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Equal treatment for addiction  
medicines?

April 2015

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## **1. Introduction**

Opioid Maintenance Therapy (OMT) is an effective treatment for opioid addiction. In Australia the main forms of OMT are methadone and buprenorphine. OMT provides a regular, consistent and long-acting opioid dose that allows people the opportunity to regain control of their lives. A long-term OMT program enables individuals to improve their physical and mental health, resume employment and/or education and strengthen their relationships with family, friends and the wider community. It also greatly reduces people's risk of fatal overdose, which kills more Australians each year than car accidents.

Better access to OMT will help address growing rates of prescription opioid misuse and overdose. Under the present system, it is cheaper and easier to procure prescription opioids than OMT. Ensuring OMT is affordable is an important strategy to help stem prescription opioid as well as heroin addiction.

This paper focuses on one major impediment to enabling more Australians to access medication-assisted treatment: the requirement that people on OMT pay a fee for each dose they receive, rather than a flat fee per script. These daily OMT fees are described in this paper as co-payments, and they are severely compromising the public health and community benefits of an exceptional form of drug addiction treatment. The effectiveness of OMT is dependent on people staying in treatment and co-payments are the main reason people drop out of treatment – often resuming illicit drug use and criminal activity. Crime related to drug misuse is estimated to cost \$3, 161 million per year in Australia.

Reform is needed to ensure better access to OMT. Co-payment relief must be provided to patients through the Pharmaceutical Benefits Scheme (PBS) to ensure a coordinated, national approach. This will increase patient retention and uptake of OMT across Australia, resulting in better individual outcomes for illicit opioid users and reduced drug-related health and crime costs to the community.

## **2. Opioid use**

The illicit use of opioids such as heroin, and pharmaceutical opioids such as morphine and oxycodone, is a serious health and social problem. Opioid users are more likely to experience mental and physical health problems, social and economic disadvantage, and poorer levels of overall well-being (Ross, Teeson et al., 2005; Dietze, Stoové et al., 2010). People who inject these drugs are at high risk from blood borne viruses such as hepatitis C and HIV/AIDS (Mathers, Degenhardt et al., 2008; Nelson, Mathers et al., 2011) and are at increased risk of

mortality, primarily from overdose (Degenhardt, Bucello et al., 2010; Degenhardt, Whiteford et al., 2013; Pierce, Bird et al., 2015).

Opioid addiction imposes a significant health and economic burden on the wider community, resulting in substantial costs to treatment and prevention services, as well as health care more generally (Collins & Lapsley, 2008; Ruetsch, 2010). Misuse of these drugs is associated with costs to the community, such as productivity loss in the workplace, organised and other crime, and social welfare expenditure (Hall, Doran et al., 2006; Ruetsch, 2010). There are also social costs associated with opioid addiction. These include poverty, family disruption, harm to the welfare of children, and contact with the justice and corrections system (Hall, Lynskey et al., 1999; Horyniak, Higgs et al., 2013).

Not all people who inject opioids are addicted to these drugs. Nor do they necessarily need or want treatment (Dean, Saunders et al., 2011). However, for those who do seek treatment, OMT is an effective strategy that enables them to reduce or cease their drug use (Mattick, Breen et al., 2009; Mattick, Breen et al., 2014). Ensuring that people who inject opioids have good access to quality OMT, benefits the individual and the wider community.

### ***3. What is Opioid Maintenance Therapy?***

OMT is the long-term provision of medication for the treatment of opioid addiction. There are two medications legally able to be used in Australia for OMT. These are methadone and buprenorphine (which is increasingly used as a naloxone combination called Suboxone®). A number of other countries have used other replacement medications for OMT, including heroin.

These medications stimulate opioid receptors in the brain and, at optimised doses, ameliorate opioid withdrawal symptoms without causing intoxication. Methadone and buprenorphine are particularly effective because they are long acting and can be administered orally, reducing the risks of injecting. They may also block the effects of other opioids which can reduce the incentive to continue opioid abuse. Due to their effectiveness in addressing illicit opioid use, both methadone and buprenorphine are listed by the World Health Organisation (WHO) as essential medicines (WHO Expert Committee on the Selection and Use of Essential Medicines, 2006).

OMT medications are potent and can cause overdose and death if inappropriately used (Bell, Butler et al., 2009). Because of this, these medications are mostly dispensed in a supervised environment where people on OMT must consume their methadone or buprenorphine in full view of a pharmacist. This is the main way of controlling administration of these drugs in order to reduce the chances of misuse or diversion to the illicit market and risks to consumers and the wider community. Some OMT clients receive a number of 'takeaway' doses a week. These can be taken home and consumed without supervision. Takeaway doses are very important

because they provide clients with some degree of flexibility which can help with paid and unpaid work, education and training, and parenting (Fraser, Valentine et al., 2007).

#### **4. Effectiveness of OMT**

OMT is an effective treatment for opioid addiction improving the mental, physical and social health of patients (Gossop, Marsden et al., 2003; Maremmani, Pani et al., 2007; Lawrinson, Ali et al., 2008; Teesson, Mills et al., 2008). OMT patients substantially decrease their use of heroin and other opioids, reduce their risk of mortality and morbidity and reduce the transmission risks of injection-related disease such as HIV/AIDS and hepatitis, and are able to increase participation in employment, parenting and community responsibilities (Cornish, Macleod et al., 2010; Grönbladh, Öhlund et al., 1990; Hser, Hoffman et al., 2001; Mattick, Breen et al., 2009; Mattick, Breen et al., 2014; Ritter & Chalmers, 2009; Teesson et al., 2008; Turner, Hutchinson et al., 2011; Ward, Mattick et al., 1998).

Participation in OMT is associated with reduced involvement in property crime and non-violent forms of criminal activity as well as violent crime (Bukten, Skurtveit et al., 2012; Gossop, Trakada et al., 2005; Hall, 1996; Havenes et al., 2012; Teesson et al., 2008).

By removing the drivers for much of the problematic behaviour associated with opioid addiction, OMT can provide people with an opportunity to make sustainable changes in their lives. In this way, OMT is an effective support to other therapeutic approaches (including withdrawal, counselling and rehabilitation) as it promotes the achievement of goals that are indicative of sustained change. For these reasons, it is a prime example of an addiction intervention that also enhances the prospects of long-term recovery.

Access to, and retention in, OMT is essential to successful treatment. OMT is most effective when patients remain in treatment for at least 12 months (Ward et al., 1998). Most available evidence suggests the majority of people leaving treatment will resume drug use (Ward et al., 1998; Winstock, Lintzeris et al., 2011). This research illustrates how important it is that issues such as co-payments do not impact on people's ability to access and stay on OMT.

#### **5. Australian policy**

OMT is an important, evidence-based strategy in Australia's overall response to drug use. Historically, the large-scale rollout of methadone maintenance, combined with other harm reduction interventions, has meant that the high prevalence of HIV/AIDS seen overseas has been avoided in Australia (Fitzgerald & Swards, 2002; Mathers, Degenhardt et al., 2008).

National policy on opioid pharmacotherapies is clear on the goal of OMT:

The broad goal of treatment for opioid dependence is to reduce the health, social and economic harms to individuals and the community arising from illicit opioid use (Intergovernmental Committee on Drugs, 2007).

This policy outlines the objectives of treatment and is explicit that retention in OMT is integral to success:

The objectives of pharmacotherapy are to:

- bring to an end or significantly reduce an individual's illicit opioid use
- reduce the risk of overdose
- reduce the transmission of blood borne diseases
- improve general health and social functioning, including a reduction in crime

These objectives are achieved by engaging and retaining people dependent on opioids in treatment (Intergovernmental Committee on Drugs, 2007).

There is a relatively stable population of around 47,500 OMT patients in Australia (Australian Institute of Health and Welfare, 2013a). This number has increased by less than 1% per year since 2010 after a period of rapid growth since 1998 (Australian Institute of Health and Welfare, 2013a). Yet, while a sizable number of people access this treatment, they face ongoing issues that can jeopardise the effectiveness of OMT. Of these issues, co-payments stand out as a problem that should be dealt with to ensure better outcomes (Kellsal, King et al., 2014). Addressing this issue is paramount if people using illicit opioids and the wider Australian community are to gain maximum benefit from the medical treatment of addiction.

## **6. Models of OMT provision in Australia**

OMT is provided in four main ways in Australia. These are:

- State and territory-funded specialist clinics. These are services for clients with extremely high needs. Specialist clinics provide adjunct services such as case management. OMT is provided at very low or no cost to the patient.
- Community-based services. These include community pharmacists and General Practitioners (GPs). These services are intended to provide services for 'stable' OMT patients. Adjunct services in this model are not necessarily provided. Patients pay anywhere from \$1 to \$10 per day for OMT.
- Private services. These are mostly found in New South Wales. Similar to community-based provision they do not provide adjunct services. They are sometimes more expensive at around \$10 per day to the patient.
- Correctional-based services. OMT is provided in most states to inmates at no cost. Depending on the jurisdiction, people may continue their OMT program or begin OMT once incarcerated (Australian Institute of Health and Welfare, 2013a; Ritter & Chalmers, 2009; Ritter & Lintzeris, 2004).

Australian jurisdictions have enlisted the support of generalist health providers such as GPs and pharmacists to provide the great bulk of OMT. In 2013, 82% of OMT prescribers were in private practice and 88% of dosing points were in community pharmacies (Australian Institute of Health and Welfare, 2013a). This model of provision requires patients to register with an authorised GP to prescribe their medication, and with a single pharmacy to provide supervised doses and takeaway doses. The pharmacist's role includes monitoring the patient's ongoing condition and alerting the prescriber of any problems.

The benefits of delivering OMT through community services rather than specialist treatment centres (or private clinics) are argued to be:

- an increase in the availability and accessibility of treatment including in regional and rural areas
- the normalisation of drug treatment as a general health concern
- that consumers feel less stigmatised attending a primary health care setting rather than a specialist program for treatment
- savings to state government expenditure as the cost shifts to patients and the Australian government (Lintzeris, Koutroulis et al., 1996; Ritter & Chalmers, 2007; Treloar, Fraser et al., 2007; Winstock, Lea et al., 2010)

The last point is an important one, as the cost-effectiveness of the community-based OMT model has allowed its expansion in order to respond to the demand for treatment. Yet, while the cost to government is low compared to other forms of drug treatment (Doran, 2007), OMT patients must carry the costs to pharmacists through program fees. Pharmacies are commercial enterprises. For these businesses to continue to provide OMT, it must remain financially viable.

## **7. What are OMT co-payments?**

OMT co-payments are an ongoing issue for both OMT patients and their pharmacists (Fraser et al., 2007; Ritter & Chalmers, 2007; Shepard, Perrella et al., 2014). While consumers are usually bulkbilled through Medicare for visits to their GP, they are charged a program/dispensing fee by their pharmacist. This co-payment varies, and can range from \$1 to \$10 daily, but has remained relatively stable for the past twenty years. For example, an OMT patient's co-payment per dose might be \$5, regardless of whether or not the person has takeaway doses (hence making fewer visits to pharmacy) or attends the pharmacy each day. The weekly co-payment cost to patients paying \$5 per day would typically be \$35, whether they received takeaways or not.

Pharmacists in most states receive no other payment for the provision of OMT, although there is a subsidy scheme in Tasmania and the Australian Capital Territory and an inducement scheme in New South Wales. Evidence suggests that consumer co-payments do not cover the costs of OMT provision (Feyer et al., 2008). However, co-payments have remained relatively stable, presumably because of the struggle consumers have paying these fees.

OMT co-payments are charged to incorporate:



- the pharmacist's time (they are required to prepare and provide the consumer's dose, and complete all paper work)
- consumables (cups, bottles, labels and cordial in some states)
- general business costs

Fees tend to be higher when OMT is provided through private clinics (mostly NSW) where OMT is their sole business.

Public clinics might also charge dispensing fees, however, these are heavily or completely subsidised by the relevant state/territory government. These clinics tend to only treat patients for a limited time before they are referred to a GP and community pharmacy. Some patients may remain at these clinics for longer if they are considered unstable or complex to a degree that would make attending a community pharmacy an unviable option. Public clinics invariably have long waiting lists and usually equate the stability required for takeaway doses with the stability to dose at a pharmacy. Thus, while being affordable, public clinics provide very limited flexibility to people, impacting on their ability to gain employment, undertake study and engage in other meaningful activities.

There is some argument that the time involved in supervised dispensing should be reflected in co-payments (Winstock et al., 2007). For instance, people on Suboxone® may be entitled to a greater number of takeaway doses, but they are not usually charged less (Winstock et al., 2007). However, as outlined above, program fees are not solely related to the cost of supervised dosing. Paperwork for OMT is similar, regardless of the way the medication is provided. Additionally, providing Suboxone® at a cheaper rate does not address the issue of co-payments in an equitable and sustainable way. It may also make the decision between buprenorphine and methadone financially driven, rather than determined on the basis of what is best for the individual patient.

## **8. The impact of OMT co-payments**

The impact of OMT co-payments on patients is profound, potentially jeopardising treatment continuity and their therapeutic relationship with their pharmacists. The cost of treatment is critical to patient satisfaction and retention in the program (Booth, Corsi et al., 2004; Winstock et al., 2007; Lintzeris et al., 1996). According to reports from advice and dispute resolution services for OMT patients, payment issues related to co-payments are the most common issue of concern, with up to 80% of patients contacting services for this reason (Rossmanith, 2011).

Research with 120 OMT patients in Victoria (Rowe, 2008) found that many faced hardship with fees and this led to adverse outcomes. Some of the key findings of the report were that:

- people on OMT often prioritise the payment of dispensing fees over basic necessities, including food and accommodation
- OMT patients on low incomes are compelled to rely on emergency relief services to meet food and accommodation needs

- a significant minority of consumers engage in crime to meet co-payments
- co-payments often contribute to a deterioration in the relationship between dispensing pharmacist and patient
- the accumulation of debt through the inability to pay dispensing fees is a primary reason for the involuntary discontinuance of treatment
- co-payments are the single greatest obstacle to retention in OMT
- the withholding of OMT encourages illicit heroin and/or other opioid use
- involuntary discontinuance of treatment is invariably followed by a return to problematic heroin use (Rowe, 2008, p.1)

This body of evidence clearly shows the detrimental impact that OMT co-payments have on consumers and how these fees can contribute to the experience of economic hardship and continuing engagement in criminal activity.

Co-payments also have a significant impact on pharmacies and their provision of OMT. A study with 669 pharmacies in New South Wales and Victoria found that only a third of pharmacies reported all clients were up to date with their co-payments (Winstock et al., 2010). It has been suggested that these fees impact on the willingness of pharmacists to provide OMT. That is, if clients were not struggling to pay fees, more pharmacists would be attracted to the program, thus providing better coverage of this much-needed form of treatment (Feyer et al., 2008).

## **9. Budgeting on OMT**

As noted previously, OMT co-payments vary. Generally, however, these fees are around \$30.00 to \$40.00 per week, but can be as much as \$70 per week. Most OMT consumers are on low incomes, with many are in receipt of government benefits such as the Disability Support Pension (DSP) or Newstart (Chalmers & Ritter, 2012; Rowe, 2008). The maximum amount a single person can receive on DSP is \$782.20 per fortnight, dropping to \$589.60 each or \$1,179.20 combined for couples on DSP. Newstart is \$519.20 per fortnight. This drops to \$468.80 per couple per fortnight if individuals are partnered with another Newstart recipient. Once \$70.00 for two weeks of program fees is taken into account, the DSP reduces to \$712.20 per fortnight and Newstart reduces to \$449.20. Program fees are about 9% of a single person's total income on the DSP and 13% of their income on Newstart. Research shows that people living on benefits such as DSP and Newstart are struggling to afford the basics such as rent and food (Australian Council of Social Services, 2012). If people have children there are far higher additional costs.

By requiring OMT consumers to pay daily dispensing fees to access their medication, we are adding to the extreme financial stress they already experience. This stress is counterproductive to the goals and benefits of OMT, including being able to parent and being an active member of the community. By keeping OMT consumers in a poverty trap we also increase their marginalisation. People on OMT face stigmatisation because of their drug use, and poverty adds to this stigma (Fraser et al., 2007).

Despite the known public health benefits of OMT, there is no systematic financial support for OMT patients experiencing difficulty paying for their medication. This places them in a unique position.

Other Australian health consumers who receive medication for chronic and/or lifestyle related illnesses such as diabetes, smoking-related illness and hypercholesterolemia are not required to pay for their medication to be dispensed (Shepard et al., 2014). Nor are recipients of opioid medication such as Oxycontin® and MS Contin®. Whereas a person receiving a month's dosage of prednisolone (an oral steroid for smoking-related illness) may pay less than \$6 if they have a Health Care Card (HCC), OMT patients may pay more than \$150 for a month's provision of medication.

The business costs of dispensing OMT are argued to be greater than the cost of dispensing medications for other chronic conditions, yet the fact remains that, unlike other patients, people on OMT pay a very high cost for their medication. This situation is discriminatory and inequitable.

## **10. OMT and pharmaceutical opioids**

The misuse of pharmaceutical opioids is a growing problem in Australia and is associated with severe harms such as addiction and overdose (Australian Health and Welfare Institute, 2013b; Roxburgh, Ritter, Slade, & Burns, 2014). Better access to OMT could address the misuse of these drugs. . The cost of oxycodone can be as low as \$6 a month, and a person receiving such opioid pharmaceuticals do not have to attend a pharmacy each day. On the other hand, OMT dispensing fees are around 25 times more expensive than prescription opioids. These cost inequities make it difficult to move people who are abusing drugs such as MS Contin® and Oxycontin® onto a treatment program. Yet, people on a supervised regime of OMT will achieve better outcomes than those receiving opioid medications in unsupervised circumstances where these drugs may be traded, trafficked and injected.

Increasing numbers of pharmaceutically-dependent people are being treated by OMT (Australian Institute of Health and Welfare, 2013a; Ritter & Chalmers, 2009). Early research finds that OMT is a promising treatment for opioid pharmaceutical dependence, with most people appearing to successfully stabilise in treatment (Nielsen, Muhleisen et al., 2013).

## **11. Cost-benefit to subsidising OMT co-payments**

With increasing health care costs and limited resources, government and policy makers require cost-effective solutions to issues such as opioid addiction. Shifting the cost of OMT dispensing to consumers through co-payments appears to reduce cost to government. However, if people

cannot stay on OMT because of these fees, there are far greater costs to the community (Collins & Lapsley, 2008).

It makes economic sense for government to address the issue of OMT co-payments. Australian researchers developed a system dynamics model of OMT to explore some of the key issues of concern, including affordability (Chalmers & Ritter, 2012). The resulting modelling found that the overall cost for the provision of OMT is almost \$11.73 million per month. Of this total, 43% is borne by state and territory governments, 33% by patients, and the remaining 24% by the Australian Government.

The cost to the community related to untreated heroin use for the same period of time was estimated to be between \$15.8 million and \$31.6 million per month, significantly higher than \$11.73 million. The 'cost burden' of ongoing heroin use includes:

- health care costs (blood borne viruses, accidents, trauma, overdose)
- crime (associated with heroin)
- family disruption, domestic violence, impact on children

It should be noted that this research did not examine the cost of untreated opioid pharmaceutical addiction. Based on their heroin-only data, the researchers concluded that if the Australian Government was to pay all program fees (estimated at around \$4 million per month) this cost would be outweighed by the economic benefits accruing to the community through social and health benefits, such as reductions in health care utilisation and crime (Chalmers & Ritter, 2012). The researchers also take into account that, if OMT co-payments were subsidised, increasing people would take up OMT. Thus, with increasing numbers of OMT patients, the total of a full fee subsidy would increase yearly government expenditure by \$81.8 million to \$175.8 million (Chalmers & Ritter, 2012).

## **12. Evidence for providing OMT co-payment relief**

There is strong evidence that providing OMT co-payment relief to patients will improve program continuity and their relationship with their pharmacist, with a number of studies evaluating fee-subsidy models.

Australian research found that affordability had an impact on treatment by comparing a subsidised group of patients (at a flat rate of \$15 per week) to an unsubsidised group (Feyer et al., 2008). Higher cost was associated with significantly poorer adherence to treatment. Other key findings were that:

- affordability was a significant determinant of treatment outcome. A subsidised arrangement as part of a national funding model may lead to better compliance and treatment outcomes
- any patient subsidy would need to take into account the real financial impact given the variability of co-payments
- there is a case for means testing of a co-payment subsidy

- co-payments greater than \$29.80 are associated with increased risk of being unable to maintain treatment (Feyer et al., 2008)

This study also investigated the option of directly subsidising pharmacies. It was recommended that incentives be provided to pharmacies to improve their satisfaction and maintain their involvement in the program, as well as to attract new pharmacists.

Another Australian study trialled three different models of dispensing fee assistance (Healthcare Management Advisors, 2007). These models were two partial OMT co-payment subsidies and a full co-payment subsidy. The findings of this research included that:

- OMT patients and pharmacists reported being satisfied with the trial funding models
- there were no statistically significant differences in satisfaction between the three funding models
- pharmacists reported that the funding models trialled had a strong positive impact on service delivery. This was mainly related to improved relationships with patients due to reduced concerns about money and chasing of bad debts
- OMT patients expressed satisfaction with the trial arrangements, with 91.4% stating that treatment arrangements were better during the trial than before (Healthcare Management Advisors, 2007)

More recently, an Australian study found that the main reason people dropped out of OMT was the cost of co-payments. People in this study reported high levels of personal debt – an issue which is linked to adverse health outcomes (Shepard et al., 2014).

The evidence shows that providing OMT co-payment assistance will enhance OMT outcomes. With co-payment subsidies, patients have better retention on OMT and a more productive relationship with their pharmacist. Further, if pharmacists do not have to deal with people struggling to pay fees they may be more likely to provide OMT, thus enhancing treatment coverage and accessibility.

### **13. A cut-through solution to co-payments**

Medications such as methadone and buprenorphine are provided through the PBS. They are listed as 'Section 100' drugs, meaning that they are part of the 'highly specialised drugs program'. To bring methadone and buprenorphine into line with other long-term medications, the conditions of their listing as a S100 must be changed to ensure that people on OMT are not paying uniquely high costs to receive their medication.

We propose that methadone and buprenorphine (when used specifically for OMT) remain as S100 drugs, but with different provisions for supply. These new provisions would be to:

- pay pharmacists a monthly fee per patient to cover the recording/dispensing fee, handling fee, counselling and pharmaceutical care

- require a monthly patient contribution. This would be \$6.00 per months for those with a HCC and \$36.90 for those without. This is in line with other PBS medications where the consumer pays a fee each time a prescription is filled

To price this model we have assumed the value of providing buprenorphine is \$9.47 per day and methadone is \$11.51. These amounts are calculated from the PBS fee paid to pharmacists, as of September 2014, for dispensing a drug of addiction (other than OMT medication) (Newton, 2014).

#### MODEL SUMMARY

**Real cost of providing buprenorphine for one month<sup>1</sup> at \$9.47 per day  
\$284.10**

**Real cost of providing methadone for one month at \$11.51 per day \$345.30**

#### Cost of subsidising buprenorphine for one month:

**Co-payment subsidy less HCC patient contribution (\$6.10) \$278.00**

**Co-payment subsidy less non-HCC patient contribution (\$37.70) \$246.40**

#### Cost of subsidising methadone for one month:

**Co-payment subsidy less HCC patient contribution (\$6.10) \$339.20**

**Co-payment subsidy less non-HCC patient contribution (\$37.70) \$307.60**

Under this model patients pay, and OMT patients are charged \$6.00 per month (if they are HCC holders) and \$36.90 (if they are not HCC holders). The PBS, however, would subsidise HCC holders up to \$339.30 per month and non-HCC holders \$308.40 per month. The Medicare safety net would come into effect as it does with other health consumers.<sup>2</sup>

Currently, there are around 37,471 people receiving OMT through pharmacies or private clinics with around two thirds (24,981) receiving methadone and the remaining one third (12,490) on buprenorphine.

Based on current patient numbers this model would cost around \$12 million per month, with methadone costing around \$8.5 million and buprenorphine around \$3.5 million.

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<sup>1</sup> One month is 30 days as for most other PBS items.

<sup>2</sup> We have costed PBS co-payments in this model at the current rate. Rates are adjusted each year.

However, if this direct payment model were to be adopted, it would be reasonable to expect greater adherence and greater uptake of OMT treatment owing to the improvement in the program's affordability. Hence, the total cost of subsidising co-payments would also increase.

To put the cost of this proposal in perspective, consider the following typical scenario:

A person suffering type 2 diabetes may be regularly prescribed some form of insulin. Lantus SoloStar® is one such form of insulin, provided to patients under the PBS scheme as a Schedule 85 drug. The wholesale price of the drug is \$408.30 per prescription (usually 5 flexpens), and the cost to the PBS is approximately \$430.00 per prescription. Often, a person would require at least one prescription per month which, if they have a HCC, would cost them about \$70.00 per year – and would cost the PBS more than \$5000.00 per year. Overall, in 2010-2011 the cost to the PBS of Lantus SoloStar® amounted to more than \$109 million.

In comparison, a patient receiving OMT to treat and control their particular chronic disease is required to pay out more than \$1500.00 per year as their patient contribution.

The model outlined above is not the only option for addressing the issue of OMT co-payments. However, it is a potential cut-through solution that brings the provision of treatment to OMT clients in line with treatment for other chronic health care issues.

## ***14. Finding an equitable solution***

OMT is an especially cost-effective response to problematic opioid dependence. Other treatment options such as withdrawal, rapid detoxification or antagonist therapy are more expensive and have limited outcomes. OMT co-payments, however, are an ongoing problem, compromising outcomes. OMT patients are often on low incomes and the high cost of treatment contributes to their poverty, making it hard for them to make positive changes in their lives.

Almost all pharmacies are commercial enterprises. They should not be expected to provide a service without payment. OMT programs require considerable paperwork and, unlike other medications for chronic conditions, patients are required to be supervised when dosed.

A subsidy scheme would reduce the financial burden on patients as well as make services more viable, therefore encouraging more providers to offer OMT. The costs of any subsidy scheme would be offset by a reduction in costs across the board for governments including justice and corrections, and health costs such as hospitals and mental health admissions.

OMT is an effective treatment that provides benefits to individuals, their families and the wider community. People on OMT should be provided the same access to medication as other Australians with chronic health issues.

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