1 September 2023, 1 March 2024, then 1 September 2024.¹

For a patient to qualify for a 60-day prescription, a doctor must assess their condition as stable and suitable for a longer prescription.

How we measured 60-day uptake

Our main data source was monthly Pharmaceutical Benefits Scheme (PBS) Date of Supply reports.² These reports contain data on the number of prescriptions, total cost, government cost, and patient cost for PBS and RPBS (Repatriation Pharmaceutical Benefits Scheme) Section 85 prescriptions. We used data on PBS prescriptions only from 1 September 2023 to 30 November 2024.

The Date of Supply reports are broken down into individual item codes. We matched these codes to the PBS listing of item codes for drugs that are eligible for 60-day prescribing.³ 30-day and 60-day prescriptions of the same drug have different item codes.

Our measure of uptake is the share of eligible medicines consumed that were filled from a 60-day script.

$$\text{Uptake}_{st} = \frac{\sum_d 2 \times \text{number of 60-day scripts}_{dst}}{\sum_d (2 \times \text{number of 60-day scripts}_{dst} + \text{number of 30-day scripts}_{dst})}$$

where d is each eligible drug, s is the stage of eligibility, and t is the month. Each d is a specific form and strength of drug. For example, we treated a 'prazosin 1 mg tablet, 100' as distinct from a 'prazosin 2 mg tablet, 100'.

This is different from the unweighted share of scripts. Because each 60-day script lasts twice as long as a 30-day script, we would expect to see it half as often in the dispensing data, even if the same number of scripts were written.

We only included drugs that were eligible for 60-day prescribing. But not every prescription of an eligible drug is suitable for a longer prescription – for example, some eligible drugs are issued without repeats. So the maximum potential uptake of 60-day dispensing is less than 100 per cent.

It takes time for the effects of making new drugs eligible to flow through. Patients' existing scripts (with repeats) could last up to six months. So the first six months of each stage should be considered a transition phase.

How much 60-day prescribing there has been?

Uptake of 60-day prescribing has been low. In November 2024, 60-day-prescribing uptake for drugs in the first stage was 30 per cent. Including all stages, the uptake rate reached 21 per cent (see Figure 1).

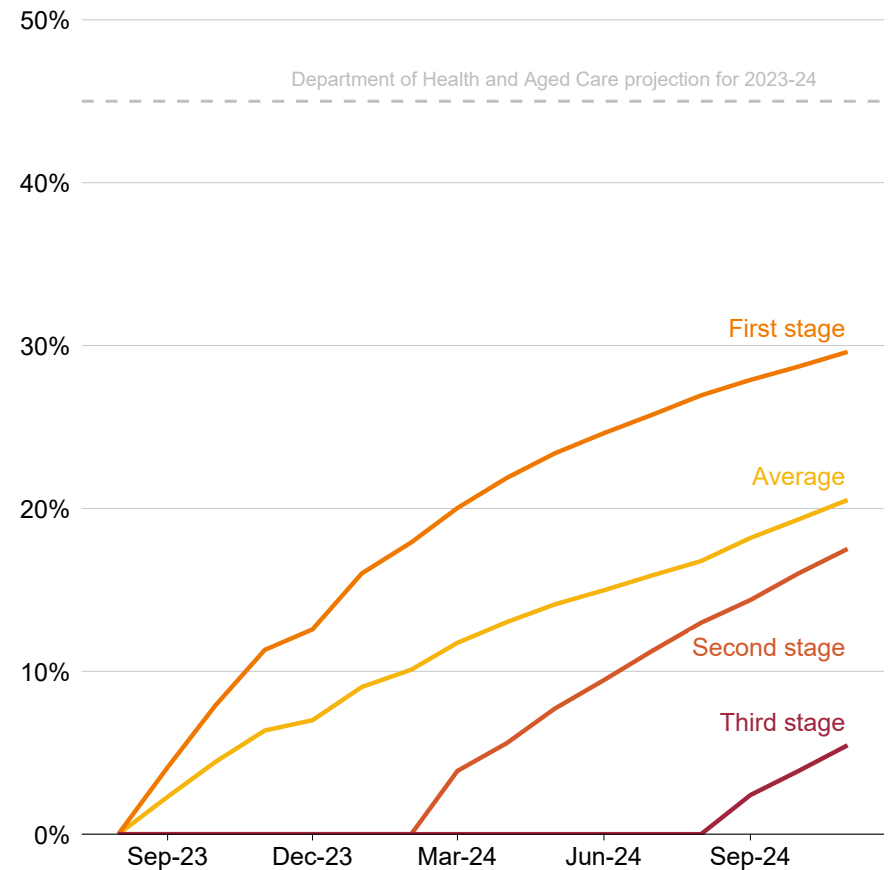
This is lower than the Department of Health and Aged Care projected. In 2023, the department predicted that uptake would be 45 per cent

1. Department of Health and Aged Care (2024a).
2. Department of Health and Aged Care (2024b).
3. Department of Health and Aged Care (2024c).

by 2023-24, and 63 per cent by 2026-27 under a full implementation approach.⁴

Because of the six-month implementation lag as consumers use up old scripts, these projections can only be meaningfully compared to uptake rates for the first stage of drugs added. For the first stage of drugs, 60-day prescribing accounted for 25 per cent of scripts by June 2024. This is lower than the 2023-24 projection of 45 per cent uptake.

Figure 1: 60-day dispensing uptake is slower than projected
Uptake rate of 60-day dispensing



Note: Drugs were added to the eligibility list for 60-day dispensing in three stages: on 1 September 2023, 1 March 2024, and 1 September 2024. There is a six-month implementation lag for each phase given it takes six months for a patient to fully exhaust their current stock of prescriptions.

Sources: Department of Health and Aged Care (2024b) and Department of Health and Aged Care (2024c).

4. Parliament of Australia (2023).

How we measured savings from 60-day dispensing

The PBS Date of Supply reports include data on the total cost, government cost, and patient cost for every patient category, drug, form, strength and presentation, in every month.

We calculated the average total cost for a 30-day prescription and the average total cost for a 60-day prescription from December 2023 to November 2024, as:

$$\text{Avg cost 60-day script}_d = \frac{\text{Total cost of all 60-day dispensings}_d}{\text{Number of 60-day scripts dispensed}_d}$$

$$\text{Avg cost 30-day script}_d = \frac{\text{Total cost of all 30-day dispensings}_d}{\text{Number of 30-day scripts dispensed}_d}$$

This calculation averages across all patient categories and across a whole year. Thus, our estimates of potential future savings assume that the composition of consumers purchasing the drug is constant.

We used the same approach to calculate the average government cost and average patient cost for each drug.

We calculated the average patient saving per 60-day script dispensed (replacing two 30-day scripts dispensed), for every 60-day dispensing drug, as:

$$\text{Saving per 60-day script}_d = 2 \times \text{Avg cost 30-day script}_d - \text{Avg cost 60-day script}_d$$

To calculate actual savings, we summed the saving per 60-day script by the number of 60-day scripts dispensed:

$$\text{Total savings} = \sum_d (\text{Number of 60-day scripts dispensed}_d \times \text{Saving per 60-day script dispensed}_d)$$

To estimate the savings at a 50 per cent uptake rate, we first calculated, for each drug, the number of 60-day scripts that would have to be written to reach 50 per cent uptake (using our uptake measure defined above).

For each drug, the maximum potential number of 60-day scripts in a given month is the current number of 60-day scripts, plus half the number of 30-day scripts (because if every patient currently on a 30-day prescription shifted to a 60-day prescription, we would see half the number of script dispensings in the data). An uptake rate of 50 per cent is half of this maximum figure:

$$\text{60-day scripts at 50 per cent uptake}_d = 0.5(\text{Current 60-day scripts}_d + 0.5 \times \text{Current 30-day scripts}_d)$$

We set the uptake rate for all drugs to 50 per cent regardless of the current uptake rate).

To calculate total savings under the 50 per cent uptake scenario, we multiplied this number of 60-day scripts by the savings per drug calculated previously.

$$\text{Savings from 50 per cent uptake}_d = \sum_d (\text{60-day scripts at 50 per cent uptake}_d \times \text{Saving per 60-day script}_d)$$

To estimate the marginal change in savings from reaching 50 per cent uptake, relative to the current state, we subtracted current total savings from the estimate of savings at 50 per cent uptake. All savings are reported for one year, based on December 2023 to November 2024 data.

To get total savings for patients and the government, we followed the same procedure with patient costs and government costs instead of total costs.

How much would patients save with higher uptake?

We estimate that patients saved \$53 million in 2023-24. The PBS calculation of patient savings was \$54.4 million in 2023-24.⁵ In the same financial year, we estimate that the government saved \$69 million.

From the introduction of 60-day dispensing in September 2023 to November 2024, we estimate that patients have saved \$114 million. Over the same period, we estimate that the government has saved \$141 million. Thus, total savings to date are estimated to be \$254 million.

Under a 50 per cent uptake scenario, we estimate annual patient savings of \$418 million based on total average costs from December 2023 to November 2024 (or an additional \$309 million incremental to current savings for December 2023 to November 2024). We estimate annual government savings to be \$419 million (or an additional \$297 million incremental to current savings).

Actual savings will differ from our estimates due to the interaction between 60-day prescribing and the new \$25 medicines policy.

5. Pharmaceutical Benefits Scheme (2024).

Statins

We report some statistics for statins. These include the following drugs, which were included in stage one of 60-day prescribing:

- simvastatin 10 mg tablet, 30
- simvastatin 20 mg tablet, 30
- simvastatin 5 mg tablet, 30
- rosuvastatin 20 mg tablet, 30
- rosuvastatin 40 mg tablet, 30
- rosuvastatin 5 mg tablet, 30
- rosuvastatin 10 mg tablet, 30
- pravastatin sodium 10 mg tablet, 30
- pravastatin sodium 20 mg tablet, 30
- fluvastatin 80 mg modified release tablet, 28
- simvastatin 40 mg tablet, 30
- pravastatin sodium 40 mg tablet, 30
- atorvastatin 10 mg tablet, 30
- atorvastatin 20 mg tablet, 30
- atorvastatin 40 mg tablet, 30
- simvastatin 80 mg tablet, 30
- atorvastatin 80 mg tablet, 30
- pravastatin sodium 80 mg tablet, 30

- ezetimibe 10 mg + simvastatin 40 mg tablet, 30
- ezetimibe 10 mg + simvastatin 80 mg tablet, 30
- amlodipine 5 mg + atorvastatin 10 mg tablet, 30
- amlodipine 5 mg + atorvastatin 20 mg tablet, 30
- amlodipine 5 mg + atorvastatin 40 mg tablet, 30
- amlodipine 5 mg + atorvastatin 80 mg tablet, 30
- amlodipine 10 mg + atorvastatin 10 mg tablet, 30
- amlodipine 10 mg + atorvastatin 20 mg tablet, 30
- amlodipine 10 mg + atorvastatin 40 mg tablet, 30
- ezetimibe 10 mg + simvastatin 10 mg tablet, 30
- ezetimibe 10 mg + simvastatin 20 mg tablet, 30
- ezetimibe 10 mg tablet [30] () rosuvastatin 20 mg tablet [30], 60
- ezetimibe 10 mg tablet [30] () rosuvastatin 5 mg tablet [30], 60
- ezetimibe 10 mg tablet [30] () rosuvastatin 40 mg tablet [30], 60
- ezetimibe 10 mg tablet [30] () rosuvastatin 10 mg tablet [30], 60
- ezetimibe 10 mg + atorvastatin 80 mg tablet, 30
- ezetimibe 10 mg + atorvastatin 40 mg tablet, 30
- ezetimibe 10 mg + atorvastatin 10 mg tablet, 30
- ezetimibe 10 mg + atorvastatin 20 mg tablet, 30

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