The heroin gap in opioid tracking is killing Americans

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August 24, 2017

Prescription drug monitoring programs (PDMPs) are state-based data banks that track opioid and other controlled substances prescribed by healthcare providers and filled by patients at pharmacies. They are supposed to cut down on the abuse and overuse of such substances by reducing the rate at which physicians prescribe opioids. While many policy makers think they're a great idea, they may be actually contributing to the rise in opioid overdose deaths.

PDPMs have been operating in most states for several years, and although the number of opioids prescribed are indeed decreasing, the death rate from opioid overdoses keeps climbing at an alarming pace, with a reported 200 percent increase between 2000 and 2014. Indeed, the most recent data from the Centers for Disease Control and Prevention (CDC) is telling; it appears that overdoses from prescription opioids are stabilizing or even waning, while overdoses from heroin are dramatically increasing.

One reason may be that heroin is cheaper than ever on the black market. In 2015 the CDC reported a record high 33,000 opioid overdose deaths, the majority of which were from heroin. But another reason may be that physicians are reticent to prescribe opioids to those who legitimately need them, forcing their patients to turn to the black market.

And PDMPs likely share some of the blame, although they were created with good intentions. California established the first PDMP in 1939, and by 1992 10 states had PDMPs in operation. Different states had different designs in their programs and they varied in their methods of operation, even though they all shared the goal of diminishing drug abuse and diversion, i.e., the movement of prescription drugs from the patient population into the recreational user community.

Today 49 states have PDMPs at various levels of development. The only holdout is Missouri. There, legislators led by State Senator Robert Schaaf, a family physician, have obstructed the legislature's attempts to establish a monitoring program on the grounds that it might risk patient privacy.

My state's PDMP has been operated by the Arizona State Board of Pharmacy since 2008. All federally licensed narcotics prescribers must participate. Their prescribing data are kept in the monitoring program, inaccessible to the general public in order to protect patient privacy.

Providers receive quarterly "report cards" comparing them to their peers in their specialty with respect to the number of times per month they prescribe various opioids, benzodiazepines, and other controlled substances. They are classified anywhere from normal to outlier to extreme outlier.

At this point the report cards are for informational and educational purposes only. Starting in October, however, Arizona will join at least 16 other states in requiring providers to first check the PMDP database on their patient in most cases before being allowed to prescribe an opioid for that patient.

Yet, even before this policy takes hold, the PDMP has significant effect on prescribers. Aware that they are under surveillance, no provider wants to be seen as an outlier. There's no telling what the long-term consequences might be for a provider with that label. I've spoken with practicing physicians across my state, and all of them agree that it's disconcerting to have "big brother" looming over their shoulders in this manner.

The ensuing chilling effect on the prescribing of opioids has led doctors to cut off some of their patients who are honestly in pain — and some of whom may have developed a physical dependence, but not an addiction (there is a difference), leading some of them to seek relief in the illegal drug market. The CDC data showing an increase in the number of heroin overdoses and a slowing in those from prescription drugs appear to bear this out.

This calls into question the value and effectiveness of PDMPs. PDMPs might succeed in making healthcare providers more frugal prescribers of narcotics. But they may also be sending more patients, in desperation, to the illegal drug market where they obtain opioids that may be counterfeit, laced with dangerous and more powerful drugs such as fentanyl and carfentanil, and where they may opt for heroin because it is actually cheaper and easier to obtain than prescription opioids.

A study released in May 2017 lends credence to this theory. Researchers at the University of Pennsylvania and Pennsylvania State University used data from all jurisdictions, as well as from the Centers for Disease Control and the US Census Bureau, to examine the effect of all PDMPs from 1999-2014. They concluded that, "PDMPs were not associated with reductions in drug overdose mortality rates and may be related to increased mortality from illicit drugs and other, unspecified drugs."

To be sure, PDMPs may serve a useful adjunct to the healthcare practitioner. Knowledge of a patient's prescription drug history can be very helpful not only when deciding whether to prescribe a narcotic, but also whether to have a serious discussion with a patient about that patient's possible drug dependency. But this should be at the discretion of the doctor.

There are many cases in which the provider knows the patient quite well, and a check of the database amounts to nothing more than a nuisance. And provider report cards that carry the risk of an outlier accusation probably only serve to exacerbate the opioid overdose problem.

If states want to continue with Prescription Drug Monitoring Programs they should convert them into useful databases for healthcare practitioners to voluntarily access, as needed, in the course of administering care to their patients. But big brother heavy handedness in these programs needs to end as it is only making matters worse.

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