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Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention

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Key messages:

- **Dispensing fees for medication assisted treatment for opioid dependence (MATOD) are inequitable and create a major barrier to treatment access, retention and optimal outcomes.**
- **State and/or federal governments must address the issue of dispensing fees and implement a more equitable system of payment in order to support MATOD clients and in particular disadvantaged clients and those on low or fixed incomes**

What is the issue?

It is well established that engagement in MATOD is associated with a range of positive outcomes including reduced heroin use, reduced risk of blood-borne virus transmission, reduced heroin-related overdose and reduced acquisitive crime associated with heroin dependence (1, 2). In addition, quality of life generally improves during treatment (3-5, 27). The literature indicates that longer treatment duration (≥ one year) and continuity of care are typically associated with greater benefits (6, 7) as are higher doses of maintenance medication (8, 9, 28,29). However, the evidence also demonstrates that the need for treatment varies from one person to the next and cycling in and out of treatment is common (10). Treatment entry may be precipitated by a crisis and a client may be seeking a degree of stability rather than aiming to cease illicit drug use completely (3).

It is important that a decision to exit treatment is planned and based on client needs and expectations. The evidence indicates that coming off treatment prematurely often leads to relapse and poor outcomes (11). There are many factors that may lead to premature departure including inadequate dosing, strained relationships with treating staff and treatment related exposure to stigma and discrimination (3, 12-14). Another factor, and the focus of this brief, is the high cost to MATOD clients in most Australian jurisdictions. There is evidence that this cost puts many clients in the unenviable position of either sacrificing life necessities to fund their drug treatment or missing

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doses and ultimately ceasing treatment. Inability to make regular dispensing fee payments frequently contributes to a break-down in the relationship between pharmacist and consumer and indirectly influences the client's untimely exit from treatment (15).

How treatment is offered

MATOD services are provided in a variety of different ways in Australian states and territories. The complex service mix includes public and private clinics and community-based services, which comprise both private GPs and privately owned and operated pharmacies.

The costs are covered by:

- The Commonwealth Government which funds the medications (i.e. methadone, buprenorphine and buprenorphine-naloxone) under section 100 of the *National Health Act 1953*;
- State and Territory Governments which provide funding for public clinics, regulatory services and other costs, including training for GPs and pharmacists ; and
- MATOD consumers who are charged program or dispensing fees by pharmacies which dispense pharmacotherapy medications

For several specialist groups, the cost of treatment is subsidised by state governments. For example, in Victoria, prisoners' dispensing fees are subsidised for the first 4 weeks post release and all young people under 19 years are fully subsidised(16). In the ACT, a subsidy of $20 per week is provided for clients who are dosed at community pharmacies and paid directly to the pharmacy (18). In NSW, pharmacies are provided with incentive payments to encourage them to dispense MATOD medications (19).

Access to treatment

It has been estimated that, on any one day, less than half of the Australians who are opioid-dependent are in treatment (17). There are many reasons why this might be the case. For example, some people don't want treatment at that point in time, some have geographical difficulty accessing treatment and some work long hours and are unable to access treatment during business hours. For many, the issue of cost and the 'consumer pays' model is the major impediment and barrier to treatment. The literature indicates that clients require access to affordable MATOD if they are to gain maximum benefit from pharmacotherapy programs.

A NSW survey (2008) claimed that around one quarter of pharmacotherapy clients were in debt to their community pharmacy (M = $71.75) and clients described skipping or being refused doses due to their inability to pay (12% and 5% respectively) (12). In another study, over 70% of community pharmacies reported giving credit to clients who were unable to pay dispensing fees (17). The literature reveals a strong association between the accrual of debt and subsequent dose refusal and/or termination instigated by the pharmacist rather than the client (20).

Dispensing fees

Community pharmacies constitute the largest proportion (85%) of pharmacotherapy 'dosing sites' in Australia. An estimated 69% of clients had their treatment dispensed at a community pharmacy on a 'snapshot day' in 2009 (18). Pharmacies are commercial enterprises which not surprisingly charge consumers a daily or weekly dosing fee to cover their dispensing related costs. However, fees vary markedly within and across states and territories as pharmacies are entirely responsible for setting their own fees based on their own assessments of cost. This differs from arrangements for other PBS prescription medications, where the Commonwealth uniformly provides a dispensing fee (and, where appropriate, a dangerous drug fee) to the pharmacy and a consistent fee is also charged to the consumer, on a 'per script', rather than a 'per dose' basis (21).

Recent research shows that the daily MATOD dispensing fee can range from $1.50 to $10 (median = $4.65 for methadone and $5 for buprenorphine preparations) (19). Therefore the average cost for 12 months could exceed $1800 and be as high as $3640. This compares with $6.00 per monthly script (capped at $360 annually) for someone with a healthcare card who requires ongoing treatment and medication for any other chronic condition such as diabetes or depression.

The evidence indicates that MATOD dispensing fees are a major barrier to treatment retention (20-23) and represent a significant financial burden particularly for the 65-75% of pharmacotherapy clients on fixed incomes or welfare support (Newstart single person allowance = $510.50 per fortnight at time of writing) (3, 19). For these clients, the cost of dispensing fees even at the lower end of the scale accounts for approximately 12% of their weekly income. Dispensing fees add to the financial burden already faced by many in this group and may effectively prevent consumers from making positive changes in their lives and participating fully in their

communities.

The seminal study by Rowe in 2008 (21) highlighted the consequences of this financial burden on clients and their families, including going without necessities, engaging in illegal activities, jeopardising treatment success due to missed doses and exiting treatment prematurely.

In conjunction with the wide range of dosing fees, there is also significant variation in dosing regimes. Arrangements can vary from daily supervised dosing to a number of take-away doses per week through to unsupervised dosing regimens, which allow for fortnightly or monthly dispensing of medication, although these arrangements are generally only available to clients on buprenorphine-naloxone. Despite these variations, there is little difference in the fees charged to consumers (24). Although this anomaly is rationalised on the basis of the cost of preparing take-away doses (21), it could also be argued that charging the same fee for supervised and unsupervised doses is unethical and a barrier to treatment retention for those on unsupervised regimes (19).

What steps can be taken to address the issue?

There are a number of strategies which could be employed to address the issue of MATOD dispensing fees. A shift towards more equitable arrangements whereby ability to pay is not a requirement for entering treatment is essential and more consistent with the overarching principles which govern healthcare in Australia (20). At the very least, the implementation of a sliding scale of payments tied to income would constitute a more reasonable approach.

Although full subsidisation would be welcomed wholeheartedly by consumers, there are a number of potential ways forward and a range of possible models involving different levels of government subsidy. State and territory governments could address MATOD related costs by partially subsidising dispensing fees and reducing the cost to the consumer to a more affordable co-payment, e.g. approx. $2 per day or 5% of the minimum wage or lowest fixed income. If this subsidy was available only to those with a Health Care Card, it would act as a kind of 'means test' to ensure financially disadvantaged clients received additional support to remain in treatment.

An approach such as this would benefit both service providers and service users alike. The client co-payment would contribute to the sustainability of the system, and encourage more pharmacies to dispense pharmacotherapy medications while addressing some of the financial barriers to treatment entry and retention for consumers.

Conclusion

MATOD is the most effective form of treatment for opioid dependence and the preferred treatment option for large numbers of opioid dependent clients. MATOD is also a cost effective treatment, with good outcomes for the consumer and the community (25). However, despite the acknowledged public health and drug treatment benefits, there is no systematic financial support for MATOD consumers. Unlike other groups with chronic conditions, (e.g. diabetes, those in need of heart or blood pressure medications, etc.) pharmacotherapy clients are required to pay dispensing fees on a daily basis. This daily dispensing regime places MATOD clients in a unique position (i.e. no other medication is dispensed or charged for in this way) and ensures that dispensing related costs are considerably higher than those for any other condition. Furthermore, this is a financially disadvantaged group already, who are doubly penalised by the treatment model (i.e. daily supervised dosing) as well as the method of payment (i.e. daily dispensing fee).

Cost benefit modelling demonstrates that, although expensive, paying for MATOD program and dispensing fees would have a net benefit for the consumer and the community (26). A recent modelling project undertaken by the Drug Policy Modelling Program (DPMP) concluded that if the Federal government were to cover all MATOD costs (approx. $4 million per month) the cost would be more than offset by the economic benefits to the community including health and social benefits such as reductions in health care utilisation and crime (26).

The issue of cost is a long-standing area of concern with the potential to undermine equitable access to MATOD and optimal retention in treatment. Addressing the issue of cost and who pays is essential if consumers and the wider Australian community are to gain maximum benefits from MATOD.

References

1. National Institute for Health and Care Excellence (NICE). Methadone and buprenorphine for the management of opioid dependence: NICE technology appraisal guidance 1142007.
2. Davoli M, Bargagli AM, Perucci CA, Schifano P, Belleudi V, Hickman M, et al. Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multi-site prospective cohort study. Addiction. 2007 Dec;102(12):1954-9. PubMed PMID: 18031430. Epub 2007/11/23. eng.
3. Rowe J. A raw deal? The hidden costs of pharmcotherapies for

Victoria's most vulnerable. Draft progress report for the Salvation Army. 2007.
4. De Maeyer J, Vanderplasschen W, L. C, Vanheule S, Sabbe B, Broekaert E. A good quality of life under the influence of methadone: a qualitative study among opiate-dependent individuals. Int J Nurs Stud 2011;48:1244-57.
5. Piralishvili G, Gamkrelidze I, Nikolaishvili N, Chavchanidze M. Evaluation of the quality of life (Whoqol-Bref) among methadone and suboxone substitution state program patients and healthy volunteers in Georgia. Georgian medical news. 2012 Dec(213):44-7. PubMed PMID: 23293233. Epub 2013/01/08. eng.
6. Zhang Z, Friedmann PD, Gerstein DR. Does retention matter? Treatment duration and improvement in drug use. Addiction. 2003 May;98(5):673-84. PubMed PMID: 12751985. Epub 2003/05/20. eng.
7. Moos RH. Addictive disorders in context: principles and puzzles of effective treatment and recovery. Psychology of addictive behaviors : journal of the Society of Psychologists in Addictive Behaviors. 2003 Mar;17(1):3-12. PubMed PMID: 12665076. Epub 2003/04/01. eng.
8. Fareed A, Casarella J, Roberts M, Sleboda M, Amar R, Vayalapalli S, et al. High dose versus moderate dose methadone maintenance: is there a better outcome? Journal of addictive diseases. 2009 Oct;28(4):399-405. PubMed PMID: 20155609. Epub 2010/02/16. eng.
9. Caplehorn JR, Bell J, Kleinbaum DG, Gebski VJ. Methadone dose and heroin use during maintenance treatment. Addiction. 1993 Jan;88(1):119-24. PubMed PMID: 8448501. Epub 1993/01/01. eng.
10. Teesson M, Mills K, Ross J, Darke S, Williamson A, Havard A. The impact of treatment on 3 years' outcome for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS). Addiction. 2008 Jan;103(1):80-8. PubMed PMID: 17995994. Epub 2007/11/13. eng.
11. Gossop M, Marsden J, Stewart D, Kidd T. The National Treatment Outcome Research Study (NTORS): 4-5 year follow-up results. Addiction. 2003 Mar;98(3):291-303. PubMed PMID: 12603229. Epub 2003/02/27. eng.
12. Lea T, Sheridan J, Winstock A. Consumer satisfaction with opioid treatment services at community pharmacies in Australia. Pharmacy world & science : PWS. 2008 Dec;30(6):940-6. PubMed PMID: 18850299. Epub 2008/10/14. eng.
13. Bao YP, Liu ZM, Epstein DH, Du C, Shi J, Lu L. A meta-analysis of retention in methadone maintenance by dose and dosing strategy. The American journal of drug and alcohol abuse. (1):28-33. PubMed PMID: 19152203. Epub 2009/01/20. eng.
14. Meier P, Barrowclough C, Donmall M. The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. Addiction 2005;100(3):304-16.
15. Lintzeris N, et al. Report on the evaluation of community methadone services in Victoria. Melbourne: Turning Point Drug and Alcohol Centre 1996.
16. Department of Health. Policy for maintenance pharmacotherapy for opioid dependence. Melbourne: Victorian Government, 2013.
17. Chalmers J, Ritter A, Heffernan M, McDonnell G. Modelling pharmacotherapy maintenance in Australia: Exploring affordability, availability, accessibility and quality using system dynamics, ANCD Research Paper #19. Canberra: Australian National Council on Drugs; 2009.
18. Australian Institute of Health and Welfare. National Opioid Pharmacotherapy Statistics Annual Data collection: 2009 report. Cat. No. AUS 125. Canberra: AIHW; 2010.
19. Feyer A, Mattick R, Schulman C, Jessop R, Soloman J, Pyper D. A national pharmacotherapy model for pharmacotherapy treatment for opioid dependence in community pharmacy. Sydney: Australian Government Department of Health and Ageing, 2008.
20. Ritter A, Chalmers J. Polygon: the many sides of the Australian opioid pharmacotherapy maintenance system: ANCD Research Paper 18. Canberra: Australian National Council on Drugs; 2009.
21. Rowe J. A raw deal? Impact on the health of consumers relative to the cost of pharmacotherapy. Melbourne: RMIT and the Salvation Army; 2007.
22. Healthcare Management Advisers. Funding Model Options for Dispensing of Pharmacotherapy for Opioid Dependence in Community Pharmacy: Final report for the Pharmacy Guild of Australia. 2007.
23. Winstock AR, Lea T, Sheridan J. Problems experienced by community pharmacists delivering opioid substitution treatment in New South Wales and Victoria, Australia. Addiction. 2010 Feb;105 (2):335-42. PubMed PMID: 20078490. Epub 2010/01/19. eng.
24. Winstock AR, Lea T, Ritter A. The impact of community pharmacy dispensing fees on the introduction of buprenorphine - naloxone in Australia. Drug and alcohol review. 2007 Jul;26(4):411-6. PubMed PMID: 17564877. Epub 2007/06/15. eng.
25. Doran C. Economic Evaluation of Interventions for Illicit Opioid Dependence. Geneva: World Health Organization, 2007.
26. Chalmers J, Ritter A. Subsidising patient dispensing fees: The cost of injecting equity into the opioid pharmacotherapy maintenance system. Drug and alcohol review. 2012;31(7):911-7.
27. De Maeyer, J., W. Vanderplasschen, L. Camfield, S. Vanheule, B. Sabbe and E. Broekaert (2011). "A good quality of life under the influence of methadone: A qualitative study among opiate-dependent individuals." International Journal of Nursing Studies 48(10): 1244-1257.
28. Strain EC, et al. (1999) Moderate- vs high-dose methadone in the treatment of opioid dependence: a randomized trial. JAMA;281(11):1000-5.
29. Strain, E. C., M. L. Stitzer, I. A. Liebson and G. E. Bigelow (1993). "Methadone dose and treatment outcome." Drug and Alcohol Dependence 33(2): 105-117.

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