SCHEDULE 8 MEDICATION

In January 1999 the Pharmacy Australia Congress issued a press release stating the Health Insurance Commission (HIC) was stepping up efforts to involve pharmacists in its 'Doctor Shopping Project' - an initiative aimed at reducing the abuse of prescription drugs in Australia.

A 'doctor shopper' was identified as "someone who sees multiple doctors to have more prescriptions filled than is clinically necessary".

In September 1999, members of the HIC visited Darwin. A meeting was held with representatives of Territory Health Services (THS), including the Chief Health Officer (Pharmacy and Poisons Branch, Alcohol and Other Drug Services); Australian Medical Association; Commonwealth Health; the Medical Board of the Northern Territory and the Northern Territory Police.

The meeting's purpose was to discuss the high levels of opiate prescribing in the NT, particularly the high levels of MS Contin (Morphine) 100mg. Pharmaceutical Benefit Scheme (PBS) Data per 10,000 people showed an upward trend in both volume and strength in the NT as compared to any other state and territory; an alarming result considering the population size compared to New South Wales (HIC, Adelaide).

HIC Adelaide also indicated that a high rate of under 35 year olds were among 30 patients who had visited over 15 doctors in a 12 month period. Assessment of the statistics found the under 35 year olds were the predominant 'doctor shoppers'.

Over prescribing and abuse of narcotics has also come to my attention through complaints to the Commission. It raises issues of public importance from a health, social and societal point of view, and warrants discussion in this Annual Report.

THE LAW

For reasons of public health and safety, many drugs are regulated. In the Northern Territory, the Poisons and Dangerous Drugs Act and the Misuse of Drugs Act apply to the use and supply of narcotics, such as schedule 8 medication.

The Poisons and Dangerous Drugs Act "regulates the sale, supply, storage, possession and use of poisons and dangerous drugs". THS controls the legal supply and use of schedule 8 medication through the Act. The NT Police control the illegal use and supply of drugs through the Misuse of Drugs Act. By law all schedule 8 prescriptions are required to be reported to THS to enable monitoring of the levels of prescribing. Prescribing rights can be removed by the Chief Health Officer.

Narcotics are known for their addictive qualities, and in prescribing such drugs, medical practitioners must weigh their therapeutic value against their potential for abuse. They are classified as schedule 8 medication pursuant to the Poisons and Dangerous Drugs Act (and Schedule 2 drugs in the Misuse of Drugs Act). Only medical practitioners, dentists and veterinary surgeons can prescribe schedule 8 medication. Medical Practitioners can only prescribe schedule 8 medication "for the therapeutic use of a particular person" and "only in relation to the treatment of a medical condition other than an addiction" (section 29 and 31 of the Poisons and Dangerous Drugs Act).

It is not an offence, however, for a medical practitioner to prescribe schedule 8 medication for a medical condition, despite that a person may have developed a dependence to the drug. Herein lies the crux of the issue.

PRESCRIBING IN THE NORTHERN TERRITORY

Narcotics are usually prescribed by medical practitioners for treatment or management of acute or chronic pain.

Medical Practitioners have a duty of care to their patients, and they have to determine on a case by case basis the circumstances of the patient's history along with the authenticity of the

pain. It is foreseeable many patients prescribed with schedule 8 medication will become dependant, however, the main reason schedule 8 medication is prescribed is for pain control.

Doctor shopping and the prescribing practices of some Medical Practitioners in the NT has resulted in an extraordinarily high level of Morphine use. In some circumstances patients, through "doctor shopping", have obtained quantities of medication which could not physically have been taken or utilised by the patient for their own use (HIC, Adelaide).

CONSEQUENCES OF OVER PRESCRIBING

There is anecdotal evidence that over prescribing of schedule 8 medication has resulted in a "black market" trade of Morphine in the NT. Prescriptions of MS Contin (Morphine) have been reportedly purchased and on sold for profit (refer to Editorial, NT News 22/11/99 p10 and Parliamentary Debates, 18/10/00 p1 - Ministerial Statement, Mr Stephen Dunham, former Minister for Health, Family and Children's Services).

In outlining the extent of the problem to Parliament Mr Dunham stated "there has recently been a great deal of media and community concern about the issue of drugs in the community, and in particular prescription morphine being diverted and used illicitly" (p1). Mr Dunham alluded to the Voluntary Notification Scheme as being one strategy the government had implemented to reduce doctor shopping and minimise over prescribing.

VOLUNTARY NOTIFICATION SCHEME

The scheme was introduced to reduce 'doctor shopping' and to reinforce obligations of the patient when prescribed schedule 8 medication. The doctor introduces a written agreement (contract) whereby the patient agrees to see only the medical practitioner and attend only one pharmacy for the dispensing of scripts. The contract is signed by both the medical practitioner and patient and entered on a data base through the THS Poisons and Pharmacy Branch. If a patient contracts with another doctor, Poisons Branch notifies both medical practitioners to prevent excess prescribing. A medical practitioner may contact the Pharmacy and Poisons Branch prior to entering into a contract, or check previous scripts. Mr Dunham wanted to ensure the effectiveness of the scheme by making it mandatory and he indicated that Medical Practitioners and Pharmacists supported the initiative (p2-3).
Another strategy is provided for within the provisions of the Poisons and Dangerous Drugs Act. That strategy is:

PRESCRIPTION REGISTER

In the NT schedule 8 prescriptions are dispensed by pharmacists, who are required to record details of each prescription filled and provide a copy of the script to the Chief Health Officer within 7 days (section 36). The details are recorded by the Pharmacy and Poisons Branch and quarterly reports are supplied on suspected "doctor shoppers". The register has a dual role in that Medical Practitioners may obtain prescribing details of patients by contacting the Pharmacy and Poisons Branch and the Chief Health Officer can assess the prescribing practices of Medical Practitioners.

It is important to note that all data relevant to the prescribing and dispensing of schedule 8 medication in the Northern Territory are held by the Pharmacy and Poisons Branch. The HIC data is not complete as it is based on medication prescribed under the Pharmaceutical Benefits Scheme (PBS).

PHARMACEUTICAL BENEFITS SCHEME

PBS is set up pursuant to the National Health Act (Commonwealth). It is a Commonwealth health program introduced to ensure access to medication (approved by the Pharmaceutical Advisory Committee) to all eligible Australians. In essence PBS makes medication more affordable to the average Australian by subsidising the cost to the public.

The scheme has potential to be abused by over prescribing. For instance, a script for 100mg of MS Contin (Morphine) will be charged at $21.90 to the patient (the level of co-payment determined by Commonwealth). However, the cost of the medication to the pharmacy is far in excess of $21.90 and the balance between the co-payment and the real cost is met by the Commonwealth of Australia through PBS (section 85 of the National Health Act).

The cost to the Commonwealth is increased in the event that a patient is on a pension or in receipt of a Health Care Card. In this case the cost to the patient is only $3.50 per script and when the safety net threshold is met they pay nothing for the calendar year. This year's threshold is set at $182.00 (National Health Act).

If schedule 8 medication is prescribed for dependency rather than the treatment of chronic pain the prescription is contrary to the PBS. This raises issues of fraud of the Commonwealth and the Medical Practitioner may be obliged to repay the Commonwealth through the HIC if the case is successfully proven.

The potential repayment ramifications and public awareness of the incidence of over prescribing has resulted in a reluctance and refusal by many Medical Practitioners in the NT to consult with and prescribe schedule 8 medication. As a consequence many of their former patients have complained to the Commission.

The HIC in Adelaide released statistics for each State and Territory in relation to the prescribing of MS Contin (Morphine) for 1997 and 1998. Statistics for the Northern Territory which follow give a clear indication of the growth of MS Contin in the Territory. Of particular concern is the significant increase in the strength of the drug prescribed.

Graph No 4 and 5: MS Contin prescribing in the NT per 10,000 people in 1998

Of relevance is the fact that the PBS data is not complete as it does not reflect medication prescribed from private scripts, hospitals or where the patient paid full price without requiring Commonwealth subsidy.

Privacy considerations prevent the HIC maintaining a central repository of all prescribing in the NT and Australia. Complete statistics for prescribing of schedule 8 medication in the NT are held by the Pharmaceutical and Poisons Branch.

THE PRESENT

Recent deaths resulting from overdoses of prescribed medication have heightened public awareness through investigations by the Coroner, complaints to the Medical Board and the Commission and increased public debate. In a recent complaint, a Medical Practitioner, has been de-registered for 6 months and his schedule 8 prescribing rights have been revoked indefinitely.

As a consequence of unfavourable publicity and HIC intervention it appears that Medical Practitioners are less willing to treat ongoing patients on schedule 8 medication. This issue is of particular concern to me, and has been highlighted by recent complaints to the Commission. Where do legitimate chronic pain patients go for treatment and ongoing prescriptions? What does a person with chronic pain do if doctors refuse treatment and cease prescribing their 100mg MS Contin (Morphine), which they have been taking daily for a year?

LONG TERM MANAGEMENT

In October 2000, Mr Dunham (former Minister for Health, Children and Family Services) indicated that in addition to the $5 million THS provides to community based drug and alcohol treatment agencies, THS had developed constructive partnerships with the Australian Medical Association and Top End Division of General Practice to extend options for opiate dependant persons, which included:

"the establishment of the specialist GP drug clinic that operates out of Alcohol and Other Drugs Services, on the RDH campus. Three local doctors have received specialised training in treating dependence, drug assessment and withdrawal and are working on a sessional basis at the clinic. The clinic has extended referral and treatment options for drug dependent persons and improved case planning and management of patients with drug issues. Alcohol and Other Drug Services is also working collaboratively with the NT pain management clinic

at RDH to improve management of patients with both pain and opiate dependence" (Parliamentary Debate, 18/10/00 p3).

Pain clinics exist in most States and Territories. The focus is on multi-disciplinary pain management. Medication may be used in conjunction with treatment but is not the sole pain management option. Patients are assessed and treated by pain specialists, general practitioners, rehabilitation specialists, and allied health professionals, including psychologists and physiotherapists with a view to long term pain management and rehabilitation.

The pain clinic in Darwin is, like in any other jurisdiction, susceptible to long waiting lists. In responding to a particular complaint, I was advised by Royal Darwin Hospital the waiting list for the pain clinic was approximately 10 months, which is in line with other states where it is usual for the waiting list to be up to 12 months. In response to another complaint relating to concerns about the chronic pain service provided by Royal Darwin Hospital, they advised:

"During 2000/01 the Royal Darwin Hospital trailed an enhanced pain service which involved the establishment of multi-disciplinary pain management clinics. The service provided a treatment program on both individual and group levels, hydrotherapy and multi-disciplinary assessments. The trial of this service was always contingent on funds and presently the service is being re-evaluated, as the enhanced service could not continue in its current form.

The Royal Darwin Hospital does still provide a chronic pain service conducted by the Rehabilitation Specialist, a clinical Psychologist and a Physiotherapist, however it is no longer supported by an extended multi-disciplinary team. Territory Health Services are currently exploring other options to provide the service.

The current service will not cease until acceptable strategies have been developed to refer current clients and new clients back to their GP's for future pain management."

It can be seen that genuine pain sufferers, who are wait listed, may be treated by their local GP who seek support and assistance from pain specialists. In the meantime they wait the 10 months or so for an assessment by the pain clinic. There in lies the cyclic nature of the problem, many GP's do not have the expertise and will not, it appears, prescribe schedule 8 medication without the patient first being assessed by the pain clinic. Where does the patient with a genuine need go to continue to obtain his / her schedule 8 medication? It appears the options are limited to:

- One of the few Medical Practitioners who legitimately provide this service and can properly monitor and assess the patient;
- An approved maintenance program;
- The "black market", and risk being labeled an addict and possibly turning to crime to pay for narcotics.

Introduction to an "approved maintenance program" is not an option in the NT as we do not have one. This would require a change in Government policy and legislation.

CONCLUSION

I am becoming increasingly concerned there is no clear and transparent treatment regime available to chronic pain sufferers who require schedule 8 medication to treat and manage their pain. It is more and more likely that without an effective Pain Management Clinic and a meaningful maintenance program many genuine patients are going to resort to the illegal and unregulated market to obtain their schedule 8 medication and that this may in turn lead to addiction, crime and even death.

It would appear appropriate to recommend that Government review the current policies and processes in relation to chronic pain management and the prescribing of schedule 8 medication and consider long term strategies to deal with the problem. As long as schedule 8 medication is prescribed legitimately for pain management the issue will be ongoing. Sadly the very use of such drugs creates instances of dependency and the person genuinely

effected by this should not be labeled and treated as a "drug addict" and unable to obtain proper treatment due to unnecessarily harsh regimes aimed at preventing abuse.

I appreciate that Government, the medical profession and patients may all have differing views on how best to deal with this problem. This conflict of views should not be given as an excuse to do nothing and nor should it be a reason to leave these people out in the cold while a resolution is being found. Adequate resources must be provided to allow people genuinely requiring schedule 8 medication and appropriate pain management to obtain proper treatment.