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Uptake and Costs of the 60-Day Dispensing Policy for Antihypertensive Medicines in Australia: A Mixed Methods Study

Tian Wang[1] | Huy L. Nguyen[2] | Isabella Tan[1] | Dean S. Picone[3,4] | Emily Atkins[1] | Sonali R. Gnanenthiran[1] | Michael O. Falster[2] | Sallie-Anne Pearson[2] | Anthony Rodgers[1] | Aletta E. Schutte[2]

[1]The George Institute for Global Health, Sydney, New South Wales, Australia | [2]UNSW Sydney, Sydney, New South Wales, Australia | [3]University of Sydney, Sydney, New South Wales, Australia | [4]Menzies Institute for Medical Research, Menzies Research Institute, University of Tasmania, Hobart, Tasmania, Australia

Correspondence: Tian Wang (tian.wang@sydney.edu.au)

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ABSTRACT

Objectives: To evaluate the uptake of a new 60-day dispensing policy for antihypertensive medicines and estimated cost savings compared with conventional 30-day dispensing; and to explore general practitioner and pharmacist perspectives on the new policy.

Study Design: Mixed methods design; analysis of Pharmaceutical Benefits Scheme (PBS) dispensing claims from 1 September 2023 to 30 April 2025; and semi-structured interviews with 20 general practitioners and four pharmacists from 13 June 2024 to 24 September 2024 to gauge their perspectives on 60-day dispensing.

Setting, Participants: General practitioners and pharmacists practising in New South Wales, Victoria and Queensland, Australia.

Main Outcome Measure: Antihypertensive prescription volumes; patient and government cost savings; and perceptions of the policy from general practitioners and pharmacists.

Results: The 60-day antihypertensive prescription volume increased from 75,500 to 877,700 over 20 months, accounting for 21.2% of all antihypertensive dispensing by 30 April 2025. We estimate the total cost savings for patients were up to ~$65 million, and the government saved ~$87 million and paid pharmacies ~$86.7 million via the Additional Community Supply Support (ACSS) payment program, with a net effect of ~$0.3 million. In interviews, general practitioners indicated varied utilisation of 60-day prescriptions, with some actively providing 60-day prescriptions, but some rarely or not at all. Barriers included keeping abreast of eligible and ineligible medicines for 60-day prescriptions and perceived resistance from pharmacists. Pharmacists were concerned about incorrect dispensing and potential medication shortages.

Conclusion: At 20 months after the introduction of the new policy, 21.2% of antihypertensive prescriptions were for 60-day dispensing. The slow uptake is likely due to low uptake among general practitioners and resistance from pharmacists. The 60-day policy has demonstrated substantial financial savings for patients. If uptake of 60-day dispensing increased to 50%, annual savings from antihypertensive medicines could rise to up to ~$165 million for patients and ~$11.6 million for the government.

JEL Classification: Cardiovascular diseases, Health services administration

Plain Language Summary

The known: In 2021–2022, ~$1.2 billion was spent on hypertension management in primary care; pharmacy fees accounted for 51% of the cost, with patients covering 82% (~$503 million) of pharmacy costs out-of-pocket. The Pharmaceutical Benefits Scheme introduced a 60-day dispensing policy from 1 September 2023 to reduce costs.

The new: By 30 April 2025 (20 months since introduction of the 60-day policy), 21.2% of antihypertensive medicines were dispensed as 60-day prescriptions, saving patients ~$65 million and the government ~$0.3 million. Key barriers included perceived pharmacist resistance and low uptake among general practitioners.

The implications: Increasing uptake to 50% could generate annual savings of ~$165 million for patients and ~$11.6 million for the government.

1 | Introduction

In Australia, over two-thirds of adults treated for hypertension have uncontrolled blood pressure, a leading risk factor for cardiovascular diseases, stroke and dementia [1], placing a substantial economic burden on the Australian healthcare system. In 2021–2022, about $1.2 billion was spent on medical and pharmaceutical management of hypertension in Australian primary care, with pharmacy fees contributing 51% of the total costs, and patients covering 82.3% (~$503 million) of pharmacy fees out-of-pocket [2]. Given that many frequently used medicines fall below the general beneficiary co-payment threshold, patients often bear the full cost of the pharmacy fees, making it an important component of the overall expenditure [3, 4].

Poor medication adherence, financial hardship and irregular follow-ups were identified as the main patient-related barriers in hypertension management [5–7]. To address these challenges and improve medicine access, Australia introduced a new 60-day dispensing policy from 1 September 2023, following the recommendations by the World Health Organization (WHO) and the Pharmaceutical Benefits Advisory Committee (PBAC) [8, 9] on longer dispensing duration to improve medication adherence. Before this policy, most antihypertensive medicines were dispensed for a maximum of 30 days, requiring monthly pharmacy visits where a supply fee is charged each time. The exceptions are diuretics (indapamide, hydrochlorothiazide, chlortalidone and amiloride/hydrochlorothiazide) and some β-blockers (metoprolol tartrate and labetalol) due to variable dosing regimens.

The new 60-day dispensing policy allows patients with chronic, stable medical conditions to collect a 60-day supply of eligible Pharmaceutical Benefits Scheme (PBS) medicines instead of every 30 days. This will reduce pharmacy visit frequency and halve pharmacy fees, with projected patient savings exceeding $1.6 billion over the next 4 years [10]. A recent analysis by the Grattan Institute estimated that with only 21% of medicines dispensed on 60-day prescription within 14 months of policy introduction, patients saved about $110 million and the government saved about $141 million [11]. However, their analysis did not break down savings by disease groups (e.g., hypertension, hyperglycaemia) or patient categories, nor did it consider the implementation of the Additional Community Supply Support (ACSS) payment program, which was introduced on 1 April 2024 to support pharmacies during this transition by offsetting financial impacts on their operations. This program is expected to substantially reduce the government net savings.

Thus, our study aims to (i) evaluate the uptake of the Australian PBS 60-day dispensing policy for antihypertensive medicines since 1 September 2023; (ii) estimate cost savings from antihypertensive medicines for both patients and the government compared with conventional 30-day dispensing; and (iii) explore the perspectives of general practitioners and pharmacists on the 60-day policy.

2 | Methods

We employed a mixed methods study design to estimate financial savings of the 60-day policy compared with the pre-existing 30-day policy for both the government and patients and to gather the perspectives of general practitioners and pharmacists on this policy.

For the quantitative aspect of this study, we analysed publicly available dispensing data from the Medicare Statistics website [12] and the PBS *Date of Supply Report* [13]. Costs are expressed directly as reported in AUD without discounting or inflation. These were analysed using Microsoft Excel 2025 version. We reported the study according to the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) 2022 statement [14] (Table S1).

2.1 | Evaluation of the Uptake of 60-Day Policy for Antihypertensive Medicines

We identified all antihypertensive medicines eligible under the 60-day policy using the *Australian Medicines Handbook* 2024 [15] in combination with PBS listings. We excluded medicines that were (i) not PBS listed, (ii) not primarily used to treat hypertension after consulting experienced pharmacists and clinicians and (iii) not listed under the 60-day policy between 1 September 2023 and 30 April 2025 (Table S2). The study endpoint of April 2025 was chosen due to its completeness of data available for all of our patient groups at the time of our study. For the remaining medicines, we compiled PBS codes for both the 30-day and the 60-day policy on the official PBS website (www.pbs.gov.au), using the search function for each individual medication. We collated data for 228 PBS item codes for 40 medication and/or medication combinations on the 60-day policy.

Dispensing and PBS spending data were extracted from the Medicare Statistics Service from 1 September 2023 to 30 April 2025 [12]. All quantitative analyses are presented as counts and proportions. We analysed dispensing volumes and proportion of medicines dispensed under both the 60-day and 30-day

policies and explored the variations in dispensing volumes across Australian states and by drug classes.

2.2 | Estimation of Cost Savings for Patients

The PBS is funded by the Australian Government to subsidise prescription medicines, with support varying based on patient category, medicine cost and annual spending. The PBS subsidises the cost of medicines above a set co-payment threshold. These thresholds were $30 (2023) and $31.60 (2024) for general patients, and $7.30 (2023) and $7.70 (2024) for concession cardholders [16]. Medicines for which the cost does not exceed the PBS co-payment threshold are referred to as 'under co-payment', and the patient pays the full cost of the medicine. Patients can apply for a 'safety-net card' and access discounted or free medicines after they have spent a certain amount on PBS medicines in a year. To maximise the accuracy of estimated cost savings, we categorised medicine dispensing based on patients with different co-payment thresholds: general beneficiaries, which includes medicines under co-payment and those receiving partial PBS subsidies; patients with concession cards, defined as health care, pension and repatriation cards; and general patients who have reached the safety net threshold.

We obtained data from the *Date of Supply Report* released on 28 July 2025 [13], containing under co-payment data up to 30 April 2025. For general patients, all 30-day antihypertensive medicines prescribed were under co-payment. To estimate patients' savings, we calculated savings per 60-day prescription as the difference between one 60-day supply and two 30-day supplies. In a small number of cases, some antihypertensive medicines under the 60-day policy reached the PBS co-payment threshold, where the government covered costs beyond that threshold. In these cases, savings per dispense were calculated by subtracting the co-payment amount from two 30-day supplies. For prescriptions classified as concessional or repatriation in the under co-payment report, patients on average paid the concessional amount per supply and thus their savings were calculated in the same way as per PBS concessional patients.

For both concession and general patients who reached the safety net, cost savings were calculated as one co-payment amount ($7.30 or $7.70) per 60-day prescription (versus two co-payment amounts for two 30-day dispenses otherwise), multiplied by total 60-day prescription volumes [16]. Detailed formulae are presented in Section S1.

2.3 | Estimation of Cost Savings and the Expenses by the Government

For general patients with medicines exceeding the co-payment threshold under the 60-day policy, we extracted actual PBS spending data to estimate PBS expenses for these medicines.

For patients with concession, for every 60-day dispense, the government saved one dispensing fee ($8.37 from July 2023, $8.67 from July 2024) and one administration, handling and infrastructure fee ($4.62 from July 2023, $4.79 from July 2024) [17] compared with 30-day dispenses. For all patients who reached the safety net threshold, the government saved additional costs from a reduced safety net fee (additional dispensing fee once patients reach the safety net threshold: $1.40 from July 2023, $1.45 from July 2024) [18].

To support community pharmacies during the 60-day policy transition, the government launched the ACSS payment program under the 8th Community Pharmacy Agreement in April 2024 [17]. This policy provides $4.79 per 60-day dispensing and $0.78 per PBS-subsidised dispensing regardless of the dispensing duration. For every 60-day dispense, the government saves one $0.78 ACSS payment from one 30-day prescription but pays one $4.79 fee for the 60-day prescription, resulting in a net additional cost of $4.01 per 60-day prescription. In addition, the government shoulders the loss of one concessional co-payment per 60-day dispense, which otherwise would have been paid entirely by the patients with two 30-day dispenses.

Monthly expenses were calculated by multiplying the savings/expenses per dispense by the monthly prescription volumes. Net savings were then estimated by subtracting total PBS expenses from total PBS savings. Detailed formulae are shown in Section S2.

3 | Qualitative Methods

We conducted online semi-structured interviews with general practitioners and pharmacists practising in New South Wales, Victoria and Queensland across varied socio-economic settings to explore their experiences implementing the 60-day dispensing policy, perceived benefits and barriers to uptake. The interview guide (Section S3) was developed with open-ended questions on these topics to allow for flexibility in responses, with probes to invite expansive responses.

3.1 | Participant Recruitment

General practitioners and pharmacists were recruited to participate in semi-structured interviews via email from 11 June to 19 September 2024. Participants were identified through professional networks (colleagues and acquaintances of SRG and staff at The George Institute for Global Health) and personal networks and from their responses to an online survey for a separate study. General practitioner interviews were conducted as part of a wider study investigating general practitioners' views on hypertension diagnosis, treatment and management. Pharmacist interviews were conducted as part of a separate study focussed on potassium-enriched salt. A total of 21 general practitioners and nine pharmacists were invited, with a target sample size of 20 general practitioners and five pharmacists. Participants were recruited using purposive sampling to capture a diverse range of age, years of practice and socio-economic status of practice location based on the Australian Bureau of Statistics Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) [19]. Sex was recorded as reported in interviewee demographics and reflects biological sex. Postcodes of practices (clinics and

pharmacies) were used to determine the IRSAD quintiles within which the practices were located (range, 1–5), with higher quintiles indicating greater socio-economic advantage.

3.2 | Semi-Structured Interviews

Semi-structured interviews were conducted online via Zoom or Microsoft Teams platforms between 13 June and 25 September 2024. Audio recordings were professionally transcribed. Interviews with general practitioners were conducted by four female researchers (SRG, IT, Katrina Kissock [KK] and Miriam Pikkemaat [MP]), each responsible for asking questions on a specific domain in relation to the wider study. All interviewers had prior experience in qualitative research. Questions on 60-day dispensing were asked by a single researcher (IT), who was not known to any of the general practitioners. One-on-one interviews with pharmacists were conducted by another researcher (KK), who also was not previously known to the pharmacists. Four of the five pharmacist interviews included questions on 60-day dispensing. The duration for the interview section on 60-day dispensing ranged from 4 to 10 min.

3.3 | Qualitative Analysis

Interview transcripts were imported into NVivo (2020, R1; QSR International) for analysis after completion of the 24 interviews. One researcher (SRG) identified emerging themes using field notes taken during the interviews. Another researcher (IT) coded the transcripts separately using reflexive thematic analysis [20]. After familiarisation of the transcripts, initial coding was conducted based on three pre-defined themes: (i) experiences with 60-day dispensing; (ii) perceived benefits to patients; and (iii) perceived implementation barriers. Recurring sub-themes were then identified and coded using an iterative process during the analysis. These were then compared with the emerging themes identified during the interviews. Results are reported as per the 32-item COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist (Table S3) [21].

3.4 | Ethics Statement

Quantitative analysis used publicly available aggregate data; hence, ethics approval was not required. Ethics approval for qualitative interviews was obtained from the Human Research Ethics Committee of UNSW Sydney (iRECS6365). All interviewed participants provided written informed consent.

4 | Results

4.1 | The Dispensing Trends of Antihypertensive Medicines Under the 30-Day and 60-Day Policy

In the first month of the 60-day policy (1–30 September 2023), 75,518 antihypertensive prescriptions (Figure S1) or 2% of total antihypertensive prescriptions (Figure 1) were dispensed as 60-day prescriptions. By April 2025, the monthly uptake had increased to 877,720 prescriptions (Figure S1) or 21% of total antihypertensive prescriptions (Figure 1). The monthly conversion rate to 60-day prescriptions for PBS-subsidised prescriptions increased from 1% in September 2023 to 18.4% in April 2025 (Figure S2), lower than for under co-payment prescriptions, which increased from 2% to 25% over the same period (Figure S3).

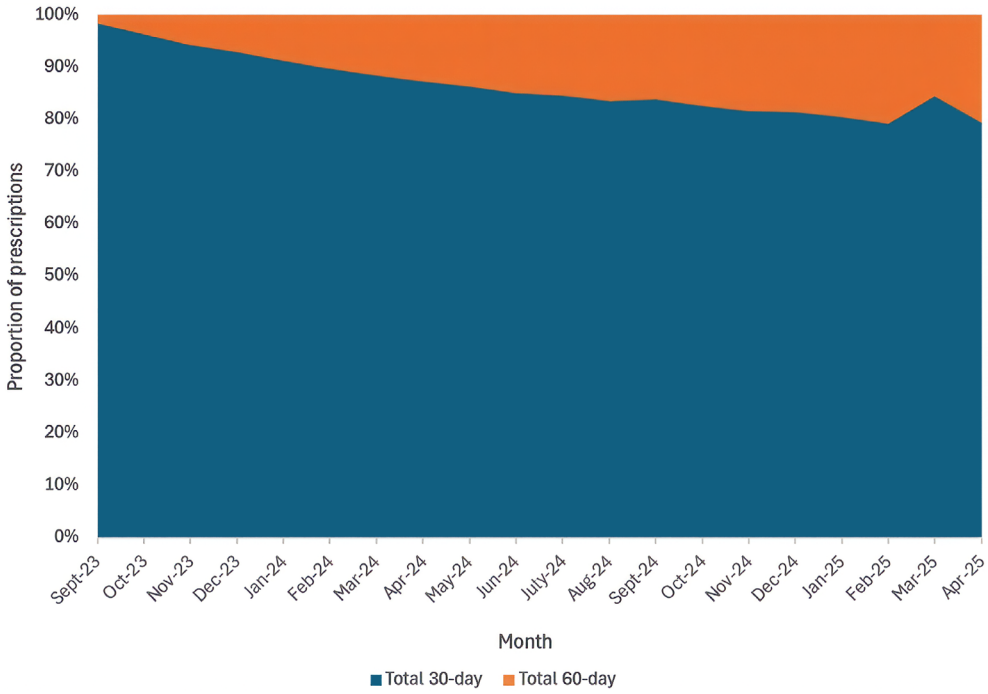

FIGURE 1 | Changes in the proportion of prescriptions for antihypertensive medicines dispensed for 30 days and 60 days (combined Pharmaceutical Benefits Scheme and under co-payment data).

4.2 | Estimated Cost Savings for Patients and the Government

From 1 September 2023 to 30 April 2025, patients saved about $65 million (Figure 2): $26 million by general patients and $39 million by concessional patients (Table S4). General patient savings grew from $0.25 million in September 2023 to about $2 million per month by April 2025 (Table S4). Concessional patient savings rose from $0.15 million in September 2023 to around $3.7 million per month in March–April 2025 (Table S4).

PBS expenditure fell by over $87 million (Table S5), with initial monthly savings rising from $0.4 million in September 2023 to over $6 million each month from November 2024 onwards. Monthly PBS savings on concessional medicines increased 10-fold from $0.27 million in September 2023 to $2.7 million in February 2024 and climbed to $6.4 million per month by April 2025 (Table S4). PBS savings for concessional patients reaching the safety net were initially small due to lower prescription volumes but increased towards the end of each calendar year as more patients reached the threshold. This saving grew from $0.17 million to $1.5 million between September and December 2023, from $0.03 million to $3.0 million during 2024 and was $0.2 million in April 2025 (Table S4).

If 60-day dispensing increased to 50% of the total antihypertensive prescription volume, estimated annual savings could reach about $165 million for patients and $11.6 million for the government.

4.3 | Estimated Additional Expenses for The Government

For PBS-subsidised prescriptions, each 60-day supply results in the government receiving one less co-payment from either the concessional or general patient. Although the initial monthly loss was small at $0.15 million in September 2023, it increased steadily with rising prescription volumes, reaching about $3.6 million in April 2025 and totalling $39 million over the study period (Table S5). Similarly, with a small number of medicines now reaching the PBS co-payment threshold under the 60-day scheme, the PBS has to cover a larger share of their cost. The additional monthly expense rose from just over $7000 in

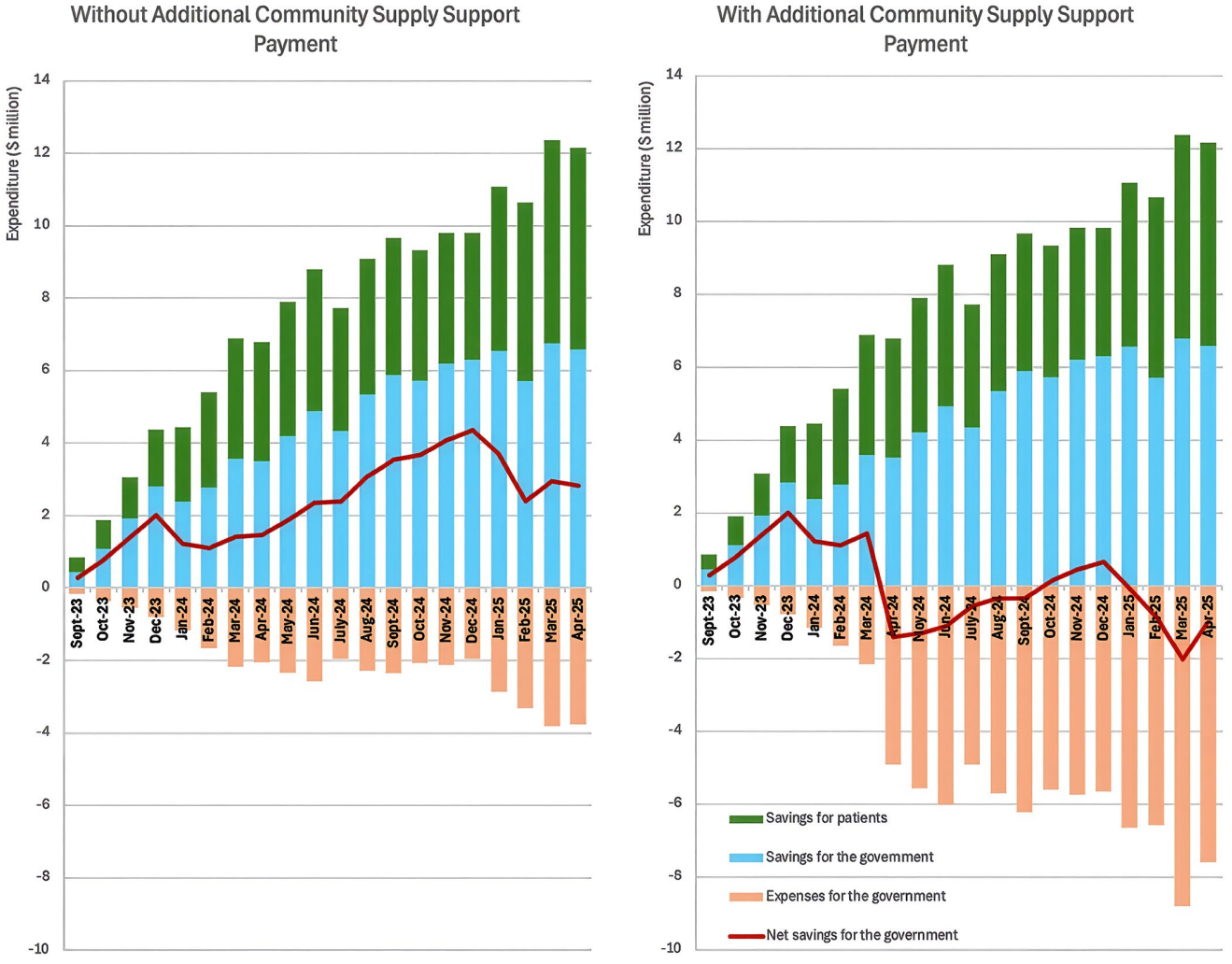

FIGURE 2 | Total savings for patients and the government, and the expenses from the government incurred by the 60-day scheme from September 2023 to April 2025.

September 2023 to over $0.1 million by April 2025, amounting to $1.35 million in total (Table S5).

The government savings was most substantially offset by the ACSS payment (Figure 2), which cost a total of $46.5 million between April 2024 and April 2025 (Table S5). Overall, the net PBS savings were $0.3 million across the study period (Table S5).

4.4 | Perceptions of General Practitioners and Pharmacists Towards 60-Day Dispensing

A total of 20 general practitioners (10 female; mean age, 46 years; standard deviation [SD], 9 years) and four pharmacists (3 female; mean age, 32 years; SD, 7 years) were interviewed. Interviewee characteristics are presented in Table 1. The themes and subthemes identified, as well as supporting quotes, are presented in Table S6. Theme saturation was reached for general practitioner interviews but not for pharmacist interviews.

4.5 | Experience of 60-Day Prescriptions

Overall, general practitioners found 60-day prescriptions acceptable if patients had stable blood pressure and it would not interfere with patients returning for follow-up.

TABLE 1 | Characteristics of interviewed 20 general practitioners and four pharmacists.

	General practitioners	Pharmacists
Sex (female)	10	3
Age (years), mean (SD)	46 (9)	32 (7)
Age (years), range	35–64	26–42
Practice experience (years), mean (SD)	15 (10)	10 (7)
Practice experience (years), range	3–36	4–20
Practice/pharmacy location		
New South Wales	16	2
Victoria	3	2
Queensland	1	0
Postcode-based socio-economic status (IRSAD quintile) [19]		
1st quintile (most disadvantaged)	3	0
2nd quintile	4	1
3rd quintile	4	1
4th quintile	3	1
5th quintile (most advantaged)	6	1

Abbreviations: IRSAD, index of relative socio-economic advantage and disadvantage; SD, standard deviation.

> I would be happy with that if someone is quite stable on their medication. I mean if they come by and see me every half a year, then I'm happy.—General practitioner No. 1.

Utilisation of 60-day prescriptions varied: eight general practitioners proactively prescribed 60-day prescriptions; six did so only upon patients' requests; and five rarely prescribed 60-day medicines. One pharmacist noted that in their pharmacy, 'about 20 per cent' of patients were dispensed 60-day medicines, and another observed that 'most of the proportion [of patients]' were dispensed 60-day medicines.

4.6 | Perceived Benefits for Patients

Twelve general practitioners and three pharmacists identified convenience as the main benefit of 60-day prescriptions for patients, particularly if patients were less mobile or lived in rural or remote areas.

> I think it's beneficial for my really rural patients. I'm very happy for them. At least they can—they don't have to come every single month for their drugs.—Pharmacist No. 5.

Ten general practitioners and two pharmacists identified cost savings for patients.

> I mean cost is a huge benefit. Especially for pensioners. Yeah, and then they don't have to see me as often I guess which is another cost barrier.—General practitioner No. 20.

4.7 | Perceived Barriers to Implementation of 60-Day Prescriptions

Two main barriers general practitioners identified were keeping track of which medicines qualified for 60-day prescriptions (reported by eight general practitioners), and reports that some pharmacies discouraged 60-day prescriptions or could be 'unhappy about it' (reported by 10 general practitioners). Some also experienced initial confusion about prescribing 60-day medicines, including navigating PBS safety-net rules and electronic prescribing software that defaulted to 30-day dispensing. Pharmacists identified barriers including incorrect dispensing and shortage of medicines in pharmacy. One pharmacist expressed cost (lost income) as a potential barrier for pharmacy owners. Five general practitioners and two pharmacists expressed concerns that patients on 60-day prescription may not return for regular follow-up appointments.

> I like to see my patients every month, because I had to review them every month, and that was really helpful. So my question is, how are these guys having reviews if they're not going okay? We can hope and trust that they go to their GP if they are health seeking, but the

> issue nowadays, as well, is difficulty in accessing your GP.—Pharmacist No. 5.

5 | Discussion

By 30 April 2025, with 21.2% of total antihypertensives dispensed by 60-day prescriptions, this new policy has led to estimated savings of ~$65 million for patients and ~$0.3 million for the government (taking into account the ACSS payment to support community pharmacies) over the first 20 months. If 60-day prescription volume increased to 50%, the estimated annual savings from antihypertensive medicines alone could rise to $165 million for patients and $11.6 million for the government.

A recent economic analysis [2] found that pharmacy-related expenses accounted for $611 million (51%) of the $1.2 billion spent on hypertension treatment in 2021–2022, with 82.3% of the pharmacy expenses paid out-of-pocket. Increasing dispensing duration could lower costs and improve medication access, with the ultimate goal of improving medication adherence. Substantial cost reductions were observed among concession cardholders, with up to 50% in pharmacy-related fees saved thanks to the guaranteed savings of one co-payment with each supply. For general patients, savings varied depending on each pharmacy pricing policy since the PBS allows for a range of prices within its parameters [16]. Exact estimates were out of the scope of this study. Additional benefits for patients may include fewer clinic or pharmacy visits, reduced travel time and enhanced convenience.

The PBS also benefited from this new policy, with monthly net savings exceeding $1 million by March 2024. However, following the introduction of the ACSS payment in April 2024 to support community pharmacies, PBS net savings fell sharply to only $0.3 million in total over the study period. The impact analysis [22] by the Department of Health, Disability and Ageing in 2023 estimated a significant loss of income for community pharmacies, at an average of $49,000 for the first year and $158,000 for the fourth year, due to the introduction of the 60-day dispensing policy. The ACSS payment was therefore critical in offsetting the financial impact on community pharmacies.

Our findings are consistent with a recent analysis by the Grattan Institute [11], which reported a slow uptake of 60-day prescriptions in the 14 months following the policy introduction. The adoption rate fell short of expectations, reaching less than half (21.2%) of the Department of Health, Disability and Ageing projected 45% uptake [11].

Dispensing durations vary between countries, with the 2025 WHO Global Report on Hypertension recommending 90-day dispensing duration to improve medication adherence, convenience and treatment continuity [23]. A large recent review including 31 countries found that 70% had a dispensing duration of at least 60 days, with 90 days being the most frequent dispensing duration [24]. Notably, the Canadian 90-day dispensing policy may contribute to its blood pressure control rate of 68%, which is more than double that of Australia (32%) [24]. Several qualitative studies highlight patients' preference for longer than 30-day dispensing, as repeat prescriptions were found to be inconvenient, time-consuming and life-disrupting [25, 26].

However, current evidence on the effect of dispensing duration on medication adherence remains limited, particularly from randomised controlled trials. An observational study that included over 200,000 patients with hypertension found that longer duration prescription of more than 29 days was associated with better long-term medication adherence [27]. Another systematic review of 13 studies comparing 60- to 120-day dispensing with 28-day dispensing found that all studies were conducted in the United States, with none being randomised controlled trials [28]. They conducted an economic analysis and found that 90-day dispensing reduced costs and improved quality-adjusted life years, even after accounting for increased medication wastage compared with 28-day dispensing. However, the studies used in the model had a moderate to high risk of bias. Further rigorous research in Australia is needed to investigate the effect of longer dispensing duration on medication access and, potentially, on medication adherence and related clinical outcomes.

When interviewing general practitioners, we found that they were positive in prescribing 60-day antihypertensives for stable patients committed to regular follow-up, but only 10 of them were actively implementing this new policy. Breadon and Hu [11] identified the low uptake of 60-day policy across all medicines, also finding that low uptake among general practitioners may be a key factor contributing to this slow adoption. Since most patients previously received 30-day prescriptions, this will remain the default-dispensing interval for most prescriptions. Some general practitioners found it cumbersome to prescribe 60-day medicines with their prescribing software [29]. Hence, to improve uptake, prescribing software should be updated to clearly indicate medicines eligible for 60-day dispensing and set these as the default where appropriate.

From the perspectives of pharmacists, their main concerns were incorrect dispensing and medication shortages. A systematic review comparing 30-day and 90-day prescriptions found that medication wastage was not different [28], suggesting these concerns may not eventuate in practice.

From the perspectives of patients, a recent survey conducted in Australia found that patients generally preferred longer dispensing intervals (60-day, 90-day or 120-day) compared with 30-day dispensing when those choices are associated with lower out-of-pocket costs [30]. Comments from general practitioner interviews also support this finding, as many identified cost-savings as a benefit of 60-day prescriptions for patients. Another important but overlooked potential benefit of longer dispensing duration is the improved efficiency for both general practitioners and pharmacists, as less time is required for prescribing and dispensing [31]. Time savings can be redirected towards diagnosis, treatment and supporting patients in managing their conditions.

6 | Limitations

We leveraged the most recently available data, incorporating changes in medication costs, dispensing fees and PBS subsidies to improve the comprehensiveness of the data and accuracy of

estimation. We included all medicines primarily used for blood pressure lowering, with the list verified by experienced doctors and pharmacists. We analysed publicly available data, ensuring transparency and reproducibility, with all analyses and methodological details provided in Sections S1–S3. To better understand the slow uptake of the new policy, we incorporated perspectives from general practitioners and pharmacists. Our findings provide valuable insights to enhance policy implementation. However, these limitations should be noted. First, in the absence of prescribing data, we applied strict exclusion criteria to remove those medicines regularly prescribed for reasons other than lowering blood pressure, likely under-estimating total cost savings. Second, for under co-payment prescriptions, actual costs to patients vary widely across different pharmacies so we used the average cost per supply provided by the PBS report. Third, our interview sample was small and interviewees were not a representative sample of general practitioners and pharmacists across Australia. However, our findings align with recent reports from the Royal Australian College of General Practitioners and the Grattan Institute [11, 30], both of which highlight low uptake among general practitioners and default 30-day prescribing settings as key barriers to broader uptake. Finally, we primarily focussed on antihypertensives as they represented one of the largest and earliest groups included across all three stages of the 60-day dispensing policy rollout, making them well suited for early evaluation. Future research should assess 60-day dispensing uptake across other chronic conditions as suitable data become available.

7 | Conclusion

Uptake of the 60-day dispensing policy for antihypertensives has been slow, likely due to low uptake among general practitioners and resistance from pharmacists. Nonetheless, the policy has demonstrated substantial financial savings for patients compared with 30-day dispensing. At 21.2% uptake of the 60-day dispensing policy, we estimate patients saved about $65 million, and the government saved $87 million in dispensing costs. However, with ACSS payment the net government savings were $0.3 million over the first 20 months. If uptake of 60-day dispensing increased to 50% of dispensing, estimated annual savings from antihypertensive medicines alone could rise to ~$165 million for patients and net ~$11.6 million for the government. Clearer communication to patients regarding the financial benefits of 60-day dispensing, and targeted strategies for prescribers and pharmacists, is essential to ensure broader implementation. These strategies encompass government-led promotion of the policy, benchmarking and feedback on practice-level uptake, and improvement of prescribing software.

Author Contributions

Tian Wang: conceptualisation, methodology, formal analysis, investigation, data curation, writing (original draft), writing (review and editing), visualisation, project administration. Huy L. Nguyen: conceptualisation, methodology, formal analysis, investigation, data curation, writing (original draft), writing (review and editing), visualisation, project administration. Isabella Tan: methodology, formal analysis, investigation, data curation, qualitative interviews, writing (original draft), writing (review and editing), visualisation. Dean S. Picone: writing (review and editing). Emily Atkins: writing (review and editing). Sonali R. Gnanenthiran: qualitative interviews, writing (review and editing), funding acquisition. Michael O. Falster: writing (review and editing). Sallie-Anne Pearson: methodology, writing (review and editing). Anthony Rodgers: conceptualization, methodology, writing (review and editing), supervision, funding acquisition. Aletta E. Schutte: conceptualisation, methodology, investigation, writing (review and editing), supervision, funding acquisition.

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Conflicts of Interest

Aletta E. Schutte has received speaker honoraria from Servier, Abbott, Sanofi, AstraZeneca, Medtronic, Omron and Aktiia and serves on scientific advisory boards for Medtronic, Alnylam/Roche, Servier, AstraZeneca, SiSU Health and Sky Labs. The Medicines Intelligence Research Program has undertaken contract research with IQVIA, unrelated to this work.

Data Availability Statement

Derived data and analytical codes are available from the corresponding author (Tian Wang) upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** mja270167-sup-0001-supinfo.pdf.