PSNC's response to the All-Party Parliamentary Group on Access to Medicines and Medical Devices' consultation paper on specials procurement

May 2019

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Introduction

The Pharmaceutical Services Negotiating Committee (PSNC) promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors. We work closely with Local Pharmaceutical Committees (LPCs) to support their role as the local NHS representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

We welcome the opportunity to be able to provide our response to the proposals set out in the All-Party Parliamentary Group on Access to Medicines and Medical Devices' consultation paper on specials procurement.

Consultation Questions

Section 1

Q. In what capacity are you responding to this consultation?

PSNC is recognised by the Secretary of State for Health and Social Care as the body that represents NHS community (high-street) pharmacy contractors (owners) in England. We work with NHS England and other NHS bodies, and with the Department of Health and Social Care (DHSC), to promote opportunities for the development of community pharmacy services, and we negotiate the contractual terms for the provision of NHS community pharmacy services. In the preparation of the Drug Tariff and any changes to reimbursement and remuneration for specials, the Secretary of State for Health and Social Care consults with PSNC.

Q. Please briefly outline your experiences with the consumption, procurement, delivery or system design of specials.

PSNC represents community pharmacy contractors in England who dispense specials in primary care. In a bid to curb the cost of specials, the DHSC in consultation with PSNC introduced the Part VIIIB section in the Drug Tariff in November 2011. This allowed listed unlicensed specials and imports to be reimbursed at a fixed Drug Tariff Price. Each year, PSNC also carries out the annual margins survey to measure any margin earned by independent community pharmacies, including on a random selection of Drug Tariff Part VIIIB and non-Drug Tariff listed specials.

Q. Has all the relevant evidence for this consultation document been taken into account? If 'No', please give details.

No; as indicated above, any margin made by pharmacy contractors on specials is analysed by PSNC and DHSC. This is to try to ensure that pharmacy contractors only earn the agreed amount of margin, which is a core part of their national NHS funding. The margin survey takes into account any discounts and rebates earned by pharmacy contractors as seen on their invoices/statements. Any professional fees linked to the supply of specials are paid to pharmacy's as part of the pharmacy contract global sum – this is agreed as a fixed amount each year, therefore any fees paid within it are not an additional cost to the NHS.

The price-inflation figures quoted in the consultation document relate to 2008/09. A more recent assessment of price-inflation figures is required to provide an informed response. Since 2010, overall spend on specials has been steadily decreasing – nearly halved – from £136 million per year in 2010 to £74 million in 2017.

Since the introduction of the new specials reimbursement arrangements in November 2011, DHSC has observed that in England the average cost for specials listed in the Drug Tariff decreased by 58% between 2011 and the first quarter of 2018.

Over the same period total number of items dispensed by pharmacies has grown from £877.2 million to over 1 billion in 2017/18. Despite the overall growth in items, over the same period, the number of specials items dispensed by community pharmacies has dropped from 709,000 to 560,000 items per year.

Between 2010 and 2017, the cost to the NHS of the average special has gone down from £191.19 to £132.64 (-31%). However, when specials are divided into Part VIIIB (Tariff-listed) and non-Part VIIIB specials (non-Tariff listed), then the average cost per item for Part VIIIB specials has gone down to £75 in 2017 whilst the average cost per item for non-Part VIIIB specials has increased to £199 in 2017. Addition of drugs to the Drug Tariff VIIIB list has contributed to an overall reduction in specials spend.

Section 2

Q. Please comment on the medical specialisms and disease areas that you are aware are affected most by the procurement of specials.
A list of the top 500 special order products by net ingredient cost/item is available on the NHS Business Services Authority (NHSBSA) website:
https://www.nhsbsa.nhs.uk/sites/default/files/2018-11/Top%20500%20Qtr%20to%20Sep%2018.xlsx

This provides an indication of the specials dispensed for different medical specialism and diseases and includes dermatology, sleep-disorders, gastroenterology, ophthalmology, among others.

Q. Do you agree with the consultation document's findings regarding price-inflation, multiple fees and additional hidden costs for specials in England?
It is inaccurate to say that most pharmacies will not obtain a non-Drug Tariff special from a far cheaper source than their usual wholesaler. Many pharmacies do have contracts with specials manufacturers and importers to obtain specials products directly. Additionally, pharmacies may not always be in a position to source a special from the cheapest supplier for patients who require a specific formulation (alcohol-free or preservative-free etc), or where the item is only supplied by a specific specials manufacturer, or if the patient requires the item urgently for same or next day delivery.

Only one professional fee is payable per specials item regardless of how many multiple small containers the specials item is dispensed into for the same patient. A handling fee of £20 is paid per specials item dispensed on a prescription if the correct endorsement is applied by the dispenser.

What is not factored into your assessment is that the current reimbursement system does not allow dispensers to claim for any broken bulk. For example, if a prescription requests 50ml of a special and the product is only available from the supplier in a 100ml pack size, the pharmacist will have paid the supplier for the 100ml but will only be reimbursed by the NHS for the 50ml dispensed and will not be able to re-use the balance (often due to limited shelf life of a specials). This results in many pharmacy contractors dispensing at a loss certain specials items ordered in pack sizes not commonly available in the market. Pharmacy contractors are effectively subsidising the NHS out of their own pockets.

We agree that additional hidden costs can arise if the correct treatment (specials or not) is not made available to the patient in a timely manner.

Q. Do you believe a saving could be made to NHS England if a new procurement system were put in place?
A central procurement system may generate some purchasing efficiencies, but nationwide distribution could present logistical (and associated financial) challenges for production units linked to the central or regional procurement centres. There may be unforeseen issues faced by pharmacies when ordering certain specials products. Patients requiring urgent (same or next day) supplies may need to be dealt with differently to avoid delays in obtaining essential medication. There is a risk of reducing choice and driving down quality if the cheapest special is sought.

There are currently around 1,200 retail pharmacies in Scotland serving a population of over 5.5 million. In England, over 11,000 pharmacies serve a total population of over 55 million. The benefits of a central procurement model may be realised in Scotland however this may prove difficult in England, as it would require a significant increase in the number of NHS production units to cater for each geographical location to help meet the demand or require each unit to increase its production capacity.

Q. Do you agree with the statement that the current procurement of specials in England impacts patient access to medicines in primary care?
No. The current procurement of specials does not impact patient access. On the contrary, the system improves access as pharmacies are conveniently located for the vast majority of the population and having the choice and competition between specials suppliers improves patient access to essential treatments.

Q. What do you consider to be the major impacts of patients requiring secondary care services to obtain a prescription for their special medicine?
Variation in prescribing of specials due to each Clinical Commissioning Group (CCG) having their own prescribing formularies. A national formulary approach would eliminate post-code lottery and also ensure GPs have flexibility to determine whether a special can be prescribed to meet the clinical needs of a patient.

Q. Please provide any other comments you may have on the current system of procurement for specials in England.

Section 3

Q. Do you believe that there is an issue with regards to the safety of specials in England within (i) primary care and (ii) secondary care?
PSNC is not aware of any safety concerns of specials dispensing within primary care.

Q. What mechanisms do you think should be in place to ensure the safety, efficacy, quality and consistency of specials?
Holders of manufacturer's specials licences and import licences are regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

Specials by their very nature are 'specially ordered' drugs to help meet the individual needs to patients. Specials can be obtained from a range of sources by pharmacists and their teams and are not all manufactured in the same way. This means that the quality, bioavailability and consistency of specials can vary even where the same product is prescribed. Since the safety, quality and efficacy of specials will not have been formally assessed by a regulatory body

there is less certainty about safety, efficacy and likelihood of adverse events. Reporting mechanisms of any adverse reactions to specials is in place via the MHRA yellow card scheme.

Q. Do you believe aseptic compounding pharmacies have a capacity issue and, if yes, what steps should be taken to relieve these capacity constraints?

Q. Is batch testing a viable solution to improve patient safety for specials?

Section 4

Q. Can you explain whether existing legislation ensures that the level of remuneration for specials is reasonable?
In addition to the usual dispensing fee of £1.26 for any item dispensed, the current level of remuneration of £20 as a handling fee for supply of a specials is considered reasonable to cover additional costs incurred by the pharmacy contractors when sourcing the product and maintaining records of specials obtained and dispensed.

Q. Does the Health Services Medical Supplies (Costs) Act provide the necessary powers to alter the procurement practices for specials in a satisfactory manner?

Q. Do you believe that The Health Services Products (Disclosure and Information) Regulations 2018 have adequately improved the provision of information on the pricing of specials.
PSNC is not aware if gathering of information on pricing of specials has improved following the introduction of the new Regulations.

Section 5

Q. Please provide any comments that you may have about the potential merits and limitations of the solutions outlined in this document:
Significant savings to the NHS on specials has already been realised following the introduction of a fixed Drug Tariff price for the most commonly dispensed unlicensed specials.

PSNC would not be opposed to further additions of specials products to the Drug Tariff and would also support the introduction of a section to the Tariff to incorporate unlicensed oral solid-dose formulation; for example, melatonin tablets. This is an approach similar to one taken by Scotland where they have a Part 7U in the Drug Tariff for commercially available products that do not have a product license and are not on the Advisory Committee of Borderline Substances (ACBS) list. For more significant changes, PSNC would expect to discuss the nature of any solution to reform supply of specials in primary care with the DHSC.

Careful consideration needs to be given before any significant changes are introduced to avoid any disruption to patients as we have seen in the past when changes were made to the home oxygen service.

a. Increasing number of specials in the Drugs Tariff

b. Central procurement

c. Batch production

Batch production may work for certain commonly dispensed specials but will not be possible for many drugs as some patients may require unique formulations due to certain intolerances or allergies; for example, 'lactose-free', 'preservative-free', 'colour-free' preparations.

d. Strict price control

e. Warning system

As part of Brexit planning, the Government has set up a national supply disruption centre. This could provide the route for reporting of any drug shortages. Reports of price hikes are received by PSNC from pharmacies and we may then consider an application for a price concession.

Q. Are there any changes, additions or new procurement systems that you would like to propose?

Q. If you support a new procurement system, which do you favour and why?

Q. Please provide any additional comments on the consultation document.