PHARMACEUTICAL DIRECTORATE

MANAGEMENT TEAM MEETING: 28TH FEBRUARY 2006

MANAGEMENT BOARD MEETING: 13TH MARCH 2006 **ITEM NO:**

UPDATE ON GROWTH IN PRESCRIPTION VOLUME AND COST YEAR TO DECEMBER 2005

INTRODUCTION

This report explores trends in prescription volume and cost for the year to December 2005 compared to the previous year. The report aims to identify whether there have been changes to the main drivers for growth in volume and cost and to estimate likely future growth in volume. All data are from PACT (Prescribing Analysis and Cost) and relate to general practice prescribing in England. Prescription volume has been analysed using the item as the measure; net ingredient cost has been used to express cost.

1. HEADLINE TRENDS

Prescription volume increased at a slower rate in the year to December 2005 (5.0% per annum) compared to the year to December 2004 (5.6% per annum). Figure 1 shows the per annum increase in items since December 2002. Since November 2004, growth in items has slowed and in recent months has fluctuated between 5.0% and 5.6%. This report examines whether the current projection for growth should be revised.

Prescription cost has fallen in the year to December 2005 (2% negative growth rate) compared to the previous year. Figure 2 shows that the rate of growth in prescribing cost has been slowing down steadily in the past three years, despite some monthly fluctuations. The implementation of the Department of Health's policy to reduce the cost of generic drugs should result in further slowing in cost growth during 2005/06.

Figure 1: Change in Rate of Growth of Prescription Numbers

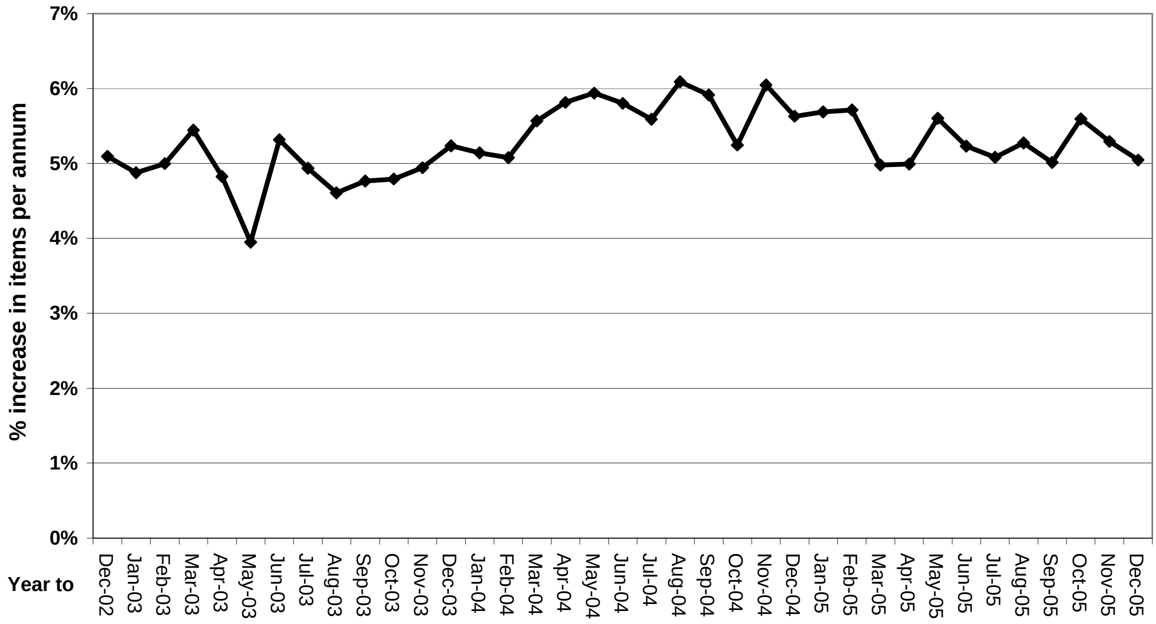


Figure 2: Change in Rate of Growth of Prescription Costs

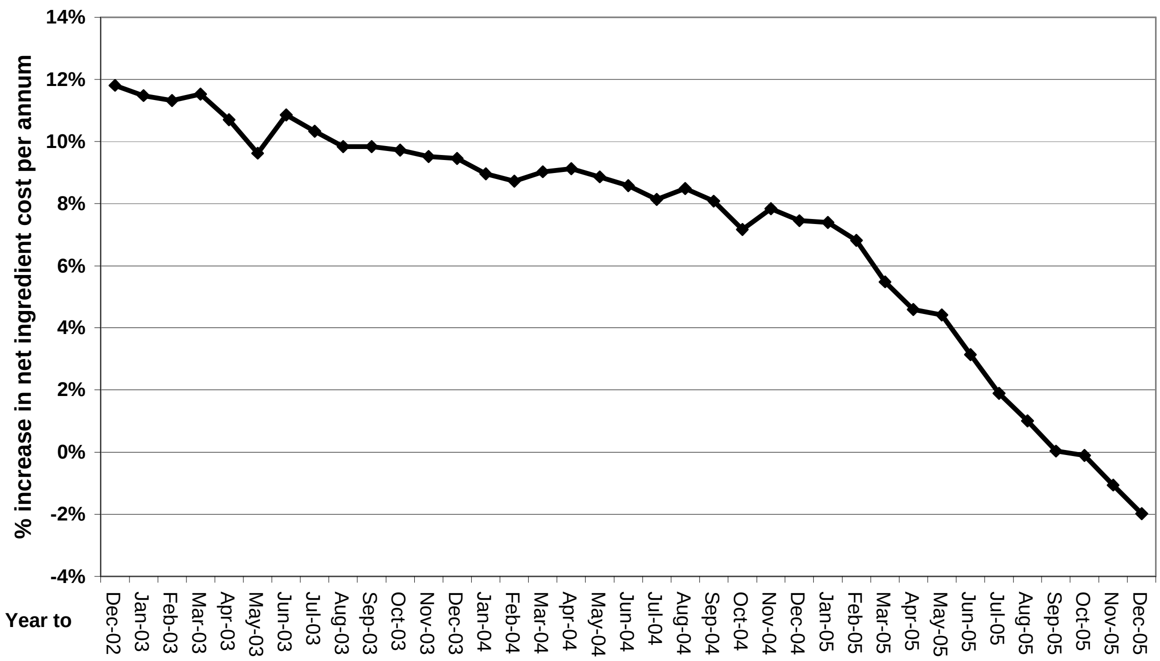


Figure 3 shows that the number of monthly items has been higher year on year with few exceptions. Figure 4 shows that cost in the current financial year was lower than in the corresponding months in the previous financial year apart from a very small increase in November 2005.

Figure 3: Number of Items Prescribed in General Practice in England

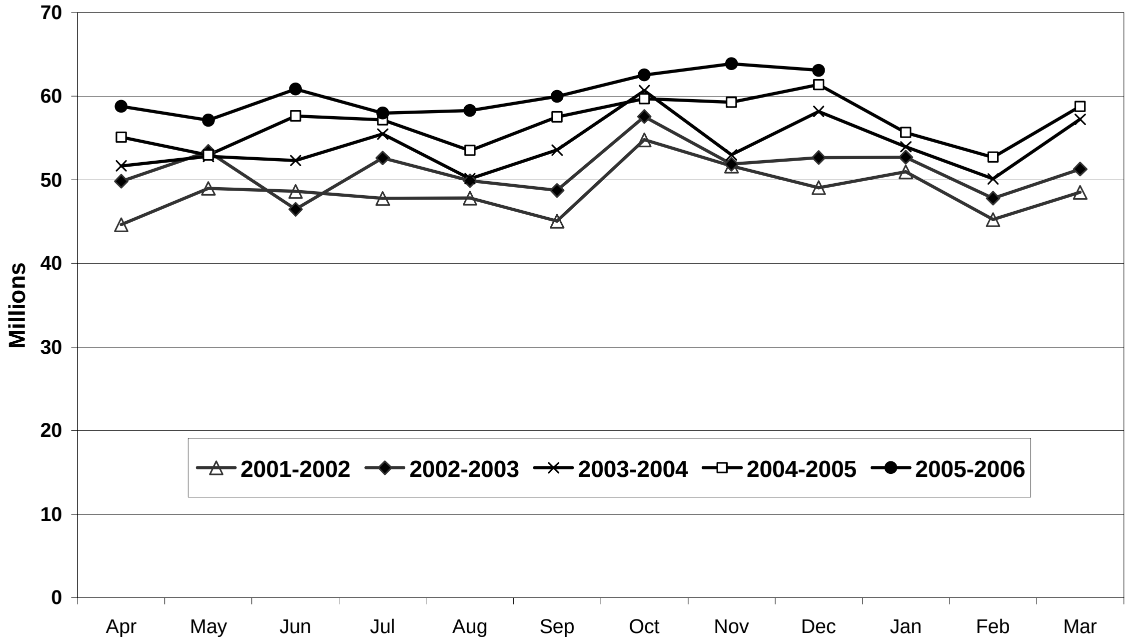


Figure 4: Total Spending on Prescribed Drugs in General Practice in England

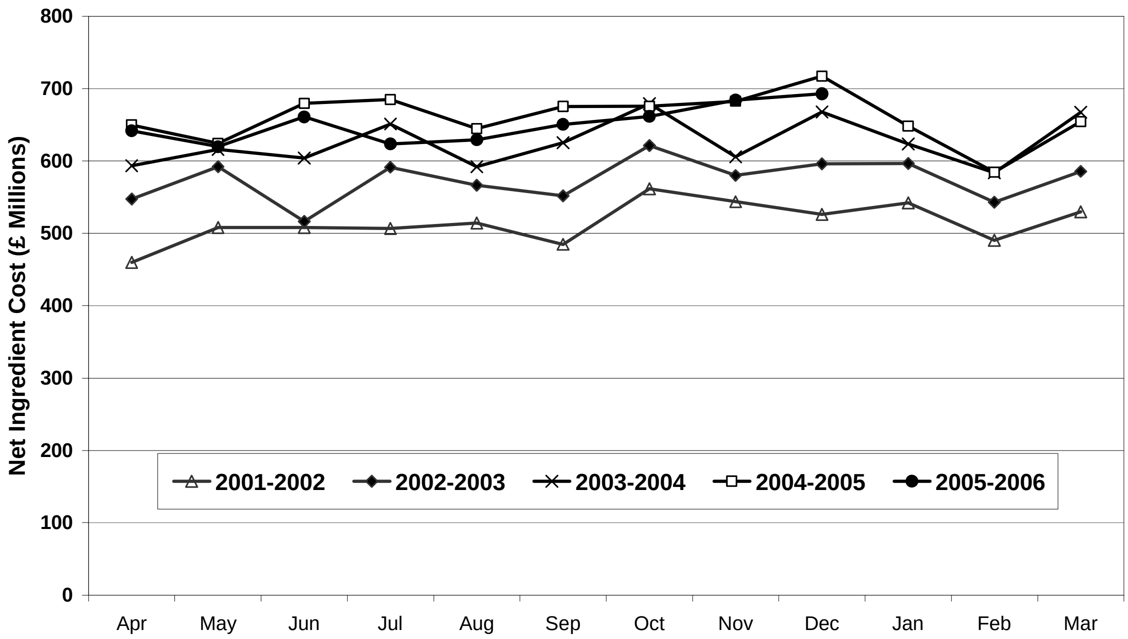
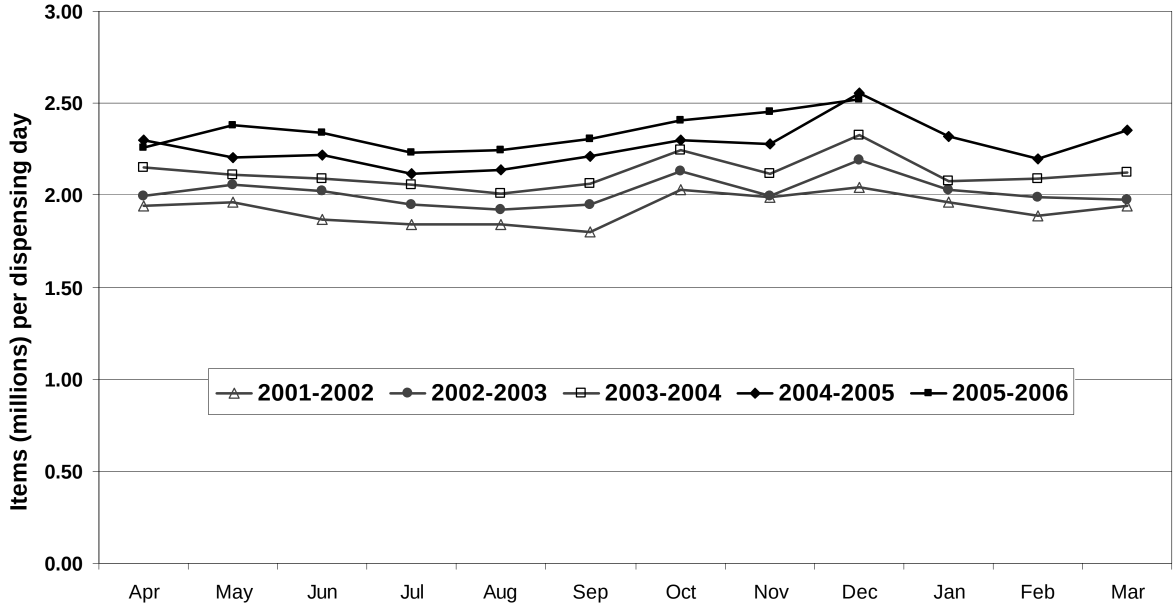


Figure 5 takes into account the number of “dispensing days” in each month. Dispensing days includes week days and Saturdays but excludes Sundays and bank holidays. When the number of items in a month is divided by the number of dispensing days, there is less variation than for items alone. The number of items per dispensing day was lower in December 2005 than in December 2004 which is unusual for December prescriptions and there is no obvious explanation for this.

Figure 5: Trend in Items by Number of Dispensing Days in the Month



2. FACTORS AFFECTING GROWTH IN VOLUME AND COST

2.1 Growth in Individual Therapeutic Areas

Table 1 compares the prescription volume and cost per annum for the six largest therapeutic areas in the year to December 2005 with the previous year. These six areas make up 76% of prescribing in the year to December 2005. Figure 6 shows that the rate of growth per annum for items has slowed for the top two areas between December 2004 and December 2005 (cardiovascular system and central nervous system) suggesting that the underlying trend is now towards slower growth in volume. Items growth for cardiovascular system drugs stood at 11.5% in the year to December 2004 but has reduced to 8.7% in the year to December 2005.

The generic prices review and the renegotiated Pharmaceutical Price Regulation Scheme (PPRS) have helped to slow cost growth for drugs for cardiovascular and central nervous systems. Cost for cardiovascular system drugs has fallen while items continue to increase. Figure 7 shows the change in the rate of growth per annum for cost between December 2004 and December 2005. The cost growth for cardiovascular system drugs stood at 7.0% in the year to December 2004 but has reduced to -12.9% in the year to December 2005.

Table 1: Volume and cost of the top six therapeutic areas by volume

	Items (millions)			Cost (£ millions)		
Therapeutic Area	Year to Dec 2004	Year to Dec 2005	% difference	Year to Dec 2004	Year to Dec 2005	% difference
Cardiovascular system	200.3	217.7	8.7	2,147.7	1,869.7	-12.9
Central nervous system	119.0	121.7	2.3	1,378.3	1,417.4	2.8
Endocrine system	54.0	58.0	7.4	766.5	815.5	6.4
Respiratory system	50.7	51.8	2.3	770.1	798.6	3.7
Gastro-intestinal system	50.9	53.4	4.8	643.9	651.9	1.2
Infections	37.3	38.3	2.7	228.0	219.3	-3.8
All others	163.5	168.8	3.2	1,973.8	1,979.1	0.3
Total	**675.6**	**709.7**	**5.0**	**7,908.3**	**7,751.6**	**-2.0**

Figure 6: Change in Rate of Growth of Prescribing for Top 6 Therapeutic Areas

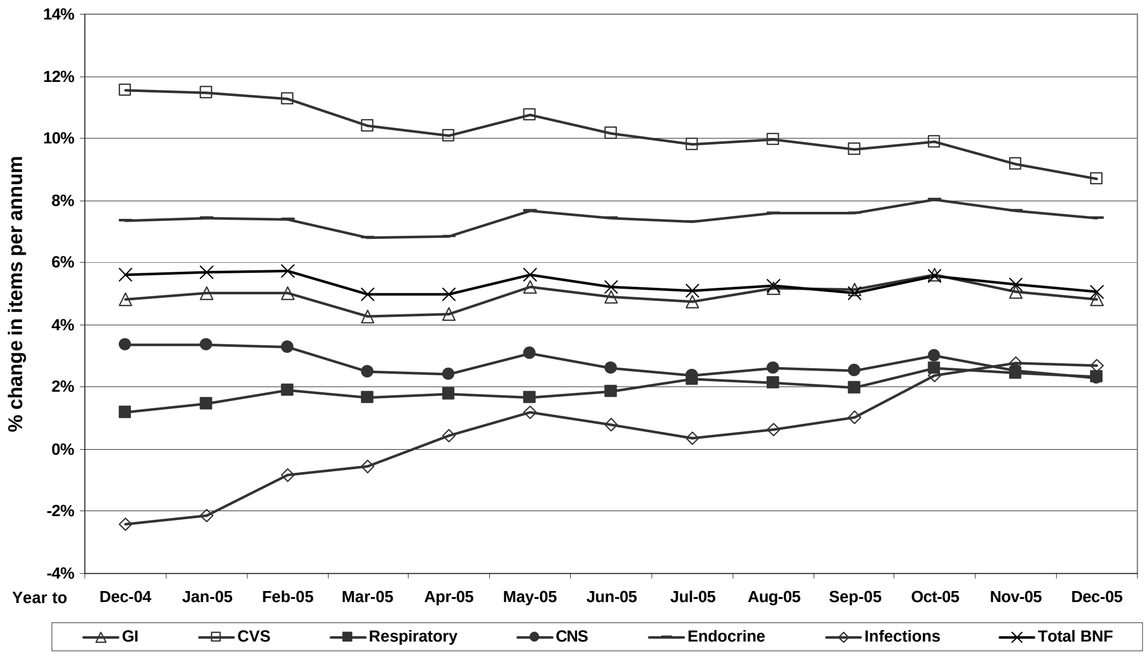
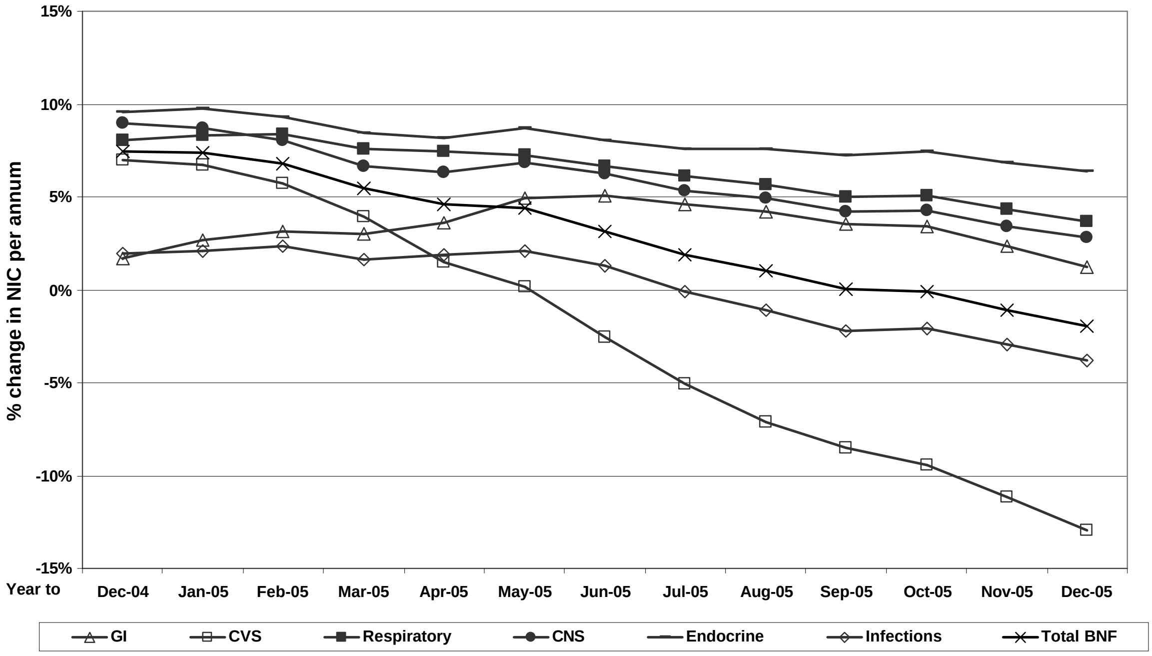


Figure 7: Change in Rate of Growth of Cost for Top 6 Therapeutic Areas



2.2 Department of Health Policies to Control Drug and Appliance Prices

From 1st April 2005 the Department of Health (DH) reduced the Drug Tariff price of drugs which are readily available by introducing a new Category M. This is expected to release £300 million in 2005/06 towards funding the new national pharmacy contract and the price reductions are impacting on the drugs bill. Items for category M drugs increased by 5% to 87.5 million in the quarter to December 2005 compared to the same time period last year. Cost for these items decreased by 16% to £347 million in the same time period.

The new pharmacy contract and the generic price reductions along with the PPRS have had a major impact on cost growth and should ensure that growth in the drugs bill stays low. None of these policies should impact on volume except for the repeat dispensing element of the new pharmacy contract. The impact of repeat dispensing is discussed in section 3.2. The medicines management elements of the new GMS and pharmacy contracts should reduce wastage of medicines and therefore help to hold back growth in volume.

The DH recently consulted on the arrangements for the provision of dressings, incontinence appliances, stoma appliances, chemical reagents and other appliances to primary and secondary care. This consultation included options for determining the reimbursement price for these items. A further consultation on the reimbursement of standard branded generic medicines closed in October and changes are expected to be implemented this year. Both these consultations, in combination with the other DH policies, should ensure minimal growth in the drugs bill.

2.3 GMS Contract, National Service Frameworks & National Institute for Health and Clinical Excellence Guidance

A new GMS contract was implemented in April 2004. It has the potential to increase prescription volume (and cost) because of the introduction of the Quality and Outcomes Framework, which rewards practices for improving patient care in a number of clinical domains. The drugs that fall into the clinical domains of the Quality and Outcomes Framework made up 42% of overall prescribing and 45% of cost in the year to December 2005. Most of the areas of prescribing covered by the current Quality and Outcomes Framework are already areas of high growth and the GMS contract helps to maintain this growth. Eight new clinical domains have been added to the Quality and Outcomes Framework for 2006/07 but this is not expected to increase prescription volume significantly.

Section 2.1: 'Growth in Individual Therapeutic Areas' shows growth in the main therapeutic areas. The increases in the cardiovascular and endocrine areas are largely due to the implementation of the NSF for Coronary Heart Disease and the NSF for Diabetes. The NSF for older people covers prescribing for stroke and osteoporosis, and therefore prescribing in the cardiovascular, endocrine, and nutrition and blood therapeutic areas is increasing as a result.

Previous reports have shown that NICE guidance is not usually a major driver of growth in volume. Technology appraisals often focus on choice of drugs therefore volume should not change appreciably as a result. Clinical guidelines focus on appropriate prescribing for specific diseases or conditions and are more likely to affect volume. NICE has recently published a technology appraisal for statins for the prevention of cardiovascular events. The consequence of this appraisal is that an estimated 1.7 million additional people in England and Wales could receive treatment. In the long term this could lead to additional prescription items in the order of approximately 2.5% of current volume. Although the uptake of NICE guidance should happen quickly, we would not expect to see a sudden increase in volume because it will take time to identify appropriate patients who are eligible for statin therapy.

It should be noted that there is overlap between the groups of drugs covered by NICE guidance, National Service Frameworks and the GMS contract. The combination of all the guidance maintains the pressure on prescribing in these areas.

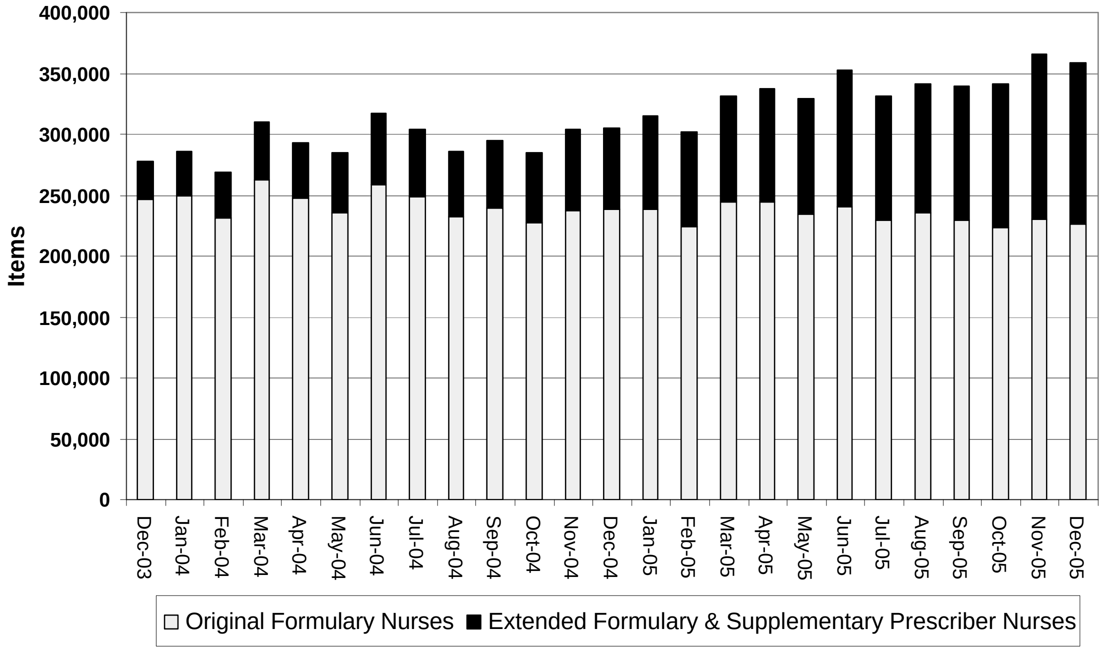
3. FACTORS AFFECTING COMPLEXITY OF PRESCRIPTION PROCESSING

3.1 Nurse Prescribing & Supplementary Prescribing

Figure 8 shows the total number of items prescribed by original formulary nurses and by extended formulary/supplementary nurse prescribers. This shows that the volume of items from extended formulary/supplementary nurse prescribers is an increasing proportion of total nurse prescribing (37%, December 2005). Overall prescribing by nurses has increased by 14.3% in the year to December 2005 when compared to the previous year.

There are currently over 4,500 extended formulary/supplementary prescriber nurses on the PPA database of prescribers. Over half (2,315) of these are practice nurses whilst 2,238 are community nurses. According to the DH, over 5,700 nurses were registered as supplementary prescribers by November 2005 however some of these nurses will be practising in secondary care. The DH has announced that from spring 2006, qualified extended formulary nurses will be able to prescribe any licensed medicine for any medical condition, with the exception of a limited list of controlled drugs.

Figure 8: Trends in Nurse Prescribing



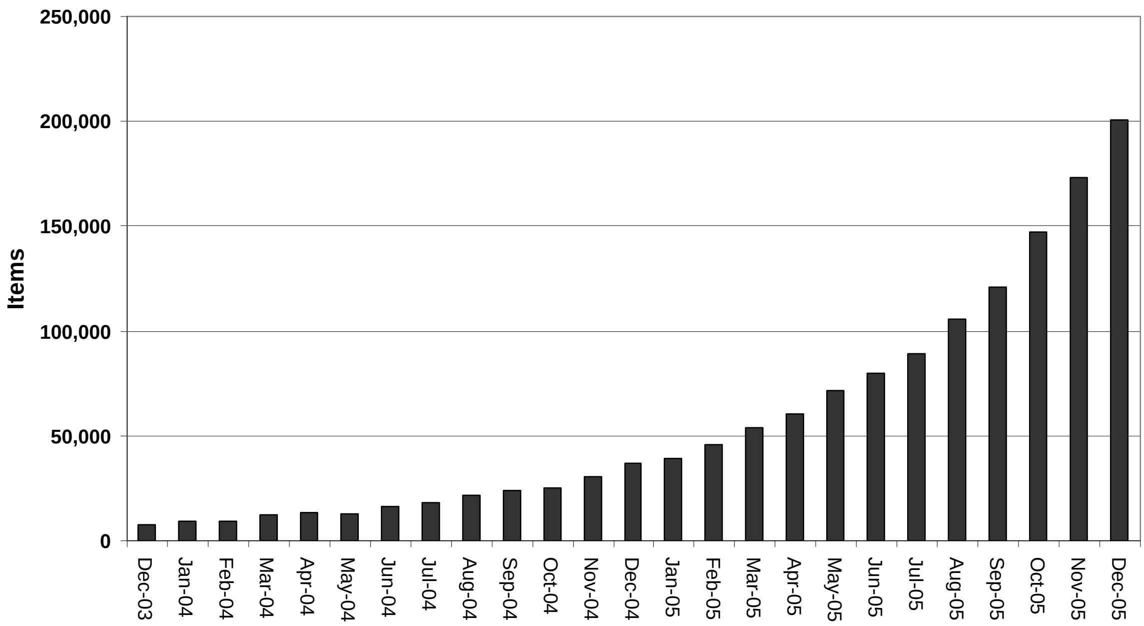
Pharmacists are also qualifying as supplementary prescribers and over 450 were registered by November 2005. In the quarter to December 2005, the PPA received 3,801 items for processing from pharmacist supplementary prescribers. The DH has announced that from spring 2006, pharmacist independent prescribers will be able to prescribe any licensed medicine for any medical condition with the exception of controlled drugs. The necessary regulations will have to be amended before this extension of prescribing can occur, and pharmacists will need to train as independent prescribers (there are already nurse independent prescribers). This initiative has the potential to increase prescription volume however the DH anticipates that it will take pressure off GPs by allowing them to focus on more complex cases thereby improving the availability of care for patients.

Parliamentary approval for amendments to medicines legislation and NHS regulations was given in April 2005 to allow more health professionals, including physiotherapists, radiographers and podiatrists, to prescribe medicines, as supplementary prescribers in partnership with a doctor. Further approval was given in July 2005 to allow optometrists to prescribe as supplementary prescribers. Supplementary prescribing should replace existing prescribing by GPs and is therefore not expected to increase prescription volume although it will increase the complexity of prescription processing. The first cohort of these prescribers has completed the necessary training but the PPA has not yet received any prescriptions written by them.

3.2 Repeat Dispensing

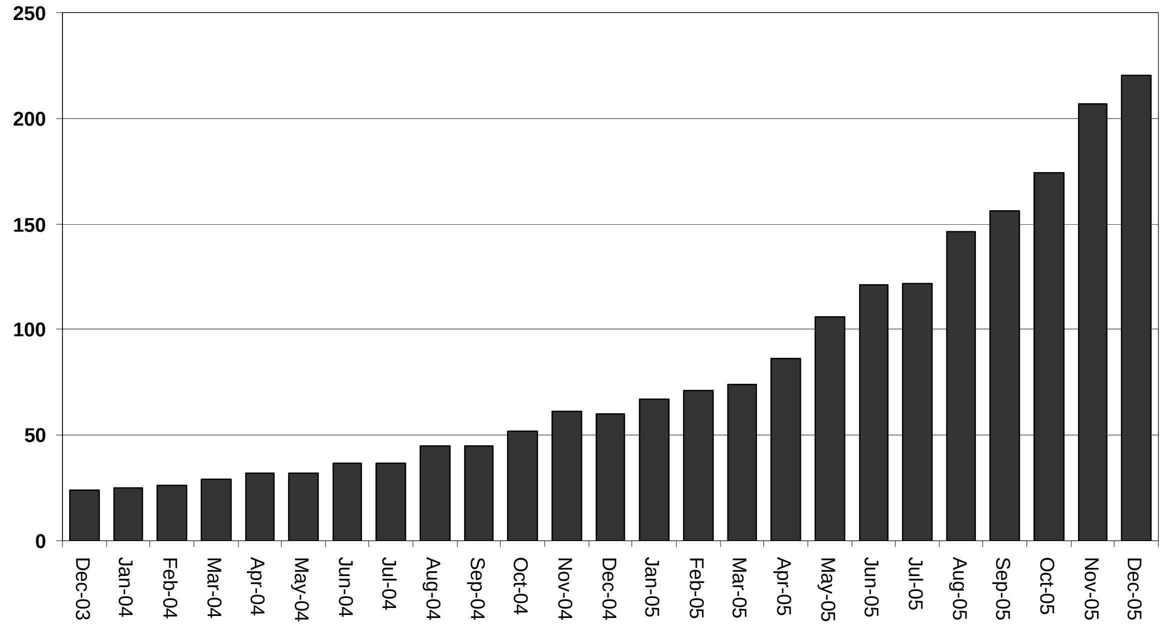
The new pharmacy contract, implemented in April 2005, includes repeat dispensing as an essential service that all pharmacies should provide. Feedback from pathfinders indicates that the level of uptake of the service in 2005/06 is unlikely to be higher than 5% of all prescription items that are appropriate for repeat dispensing. Figure 9 shows the increase in repeat dispensing items between December 2003 and December 2005.

Figure 9: Trends in Repeat Dispensing Forms



The number of PCTs submitting repeat dispensing items each month has increased substantially since the beginning of the pilot. Following the implementation of the new pharmacy contract in April 2005, repeat dispensing has become an essential service. However, not all PCTs have implemented repeat dispensing yet. Figure 10 shows that repeat dispensing items were submitted from pharmacies within 220 PCTs in December 2005. Our previous estimates assumed that uptake would be across 230 PCTs by this stage, which indicates that repeat dispensing is rolling out at a similar rate to that predicted by our model.

Figure 10: Primary Care Trusts with Repeat Dispensing Items

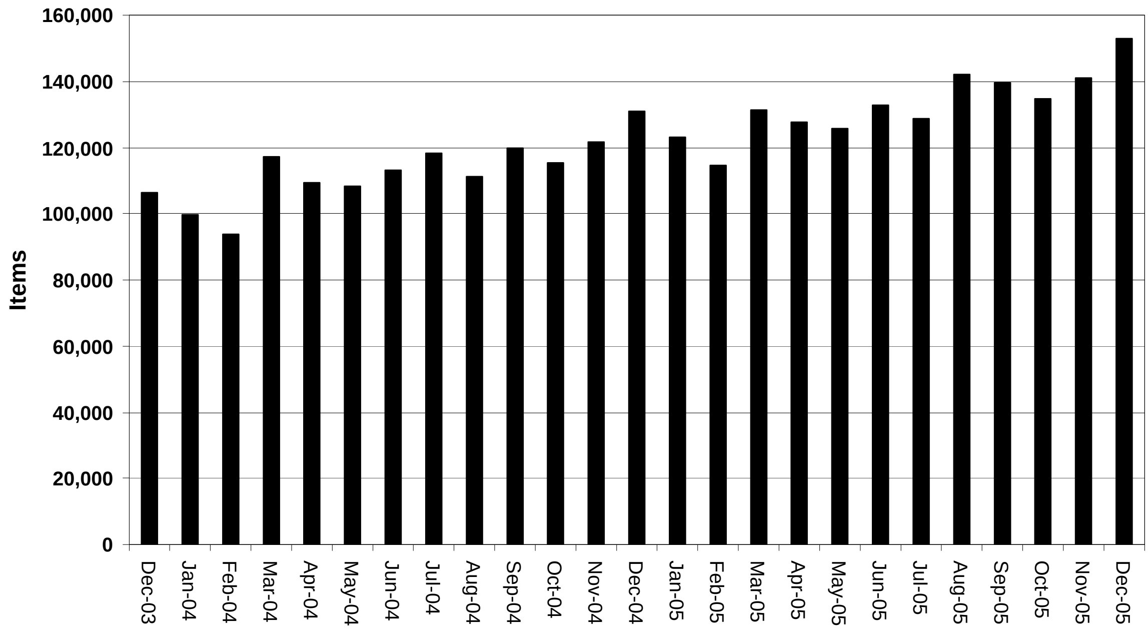


Overall, the extension of repeat dispensing to all pharmacies is likely to add 0.6% to volume growth by the end of 2005/06.

3.3 Local Pharmaceutical Services

Local pharmaceutical services (LPS) are pilot schemes to make greater use of pharmacists' skills. Under the LPS scheme, pharmacists take on extra responsibilities in addition to dispensing. This provides opportunities to develop local arrangements which address local priorities and meet local needs. Contracts for LPS are held between PCTs and LPS providers. Some contracts concentrate purely on pharmaceutical services whereas others use the flexibility of LPS to provide a broader range of services such as diagnostic testing, therapeutic monitoring or provision of training and education. 31 PCTs have now received approval for LPS pilot sites. Applications for further pilots were invited in 2005. Figure 11 shows the number of items dispensed through LPS schemes since December 2003. The impact of LPS is likely to be on the complexity of prescription processing rather than increasing prescription volume.

Figure 11: Items Dispensed through Local Pharmaceutical Services



SUMMARY

- Prescription volume for the year to December 2005 increased by 5.0%.

- Total volume growth of 6% was forecast at the beginning of 2005/06, however taking into account current growth and the continuing slow roll out of repeat dispensing an increase in volume of more than 5.5% is unlikely.

- Cost has fallen (2% negative growth) in the year to December 2005 compared to the previous year. Further reductions in drug expenditure are expected as a result of the generic price reductions introduced by the Department of Health.

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Statistician

22nd February 2006