Response by the National Pharmaceutical Association
to the
Report by Auditor General for Wales

THE PROCUREMENT OF PRIMARY CARE MEDICINES

1 Introduction

1.1 The NPA represents the owners of community pharmacies in the UK. We have in membership the owners of around 11,000 pharmacies representing just about all except Boots.

1.2 We welcome the publication of this report and fully recognise the need for the Auditor General to focus upon ways of ensuring that the most cost effective use is made of medicines to ensure that taxpayers get value for money. However, this report appears to adopt a narrow focus almost exclusively on the cost of medicines and in so doing does not give sufficient weight to the overall healthcare context of medicine use. In particular, it makes little reference to the benefit medicines bring to improving patients' health and wellbeing and their impact on reducing demands on other more expensive components of healthcare.

1.3 Paragraph 3 of the Executive Summary to the Report, in making reference to the potential £50 million savings it is suggested can be made, points out:

"…securing potential savings on this scale in practice is not straightforward and is not guaranteed. It would involve establishing centralised contracts and this in turn would bring risks and practical challenges for the Assembly's NHS Directorate"

1.4 We agree with this statement, which reflects the balanced way in which he report deals with direct procurement and highlights the very real and significant risk associated with implementing changes to the current procurement and supply arrangements. It also flags up the need to take full account of the broader implications of its recommendations which the Report does. Part 4 is dedicated to the wider considerations for primary care medicine procurement. In particular, this part of the report points out that the Assembly will need to assess the impact of direct procurement arrangements upon pharmacy and medicine services.

1.5 In addition to the need to factor in the outcome of the Department of Health's Generic Inquiry, the report makes reference to the OFT Report on the Control of Entry Regulations and Pharmacy Services in the UK and the Assembly's Pharmacy Strategy document *Remedies for Success*. It is our view that moving to direct procurement without due consideration to the potential negative effects could seriously threaten the current supply to patients. From a pharmacy perspective, given that remuneration is almost exclusively related to product supply, very careful consideration needs to be given to the impact on income and

thus pharmacy viability of any alterations to procurement arrangements. This is of course precisely what happened with the OFT Report and was the principal reason why the Welsh Assembly rejected this Report's recommendation.

1.6 We are very pleased to see the Report acknowledging a number of other means of controlling expenditure. These include increasing the number of products prescribed generically, reducing prescribing of products of questionable clinical value, better product selection by GPs and reducing drug wastage through improved medicine management. The report suggests that taken together these could produce saving in the order of £46 million. This is virtually the same figure the report estimates could come from the supply of primary care medicines at secondary care prices. These initiatives are welcomed by the NPA. They represent existing opportunities that are not predicated upon direct procurement and which provide scope for an enhanced role for community pharmacists in providing health gain and value for money. Most significantly, Medicines Management initiatives, as well as maximising the use of scant NHS resources, also brings clinical benefits to patients. The NPA has an established track record in this area, and would be pleased to work the NHS in Wales to support this work

2 Primary Care Medicines Procurement - Existing Pricing Controls

2.1 In the words of the Report, the procurement of medicines is a complex mixture of market forces, government regulation and government-industry agreement. The Report also acknowledges that Wales is affected by events in the UK and beyond (Paragraph 2.2). The Report goes on to make reference to the PPRS and reimbursement arrangements affecting community pharmacy contractors and, in particular, the operation of the discount clawback. Taken together, the PPRS and discount clawback work to cap overall Government expenditure. The efficiency of these capping mechanisms will be directly proportional to the volume of drugs covered by the two schemes, which at present is virtually all primary care medicines. There is an economy of scale here which will be undermined by attempts to draw up individual approaches. To put this another way, removal of medicines from the PPRS or discount clawback arrangements will require compensatory adjustments to these arrangements so savings in one area will be cancelled out in the other.

2.2 As the report points out, the PPRS places a cap on industry profits thereby ensuring that these are not excessive. It allows a reasonable margin to be made to ensure that the industry continues to invest in research and development. A move to direct procurement will inevitably undermine the PPRS arrangements and could lead to a reduction in research and investment so important in bringing new and innovative products to market and thus improving the health and well being of patients.

2.3 One of the key features of the PPRS, and something we do not believe has been given sufficient weight in the report, is that manufacturers are free to set prices to adjust to market conditions. Because revenues rather than prices are controlled under the PPRS, manufacturers are free to cross subsidise between secondary and primary care. Manufacturers do discount heavily in secondary care but achieve overall PPRS targets by balancing prices charged in primary care. Accordingly, the assumption that there will be an overall saving by direct procurement of medicines in primary care is mistaken. Any reduction achieved in primary care must be mirrored by a corresponding increase in secondary care.

2.4 As far as the discount clawback is concerned, the Report suggests that contractors do beat this and so make a profit on purchased medicines. It has been made clear to the Department of Health, in discussions around generics and the new contract, that the pharmacy network will not be financially viable if there is total discount recovery. Nor will the system continue to derive financial benefit to the NHS if incentives are stripped out of it. It is common ground that there must be a “fair

return" for pharmacy and work is well underway on a "cost of service" model. The impact of moves toward direct procurement of medicines will need to be factored in to these ongoing discussions. Importantly, modelling and predictions made in this area will be dependent upon the volumes of medicines covered under the arrangements. Removing product from inclusion in the scheme will inevitably undermine the validity of modelling and thereby frustrate the ambition of both Government and pharmacy toward ensuring that pharmacy makes a fair and reasonable return on investment in health service provision.

2.5 Discussions on remuneration and reimbursement must be looked at in the current context of pharmacy development. It is now established government policy that greater use needs to be made of community pharmacy in delivering NHS targets. *Remedies for Success* sets out the ways in which it is intended this should happen in Wales. The comprehensive pharmacy service of the future must be supported by fair and reasonable arrangements for NHS remuneration, which allow pharmacists a reasonable return on investment in the provision of patient centred services. As things stand, remuneration is almost exclusively linked to product supply, so any moves which adversely affect pharmacy income and thus its ability to fund and invest in service provision and development, will frustrate the planning and delivery of pharmacy service and thus overall health planning in Wales. As a start point therefore, there must be clarity on the impact of any alterations to procurement arrangements upon provision of pharmacy services.

3 Stock Supply Management

3.1 The existing supply arrangements have a sound track record of maintaining a highly efficient and cost-effective product distribution service. Indeed the Report acknowledges this. Paragraph 3.16 states that security of supply is important for ensuring that patients receive the medicines they need, when they need them, and this is a strength of the current system. In achieving this, pharmacists are supported by a wholesaler network that guarantees, in most cases, at least twice daily deliveries. The current arrangements assure security of supply. The wholesaler/pharmacy network allows for product to be moved quickly to deal with local variation in need and to allay short term supply difficulties. A centralised procurement system could remove some of the cushion that allows the system to deal expediently with emergencies. It would also alter dramatically the dynamics of the system, with potentially serious consequences on the security of supply to patients. Wholesaler profitability follows the pareto principle; profitability is derived from around 20% of the high value fast moving products and this supports the remaining 80% of products. Clearly the removal of any of the products from the profitable end of this equation will seriously undermine the ability of wholesalers to maintain the depth and breadth of service currently on offer with the inevitable negative knock on effects on patient care.

3.2 Under present arrangements, all the risk associated with stock management rests with pharmacy contractors. Pharmacies own the stock they supply against prescriptions and are paid by the NHS three months in arrears. They are responsible for providing the capital needed for stock and for meeting costs associated with dead stock.

3.3 Whilst, it might be very easy to under-estimate the logistical difficulties associated with supply. We are very pleased to see that the Report has not done this. On the contrary, paragraphs 3.15 – 3.27 set out very comprehensively the potential downsides associated with direct procurement arrangements and set out a number of reasons why achieving savings from centralised procurement would not be straightforward for Wales acting alone. These include:

- Centralisation increases risk to security of supply
- Low prices may be harder to negotiate for primary care than secondary care
- Achieving low prices for primary care medicines may lead to higher prices for secondary care medicines
- The achievement of low prices will be limited by the expertise and effort NHS Wales can devote to negotiating contracts
- Centralisation would require changes to the contracts of primary care contractors and may require primary legislation

3.4 However, having set out a comprehensive list we are surprised that the Report goes on to recommend at Paragraph 3.38 that following the Department of Health Review into generics, unless the Department makes changes to procurement across the UK rendering centralisation inappropriate, the Assembly's NHS Directorate should consider piloting centralised contracts with a small number of medicines. We must say that we find this recommendation an odd conclusion in the absence of any analysis of the "substantial risks and practical problems" highlighted so clearly and comprehensively in the preceding paragraphs of the report.

3.5 Further, we see difficulties associated with the use of pilot studies. At one end of the scale, these will be so small as to be non representative. At the other end, they would be of such a size as to distort the current arrangements. Where significant volume or value products are selected, as is likely to be the case given the findings highlighted in Paragraph 3.8 of the Report, there will need to be a compensatory adjustment to the discount clawback arrangements. But in any event, trials are unlikely to be representative. We would expect that medicine suppliers would be likely to submit artificial prices in order to ensure that their products are included in pilot schemes.

3.6 In Paragraph 4.8 of the Report, reference is made to the Essential Small Pharmacy Scheme (esps) and whether the Assembly should use its powers to reform the scheme. It is worth pointing out that the scheme involves a subsidy for a small number of pharmacies, its structure is such that it offers only very limited financial support to the small number of pharmacies who are eligible. The esps subsidy is currently derived from overall contractors' remuneration and so is actually paid by contractors rather than the Government. Thus any increase in esps subsidy would have the effect of reducing the payments to non-esps pharmacy contractors. Given the poor level of pharmacy remuneration, there is little prospect of increasing the esps subsidy above the current levels.

4 Other Means of Cost Control – Making Better Use of Pharmacy

4.1 We are pleased to see that the Report has focused on other issues that need to be taken account of before decisions on direct procurement. In particular, we are pleased to see a focus on the importance of prescribing behaviour and medicine management. As the Report points out at Paragraph 4.14, GP prescribing behaviour and effective medicines management are important factors in determining the overall expenditure on medicines in Wales. We support the recommendation that the Assembly's NHS Directorate obtains research to assess the effectiveness of initiatives to improve prescribing behaviour. We would like to suggest that as part of this, greater use could and should be made of community pharmacists in interacting with local GPs toward improving prescribing behaviour.

4.2 We also fully endorse the recommendation that the Assembly supports supplementary prescribing. Supplementary prescribing by pharmacists will see better use being made of their skills, an easing of the GP workload and better and more cost effective use made of prescribed medicines.

4.3 The most expensive medicine is the one that is not taken! The Report highlights the potential waste of medicines in Wales – around £15.6 million. Improved medicines management will lead to savings and to improved patient care. Community pharmacists have a key role to play in medicine management and concordance and we are pleased to see this is acknowledged in the report

5 Summary

5.1 It is quite right for the Auditor General for Wales to focus on the need to control medicines costs given the large expenditure on medicines - £410 million – in Wales. However, the Report fails to give sufficient weight to the efficacy of existing mechanisms of control on medicines expenditure – a combination of the prescription price regulation scheme and the discount clawback. The efficiency of these capping mechanisms will be directly related to the volume of drugs covered by the two schemes, which at present is virtually all primary care medicines. Removal of medicines from the PPRS or discount clawback arrangements will require compensatory adjustments to these arrangements so any savings in one area will be cancelled out in the other.

5.2 As the Report acknowledges there are huge risks associate with a move to direct procurement, not least of which is the potential to adversely affect distribution networks and thus pharmacy services provided to local communities. This risk, the uncertainty about the amount of savings that could be made and the impact direct procurement will have upon ongoing reviews including the Department of Health's generics review and ongoing discussions around a new pharmacy contract, suggest that now is not the appropriate time to move to direct procurement.

5.3 However, the Report goes on to highlight a number of other means of controlling expenditure: improved prescribing – including supplementary prescribing - and medicines management. These represent existing opportunities that are not predicated upon direct procurement and which provide scope for an enhanced role for community pharmacists in providing health gain and value for money. Indeed, and as the report acknowledges, taken together they are capable of delivering savings that are at least as good as could accrue from the supply of secondary care medicines at primary care prices.