Prescription drug monitoring in Australia: capacity and coverage issues

"To be effective, a [monitoring program] must collect… prescription data, and flag potential misuse and diversion"

Recent years have seen increases in prescription of pharmaceutical opioids and benzodiazepines, and in the associated harms.[1] This presents challenges for clinicians and governments regarding appropriate monitoring and responses. Real-time prescription drug monitoring programs (RT-PDMPs) are being considered in Australia[2,3] to enable detection of drug diversion (when drugs are transferred from a licit to an illicit channel of distribution or use), and inappropriate prescribing or dispensing. RT-PDMPs are supported by professional bodies, but challenges exist for policy makers in terms of capacity and coverage.

Capacity

The success of RT-PDMPs requires clear delineation of what information will be collected, who will have access to it, and how long records will be kept to ensure patient and practitioner privacy. Tasmania's RT-PDMP (currently the only Australian RT-PDMP) offers benefits over systems which do not provide real-time data,[2] but other jurisdictional policy makers must determine whether their systems will be proactive (eg, identify those at risk of abuse), or reactive and rely on prescriber and dispenser requests once a patient is deemed at risk. There is also concern that patients with genuine needs may not receive appropriate prescriptions for fear that they, or the prescriber, may be flagged as a misuser.[3,4]

RT-PDMPs pose challenges regarding the capacity of health and/or law-enforcement departments to respond. In Australia, 55 000 people were identified as doctor-shoppers in 2005–06.[1] The ability of the current system to meet these demands is lacking, with prescribers estimated to be notified in only 5% of doctor-shopper cases.[5]

An RT-PDMP will increase demand for professional development and specialist support for addiction and pain management, a particular challenge given the current gaps in training and significant shortages of relevant specialists. Potential RT-PDMP administrators, including health and law-enforcement bodies, will need capacity to analyse, interpret and disseminate findings through suitable channels, with necessary policies in place to facilitate appropriate responses.

Coverage

The proposed RT-PDMPs seek to monitor only S8 medications.[2] Some opioids (eg, tramadol and codeine) and benzodiazepines (except alprazolam and flunitrazepam) will be excluded, despite their contribution to harm. Such reduction in capacity decreases the ability to investigate possible shifts in prescribing habits towards non-monitored medications. One solution involves staged inclusion of other drugs to respond to changes in prescribing trends, and as new drugs become available.[3]

To be effective, an RT-PDMP must collect Pharmaceutical Benefits Scheme and private prescription data, and flag potential misuse and diversion at the time of prescribing and dispensing. Diversion can also occur after dispensing (eg, drug sharing and online sales including cryptomarkets which enable online purchaser anonymity),[6] but research in these areas is limited. Diversion cannot be entirely identified by RT-PDMP, which highlights the need for clinicians to adopt safe prescribing practices and communicate clearly with patients about their responsibilities.

RT-PDMP may become available outside Tasmania, but issues of coverage and capacity require policy maker attention before implementation to ensure more appropriate monitoring of prescription medications.[3]

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References are available online at www.mja.com.au.

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