TALKING POINT

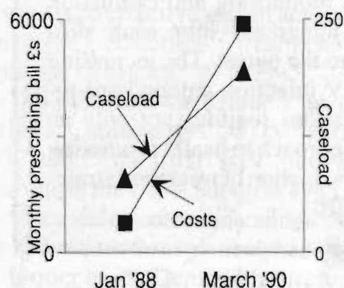
The cost of prescribing

Using methadone to attract and retain clients may make good anti-HIV sense – but who's going to pay the drug bill?

SINCE THE FIRST *AIDS and Drug Misuse* report from the Advisory Council on the Misuse of Drugs in March 1988, drug misuse services have been encouraged to attract drug users into services, maintain contact with them, and alter their behaviour away from 'harmful' practices. In conjunction with outreach initiatives, this 'catch and keep' philosophy has produced a rapid and significant increase in clinical workload for many drug services.

Many such services have received AIDS-related funding for new workers but there has not generally been parallel funding related to the cost of prescribing methadone for opiate users. The costs associated with one community drug team in north-west England may be taken as typical of many drug services.

AT THIS SERVICE, client caseload in January 1988 was 80 and the referral rate was about 15 clients a month. Around 150 prescriptions were issued per month at a cost of about £750 for the 300 items entered on the prescriptions.



By March 1990 the service caseload had risen to 194 (142 per cent up) and the referral rate was 19 clients per month. In that month, 552 prescriptions (270 per cent up) were issued authorising the dispensing of 1647 items (450 per cent up). The disproportionate increase in the number of items probably reflects a recent influx of new clients, who tended to be issued prescriptions to be dispensed daily as opposed to weekly.

While the increased 'productivity' of the service is laudable, doubling from 20.5 clients per full-time equivalent worker in 1988 to 41 a year later, this has produced almost a *700 per cent* increase in prescribing costs – the total sum for March 1990 being £5856. The local district health authority has allocated almost £30,000 from its general budget for the service's prescribing costs in the year 1990/91, but the projected full year sum is almost twice this figure – apparently a result of forecasting based on low client activity last summer.

INCREASED COSTS are *not* related to maintenance prescribing, the average length of contact being about ten months, but are mainly a function of the high clinical workload. Escalating costs are caused by increased client numbers (factor of 2.4); more frequent dispensing (factor of 2.3); and the general increase in pharmacy charges (factor of 1.5).

This last factor highlights a dilemma facing services; it is the cost of using community pharmacists to dispense methadone prescriptions that causes most of the expense. Methadone itself is very cheap (just over £1 for 100mg) but community pharmacists attach a large fee to dispensing controlled drugs (over £3.50 per dispense in the example cited above).

As a result, some community drug teams in the North West are turning to hospital pharmacies for methadone dispensing – arguably a damagingly retrograde shift away from a community base, apart from the sheer inconvenience to clients and to hospital pharmacies.

General practitioners are arguably another potential solution: family practitioner committee (or family health service authority) budgets might absorb these costs more easily than a district health authority.

However, apart from the well-documented reluctance of GPs to treat heroin users, the introduction of indicative drug budgets and budget-holding practices may well exacerbate the difficulties of enticing GPs into a prescribing role.

Services are faced with budget overspends, changing the way they dispense, or turning clients away

Reducing the frequency of dispensing is also a possible cost-saver. However, this may not only lead to unpleasant ethical dilemmas when clinical decisions are based on cost, but may also draw criticism from coroners for the possible rise in overdose deaths; this has already come about in one district in the north west of England.

THE DEPARTMENT of Health and the Advisory Council on the Misuse of Drugs have both encouraged services to attract and retain drug users; methadone prescribing is accepted by most as a legitimate 'treatment' option and services are encouraged to use community-based facilities wherever possible. But neither body appears to have accounted for the bottom line cost implications of these policies – costs which may amount to over £1,000,000 per annum for prescribing in the North West region alone.

Services are faced with options which include budget overspends (fairly unpopular with district health authorities, particularly this year), changing the way they operate their dispensing, or turning clients away. None of these seems reasonable from a clinical perspective or with regard to the various guidelines issued from on high. Waiting for general practitioners to realise what a rewarding client group heroin users could be to rely on what seems a distant if not unachievable goal. Perhaps there is a need for guidelines from the Advisory Council or from the Department of Health on how services can find the money to implement their policy recommendations. ■

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