

Consultation on Simplification of Reimbursement Rules for NHS Dispensing Contractors

Summary of responses

1. Introduction

In September 2005 the Department of Health consulted on a package of proposals designed to simplify the reimbursement arrangements for NHS dispensing contractors. The consultation closed on 30th November 2005.

The intention of these proposals was to simplify the reimbursement processes for pricing prescriptions, to make the rules more transparent to dispensing contractors, and to build into the system the ability to cope with increasing number of pack sizes, while at the same time promoting the use of patient packs. These measures would also enable the Prescription Pricing Authority to re-engineer its systems in preparation for making efficiency savings from the rollout of the Electronic Prescription Service (EPS) within the NHS.

The consultation paper sought opinions on a range of measures designed to bring about this simplification, including:

- Simplifying the broken bulk arrangements.

- Changing the reimbursement arrangements when a calendar pack nearest to the quantity prescribed has been dispensed.

- Listing a reimbursement price for the most common specials.

- Simplifying the out of pocket expenses arrangements.

- Abolishing the common pack list, and reforming pack size calculation arrangements.

- Replacing the zero discount lists with a single, limited list, including criteria for placing products on the new list.

- Establishing one price for products in category M.

- Introducing a dispensing discretion with regard to the quantity dispensed, to allow the dispensing of patient packs more often.

Details of the background and rationale behind these proposals are in the consultation document, available on the Department of Health website at www.dh.gov.uk.

2. Responses to the consultation

A list of respondents is at **Annex A**. Of the 66 responses:

14 were from pharmaceutical manufacturers or their representatives.

25 were from dispensing contractors, pharmacy businesses, or their representatives.

11 were from NHS bodies (PCTs, SHAs and Special Health Authorities)

9 were from medical practices or their representatives.

2 were from professional organisations.

5 were from other individuals and groups, including pharmaceutical wholesalers.

3. Simplifying the broken bulk arrangements

Consultation questions

In respect of this proposal, the following question was asked:

“What are your views on the proposal to simplify the broken bulk arrangements?”

Summary of responses

The general reaction to this proposal was positive. However, a number of responses commented that those medicines ‘readily available’ are not necessarily frequently prescribed. They therefore suggested exempting the most commonly prescribed medicines from claims, as contractors would have opportunity to dispense residual stock of common items. However, the consultation paper noted that ‘readily available’ medicines would mean those in categories M and A of the Drug Tariff. These are the most commonly prescribed these items.

Respondents noted that these arrangements would create some winners and losers. They welcomed continued availability of individual claims, recognising that bulk pack dispensing is still appropriate in some cases.

There was concern from some contractors that replacing individual claims with a flat payment would leave them out of pocket. This, they argue, is because different prescribing habits result in wide variation in the amount of broken bulk claims made. One response suggested extending the period for which the broken bulk claim applied from six to twelve months, due to the long shelf-life of many products. Two responses suggested that broken bulk should be added to the schedule of payments for purposes of transparency. There were also suggestions that the broken bulk arrangements should be extended to cover dressings and appliances.

It was also noted that this proposal may cause problems for contractors dispensing to nursing homes, where large packs of common drugs are often used. There was also concern that this measure would have a

disproportionate impact on small premises, which have fewer opportunities to dispense residual stock, leading to a greater reliance on broken bulk claims. Some respondents argued that increased patient pack dispensing would reduce the number of broken bulk claims.

4. Calender packs, patient packs and the dispensing discretion

Consultation questions

In respect of these proposals, the following questions were asked:

“What are your views on the proposal to allow the dispenser to dispense the calender pack (or sub-pack) nearest to the quantity prescribed and pay them for the quantity prescribed?”

What are your views on:

The proposal for a dispensing discretion with regard to the quantity dispensed to enable a patient pack to be supplied

The size of any discretion (i.e. 10%, 20%, etc.)

The limits that should be placed on the use of the discretion

The accompanying reimbursement approach? “

Summary of responses

The majority of responses commenting on this proposal were in favour of both the dispensing of a calender pack and the dispensing discretion. However, many respondents commented that payment should be based on the amount dispensed rather than that prescribed. There was concern from some that under the proposed arrangements Primary Care Trusts would encourage the prescribing of smaller amounts than an available patient pack, which dispensers would then have to round up, thereby losing out financially. Some believed that in such cases pharmacists would rather snip packs, undermining the intention of increasing patient pack dispensing.

It was also argued that pharmacists might use the discretion only when it suited them financially, and would continue to snip packs in all other cases. One respondent suggested a ban on snipping for this reason. It was also suggested that pharmacists should be able to round only to the nearest pack, rather than sub-pack, as a sub-pack would not contain an information leaflet.

A number of respondents commented that the discretion could be used to synchronise a patient's medicine regimen, dispensing the same amount of each drug.

A large number of responses also commented that standardisation of pack sizes would reduce the need for a dispensing discretion. Some of those opposing the proposal suggested pack standardisation as an alternative. Many others thought it a preferable long-term solution.

Those commenting on the size of the discretion generally favoured either 10% or 20%, although as little as 7% and as much as 25% was suggested, along with one comment that it should be 'as large as is necessary'.

Many respondents suggesting limitations on the discretion recommended that the prescriber should be able to override it by ticking a box on the prescription form, although there were comments that this would mean extra work for both the prescriber and the PPA. There were also requests for certain items, such as controlled drugs and antibiotics, to be excluded from the discretion as a matter of course.

5. Listing of Specials

Consultation Questions

In respect of these proposals, the following question was asked:

“What are your views on the proposal to list a reimbursement price (including out of pocket expenses) in the Drug Tariff for the most common specials?”

Summary of responses

A majority of the responses to this proposal approved of the proposed changes, but a number concerns were raised. The workability of the proposal was questioned, with respondents raising a number of issues such as the problems of defining the top 150 specials and of setting prices for bespoke products. It was also pointed out that the main manufacturing costs of specials are 'fixed' costs, meaning that reimbursement per 100ml would be unfair for all other amounts.

A number of respondents also argued that data on specials dispensed from hospital pharmacies should be excluded from price calculations, as products from hospital pharmacy are often subsidised, and because hospitals do not operate under the same commercial pressures as private sector manufacturers. There were also questions as to why historic prices would be used to set tariff rates, rather than current ones.

It was noted that this proposal would have the effect of driving competition and encouraging transparency within the specials market. Yet there were concerns that the quality of product and service might be affected, for example discouraging manufacturers from offering additional services in conjunction with their products.

Some respondents argued that the need for specials should be reduced through extemporaneous dispensing by pharmacists. There were suggestions that this could be an enhanced service under the new contract, or that one pharmacy in each area could provide such services – with specials manufacturers being used only for complex formulations. However, other respondents argued that extemporaneous dispensing should not be encouraged for safety reasons.

There were also concerns about possible manufacturers' price rises meaning an annual update of Tariff rates would be too infrequent to react to the market. There was also concern that these proposals would force contractors to 'shop around' to find specials at or below Drug Tariff price. Currently, all contractors do not have access to all suppliers, meaning they might not be able to take advantage of low prices.

6. Out of Pocket Expenses

Consultation questions

In respect of this proposal, the following question was asked:

“What are your views on the proposal to only allow out of pocket claims in excess of a set limit and to compensate contractors with a flat payment per month?”

Summary of responses

The general reaction to this proposal was positive. However, a number of respondents argued that a flat payment would not compensate for the cost of delivering and storing specialist medicines, meaning it has the potential to leave either wholesalers or contractors out of pocket. Some respondents further argued that this may therefore discourage contractors from dispensing items on which out of pocket expenses are incurred. It was also noted that the listing of the top 150 specials in the Drug Tariff (another proposal consulted on in this paper) would significantly reduce the need for individual out of pocket claims however.

Some respondents suggested that pharmacist declaration of out of pocket expenses on form FP34C, a system introduced in February 2006, was a fairer system than that proposed. However, other respondents were concerned that this method may be unreliable, as there is no system for verifying those expenses declared.

One respondent suggested that the Department should investigate the scale of handling charges, feeling they were currently too high. One manufacturer also suggested that wholesalers were claiming specials handling costs against normal pharmaceutical items, and that the NHS was therefore paying for out of pocket expenses which had not been incurred. There was also a

request for the out of pocket arrangement to be extended to those appliances listed in part IX of the Drug Tariff.

7. Abolition of the Common Pack list and, where pack size is not indicated, basing reimbursement on the pack with cheapest unit cost.

Consultation question

In respect of this proposal, the following question was asked:

“What are your views on the proposal to abolish the list of commonly used pack sizes and, where the contractor does not indicate which pack was used, base payment on the pack with the cheapest unit cost?”

Summary of Responses

A majority of the responses approved of the proposed changes. There was a request to clarify exactly what was meant by ‘lowest unit cost’ however. A number of respondents also suggested moving products to Category M where possible.

There was concern that this measure might encourage dispensing from bulk packs, as only the pack with cheapest unit cost would be properly reimbursed without endorsing. Many respondents, including some who approved of the proposal, therefore suggested basing reimbursement on the cheapest available patient pack. There was also concern that this proposal would increase the amount of endorsing required.

It was also noted that the proposal might lead to wholesalers holding superfluous pack sizes, which would be difficult to sell. For this reason, one respondent requested phased implementation of this proposal.

8. Abolition of the zero discount lists, to be replaced by a single, limited list.

Consultation question

In respect of this proposal, the following question was asked:

“What are your views on the proposal to abolish the zero discount lists and introduce a limited list where the full Drug Tariff or manufacturers list price will be paid?”

Summary of Responses

Overall, respondents reacted positively to this proposal. However, a number of concerns were raised. Some respondents argued that the ZD and clawback system interferes with the market. The abolition of clawback was therefore suggested, as was the abolition of ZD. One respondent argued that a loss of ZD status would mean that additional services, such as advice on using the items, would no longer be available due to an inability to cover costs. One association noted that this measure assumes manufacturers should offer discount, even though it is not in their interest to do so.

Some respondents were against the proposed changes, the main concern being that dispensing non-discounted items which were not on the list would leave contractors out of pocket. It was argued that there is wide variation in the numbers of ZD items dispensed, with some specialist pharmacies being heavily reliant on them. The fairness of adjusting the deduction scale, which would compensate all contractors equally, was therefore called into question. Two respondents asked what would happen if a product was available with discount from certain suppliers only – a situation currently covered by ZD list B. It was also argued that the proposed conditions for adding a product to the list were too restrictive.

A number of respondents suggested that additional categories of product should be added to the new list. These included cold storage items, foods, and cytotoxic/cytostatic items. Many respondents also argued that this proposal should be implemented in the context of a wider review of the clawback mechanism.

9. Single reimbursement price for Category M products.

Consultation question

In respect of this proposal, the following question was asked:

“What are your views on the proposal to establish one Category M price for a chemical entity rather than differing prices relating to pack size?”

Summary of Responses

A majority of responses were in favour of this change, approving of the benefits in terms of simplification which this measure would bring, including pharmacists no longer having to endorse pack size.

Although they broadly approved of the proposal, there were questions from manufacturers around whether this proposal might distort the market, as some pack sizes would become more economically viable than others. It was suggested that this may reduce choice of pack size in future.

There was also concern that this proposal would discourage production of packs with 'value added' features, such as information in braille or easy to open packs for those with dexterity problems. One organisation queried whether there would be different prices for different strengths of the same chemical entity.

It was suggested by one respondent that the proposed change might cause problems for pharmacy computer systems, as Category M items would require endorsing differently from other categories of generic drugs.

Respondents' greatest concern was that this measure would discourage patient pack dispensing, as a standardised price per tablet would make bulk pack dispensing more economically attractive. Many respondents therefore suggested that the reimbursement price should be a weighted average of patient pack prices only. One response suggested monitoring the situation to ensure increased bulk dispensing does not occur.

It was also suggested that items in category M should be exempted from clawback, as the category M price is calculated based on actual market prices rather than manufacturers' lists.

List of responders

Pharmaceutical manufacturers and industry representatives:

1. Association of the British Pharmaceutical Industry (ABPI)
2. Alharma Ltd.
3. Association of Commercial Specials Manufacturers (ACSM)
4. BCM Specials
5. British Generic Manufacturers Association (BGMA)
6. Cardinal Health, Martindale Products and Specials
7. Discovery pharmaceuticals
8. GlaxoSmithKline
9. Infant and Dietetic Foods Association
10. IPS Specials and World Medicines
11. IVAX Pharmaceuticals
12. Quantum Specials Ltd.
13. Rosemont Pharmaceuticals
14. The Specials Laboratory

Pharmacists, pharmacy businesses and representative organisations:

15. Alliance pharmacy
16. Association of independent multiple pharmacies (AIMp)
17. Avon LPC
18. Boots the Chemist
19. Company chemists' association
20. Devon LPC
21. Lloyds Pharmacy
22. Martin Bennett (Wicker Ltd.)
23. Mr Chris Howland-Harris (Ashgrove Pharmacy)
24. Mr E.C. York
25. Mr Graham Black
26. Mr John Ryan
27. Mr I. R. Hargrave
28. Mr John Murtagh
29. Mr Nick Gompels
30. Mr P. Sendall (Alleycare Ltd.)
31. Mr Simon Wilson
32. Mr Tony Pinkus
33. Ms Sheelagh Hillan (Randalstown Pharmacies)
34. National Pharmacy Association (NPA)
35. North Yorkshire LPC
36. Pharmaceutical Services Negotiating Committee (PSNC)
37. St Helens & Knowsley LPC
38. Suffolk LPC
39. Torrington Park HCC

NHS Bodies:

40. Bristol North PCT
41. Bedfordshire Heartlands PCT
42. Bradford South and West PCT
43. Chesterfield PCT prescribing subgroup
44. Dorset and Somerset SHA
45. Ipswich PCT
46. Mid-Devon PCT
47. NHS Counter Fraud and Security Management Service
48. Prescription Pricing Authority
49. Taunton Deane PCT
50. Tendring PCT

Medical practices / organisations:

51. Bodowen Surgery
52. Dispensing doctors' association
53. Dispex Ltd. (Representing dispensing Doctors)
54. Dr Barton and Partners
55. Drs Langley, Parry-Smith, Smits, Evans and Morris
56. Grimston medical centre
57. Mr Richard Upton (Old Mill and Millgates Medical Practice)
58. Strensall Medical Practice
59. Wallingbrook Health Centre

Professional Bodies:

60. British Medical Association
61. Royal Pharmaceutical Society of Great Britain

Other:

62. Mr Berwyn Owen (Pharmaceutical advisor, North Wales)
63. British Association of Generic Distributors (BAGD)
64. British Association of Pharmaceutical Wholesalers (BAPW)
65. OTC Direct Ltd.
66. UniChem Ltd.