

New pharmacotherapies for alcohol dependence: are they being used and what do they cost?

Christopher M Doran,* Julia E Fawcett,†
Anthony P Shakeshaft,‡ Marian
D Shanahan,§ Richard P Mattick¶

*Health Economist, †Research Officer, ‡NHMRC Fellow and Senior Investigator, §Health Economist, ¶Director, National Drug and Alcohol Research Centre, University of New South Wales, NSW 2052. C.Doran@unsw.edu.au

TO THE EDITOR: An estimated 512 935 Australian adults satisfy criteria for alcohol dependence (3.5% of the population aged 18 years and over).¹ Pharmacotherapy for this condition typically comprises a benzodiazepine, such as diazepam, for withdrawal and disulfiram for relapse prevention.² Acamprosate and naltrexone have also recently become available for treating alcohol dependence in Australia, but little is known about their uptake or cost.

One indicator of uptake is the proportion of alcohol-dependent individuals who have a script filled. Based on the number of scripts for these drugs filled in Australia in 2001, and assuming 50% compliance with the recommended treatment periods, we estimated that 4602 people took acamprosate and 8899 naltrexone in that year (Box). This is equivalent to a maximum of about 3% of alcohol-dependent individuals

taking either drug (13 501 individuals using either drug/512 935 alcohol-dependent individuals).

We also estimated the cost of visits to medical practitioners for scripts for these drugs, assuming that most were written by general practitioners, and the costs of the drugs themselves to the Australian government and to individual patients (Box). Total treatment and medication cost of the two drugs in 2001 was \$7 420 741.

These estimates are based on assumptions about the relevant population subgroup (age ≥ 18 years), rate of compliance with the recommended regimen (50%), source of scripts (GPs), and GP fees (first visit, \$25.05; subsequent visits, \$11.14). Varying these assumptions makes little difference to the likely uptake of either acamprosate or naltrexone; applying more conservative assumptions suggests that either medication is unlikely to have been used by more than 5% of alcohol-dependent individuals in Australia. Although use of these medications is not necessarily appropriate for all dependent individuals, their low uptake raises serious concerns about why they are being under-utilised: it may be because they are poorly marketed, or it may be that they are of limited effectiveness in Australia outside the context of clinical trials. The latter possibility is exacerbated by the nebulous nature of the comprehensive

treatment programs recommended for their use.⁵ Without methodologically rigorous Australian data, it is difficult to confidently allay such concerns. However, these results indicate a considerable amount of resources are being devoted to acamprosate and naltrexone as treatments for alcohol dependence, with little Australian evidence as to whether this investment represents value for money.

- Hall W, Teeson M, Lynskey M, Degenhardt L. The 12-month prevalence of substance use and ICD-10 substance use disorders in Australian adults: findings from the National Survey of Mental Health and Well-Being. *Addiction* 1999; 94: 1541-1550.
- Mattick RP, Jarvis T. An outline for the management of alcohol problems: Quality Assurance in the Treatment of Drug Dependence Project. Canberra: Commonwealth Department of Human Services and Health, 1993. (Monograph no. 20.)
- Health Insurance Commission. Pharmaceutical benefits schedule items statistics. Available at: www.hic.gov.au/statistics/dyn_pbs/forms/pbs_tab1.shtml (accessed Apr 2003).
- MIMS Australia. MIMS annual. 26th ed. Sydney: Medi Media Australia, 2002.
- Australian Department of Health and Ageing. Schedule of pharmaceutical benefits for approved pharmacists and medical practitioners. Canberra: The Department, 2001.
- Australian Department of Health and Ageing. Medicare statistics. March quarter 2003. Table B6. Average patient contribution per service (patient and bulk billed services out-of-hospital only). Available at: www.health.gov.au/haf/medstats/index.pdf (accessed Jul 2003). □

Gestational diabetes mellitus: accuracy of Midwives Data Collection

Robert G Moses,* Alison J Webb,†
Christine D Comber‡

*Clinical Director, †Nurse, Diabetes Service; ‡Nurse, Department of Obstetrics and Gynaecology, Illawarra Area Health Service, PO Box W58, Wollongong West, NSW, 2500. mosesr@iahs.nsw.gov.au

TO THE EDITOR: Gestational diabetes mellitus (GDM) is glucose intolerance of variable severity with onset or first recognition during the current pregnancy.¹ GDM is one of the conditions requiring an entry on the New South Wales Midwives Data Form. Effective healthcare planning is dependent on accurate data collection. To our knowledge, the verity of the midwives data with respect to GDM, or indeed other entities, has not been checked for many years.

A previous article has demonstrated that the accuracy of GDM data collection is poor, with the incidence of GDM being under-reported.² Recently, an article from Victoria also showed a recorded rate of GDM about half that of the acknowledged incidence.³ We

Use and cost of new medications for alcohol dependence in Australia in 2001

	Acamprosate	Naltrexone
Number of scripts filled ³	27 613	13 349
Estimated number of users*	4602	8899
General practitioner visits		
Estimated number [†]	13 807	8899
Estimated cost [§]	\$251 129	\$240 794
Medication cost ^{3,5}		
Cost to government	\$4 442 204	\$2 115 315
Estimated cost to patients [¶]	\$252 407	\$118 892
Total cost	\$4 945 740	\$2 475 001

* Number of scripts filled/number of scripts needed for recommended treatment period (12 months for acamprosate and 3 months for naltrexone,⁴ with each script providing one month's supply⁵)/compliance (assumed to be 50%).

† Based on 6 visits per year for acamprosate prescription (12 scripts; 1 repeat per script), and 2 visits per year for naltrexone prescription (3 scripts; 1 repeat per script), but assuming 50% compliance with recommended treatment period.

§ Based on 2001 Medicare rates (85% of MBS code 23 [\$25.05] for first visit, and 85% of MBS code 3 [\$11.14] for subsequent visits) plus mean patient cost per GP/vocationally registered GP visit for 2001 of \$2.62.⁶

¶ Taking into account variation in patient Medicare classification (general, concessional or safety net), which varied over the year.^{3,5}



Health Care Providers



About HIC
Your Health
Health Care Providers
Health Software Vendors



HEALTH STATISTICS

You are here: [HOME](#) > [HEALTH STATISTICS](#) > [STATISTICAL REPORTING](#) > [PBS](#)

Use of Health Information

HIC Statistical Reporting

Medicare

Pharmaceutical Benefits Scheme

Pharmaceutical Benefits Scheme Item Reports

Pharmaceutical Benefits Scheme Group Reports

Child Care Rebate

Australian Organ Donor Register

Australian Childhood Immunisation Register

Divisions of General Practice

Practice Incentives Program

GP Immunisation Coverage

Monthly & Quarterly Standard Reports

Frequently Asked Questions

Privacy & Security

HIC Statistic Contacts

Pharmaceutical Benefits Schedule Item Statistics

These reports produce statistics on requested items in the Schedule of Pharmaceutical Benefits. Item numbers are described in the [PBS Schedule online](#). Several report formats are available. Please read the [important information](#) outlined below whilst waiting for your report.

Select Report Options:

- Item Number(s):
eg. 1883D (single item) or 1884E, 1889K (list of items)
- Report on:
- Report Format:
- Start date:
- End date:

Important Information

- Your report may take up to 2 minutes to be created and returned to you, depending on the work load of the server and the volume of traffic on the internet.
- PBS item descriptions can be looked up in the current Schedule of Pharmaceutical Benefits book or [PBS Schedule online](#) (maintained by the Department of Health and Ageing).
- Scheme - Statistics are supplied for both the Pharmaceutical Benefit Scheme (PBS) and Repatriation Pharmaceutical Benefit Scheme (RPBS, ie. items supplied to war veterans)
- Patient category - The patient category refers to the patient's eligibility status at the time of supply of the benefit. The patient (or patient's family unit) may migrate to another category (safety net) after eligibility expenditure thresholds have been attained. The Patient Categories are:
 - PBS - General - Ordinary
 - PBS - General - Safety Net
 - PBS - Concessional - Ordinary
 - PBS - Concessional - Free Safety Net
 - PBS - Other - Doctor's Bag Order Form (DBOF)
 - RPBS - Ordinary
 - RPBS - Free Safety Net
- Patient Contributions - General patients, who do not hold a concession card (General - Ordinary), pay a maximum contribution towards the cost of each PBS medicine. The maximum patient contribution is \$23.10. The Government pays the remainder. Holders of a Department of Social Security or a Department of Veterans' Affairs treatment card pay \$3.70 towards the cost of each PBS medicine.
- Only items contained in the Pharmaceutical Benefits Schedule appear in these statistics. Items supplied to general patients, costing less than the \$22.40, do not receive a PBS benefit and are therefore not included. If you require statistics at a more detailed level (eg. broken down by patient age, gender, postcode etc.) please [contact us](#) detailing your request and supplying your phone and fax numbers. The HIC charges on a cost recovery basis for providing more detailed statistics and their provision is subject to privacy considerations.
- The figures reported relate to the value (benefit) or volume (services) of PBS and RPBS services that have been processed by the HIC. They refer only to paid services processed from claims presented by approved pharmacies. They do not include any adjustments made against pharmacists' claims, any manually paid claims or any benefits paid as a result of retrospective entitlement or refund of patient contributions.

- The figures do not contain Section 100 items (highly specialised drugs available through hospital pharmacies for out-patients).
- State/Territory is determined according to the address of the pharmacy supplying the item.
- Month is determined by the date the service was processed by the HIC, not the date of prescribing or the date of supply by the pharmacy.
- Monthly figures may vary due to the varying number of processing days in a month, which depends on the number of days in the month, public holidays, overtime worked etc.
- A financial year is 1 July to 30 June.
- The HIC has taken every care to ensure the data supplied is accurate but does not warrant that the data is error free and does not accept any liability for errors or omissions in the data.
- Instructions on how to download the statistics into a spreadsheet are contained in [Downloading Statistical Information](#).
- This page is best printed in landscape mode.

Last Updated July 25, 2003
Copyright @ 2002 HIC
www.hic.gov.au | [Legal Notices](#)

