House of Commons

Committee of Public Accounts

Department of Health: Prescribing costs in primary care

Second Report of Session 2007–08

Report, together with formal minutes, oral and written evidence

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The Committee of Public Accounts

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Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee's email address is pubaccom@parliament.uk.

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Summary

Around a quarter of all expenditure in primary care is on drugs, and both the volume of drugs prescribed and their total cost are increasing. In 1996, 485 million prescriptions were dispensed in England; by 2006 this had increased by 55% to 752 million. Over the same period the primary care drugs bill increased from £4.0 billion to £8.2 billion: a 60% increase in real terms. Growth has been driven by the licensing of new treatments, the discovery of new opportunities to treat disease through existing medications and moves to earlier treatment of some diseases. Efficient management by the Department of Health (the Department) and NHS bodies can however make the drugs bill more affordable without affecting patient care.

In recent years there has been a substantial increase in prescribing lower cost, generic versions of drugs, rather than more expensive brand name drugs. There are a number of examples of good practice where progress has been made: for example by supporting GPs to switch patients' medication to lower cost generic forms where appropriate, by working with local opinion-leaders to promote better prescribing, and by using benchmarking data to help GPs peer-review their prescribing practices.

There is however still scope for further savings to be made, through GPs following official guidelines more often and prescribing generic and other cheaper drugs where suitable. There is wide variation between Primary Care Trusts (PCTs) in the proportions of lower cost drugs being prescribed for some common conditions, for example between 28% and 86% for statins. The National Audit Office has estimated that £200 million a year could be saved without affecting clinical outcomes, money which could be used to treat patients. The Department does not know the extent to which drugs being prescribed are not taken and wasted, though the value of drugs returned to pharmacists alone is estimated to be at least £100 million a year.

On the basis of a report from the Comptroller and Auditor General,[1] we took evidence from the Department on prescribing costs in primary care, and the scope for better use of the £8 billion a year spent by the NHS on prescription drugs.

1 C&AG's Report, *Prescribing costs in primary care,* HC (Session 2006–07) 454

Conclusions and Recommendations

1. **The NHS could save more than £200 million a year, without affecting patient care, by GPs prescribing lower cost but equally effective medicines.** Many drugs are available in both branded and generic versions, and the latter is usually much cheaper than the brand name drug, for which the manufacturers have to recover research and development costs.

2. **The proportion of prescriptions written by chemical name rather than by brand name, known as generic prescribing, rose from 51% in April 1994 to 83% in September 2006.** But only 59% of prescription items were actually dispensed as generics in 2005, mainly because not all drugs prescribed were available in generic form. For some common conditions doctors have a choice of clinically equally effective drugs, some of which are available in generic form whilst others are only available as branded medicines. Where it is clinically appropriate, GPs should prescribe those available in generic form.

3. **The proportion of lower cost prescriptions for some common conditions varies greatly between Primary Care Trusts (PCTs), for example between 28% and 86% for statins.** Strategic Health Authorities should work with the National Prescribing Centre to spread best practice in prescribing and help those PCTs that have difficulty implementing switching programmes to learn from PCTs that have successfully done so.

4. **Comparing GP practices and PCTs on indicators of efficient prescribing is an effective way of influencing prescribing behaviour.** The Department, in conjunction with the NHS Institute for Innovation and Improvement, should develop more 'Better Care, Better Value' prescribing indicators to measure the proportion of generics dispensed and the level of potential savings where more cost effective prescribing would generate significant savings, such as for renin-angiotensins used to treat high blood pressure. Strategic Health Authorities should use these indicators to hold PCTs to account for prescribing costs.

5. **Despite large variations between PCTs in prescribing efficiency, nearly all GP practices achieve maximum points on the 'medicines management' indicators in the Quality and Outcomes Framework.** Practices are rewarded for meeting a prescribing adviser 'at least annually', and agreeing 'up to three' actions relating to prescribing. The Department should strengthen the medicines management indicators when the Quality and Outcomes Framework is next renegotiated, and set more ambitious prescribing improvement targets for practices in order to be awarded the medicine management points. The Framework should also reward GPs for prescribing drugs that are available in generic form when clinically appropriate.

6. **One in five GPs responding to the NAO's survey said pharmaceutical companies had more influence on prescribing decisions than official advisers.** Whenever a gift is given by a company there is a risk that it will have an inappropriate influence on the recipient's behaviour. The Department should specify the minimal level above which gifts, hospitality, etc provided to prescribers by pharmaceutical companies

should be disclosed to the PCT. PCTs should publish an annual register of this information.

7. **Hospital consultants' prescribing choices are bound by agreed 'formularies' of cost effective drugs, but GPs are generally not subject to formularies.** Although prescribing decisions must be sensitive to the needs of the individual patient, evidence on the cost and clinical effectiveness of treatments for a particular disease should apply consistently across the country. The Department should encourage PCTs to pilot joint primary/secondary care formularies. Strategic Health Authorities should work with the National Prescribing Centre to promote agreement and consistency of formularies across primary and secondary care, and across PCTs.

8. **88% of prescription items are dispensed free, and the remainder for a standard charge not directly linked to actual cost.** The Department should do more to make patients aware of the costs of drugs, and hence the importance of not wasting them, for example by displaying on dispensed drugs information such as the cost of the specific items dispensed or an indication of the typical cost of items to the NHS.

9. **Unused and wasted drugs cost the NHS at least £100 million a year.** The Department of Health does not have robust or up to date information on the cost of drugs wastage or a good understanding of the varied and complex reasons why patients do not always use their drugs. It should commission research to establish the extent to which medicines are not used, and establish the reasons why patients do not take their drugs.

10. **Generic versions of drugs can vary considerably in appearance, colour and packaging.** This variation can be confusing for patients, particularly elderly patients on several medications, and can increase the risk of patients taking their drugs wrongly, or not at all. The Department should explore with the industry the scope to achieve greater consistency of appearance, labelling and/or packaging of the more common drugs supplied to the NHS.

1 The scope for savings in prescribing

1. The NHS in England spent £8.2 billion on prescription drugs in primary care in 2006, around a quarter of the total expenditure on primary care. There were 752 million prescription items dispensed: an average of 14 items per head of population, although patients over the age of 60 received a much higher average of 38 prescription items per head in 2005 compared to an average of 4 items per head for patients under 16. The average cost to the NHS of a prescription item was £11, but 88% of prescriptions were dispensed free to patients. The volume of drugs dispensed and their cost is increasing, as new treatments are approved, new opportunities to improve health through medication are identified and the Department of Health introduces new policy initiatives and National Service Frameworks to target certain conditions.[2]

2. Many drugs are available in both branded and generic versions. A pharmaceutical company creating a new drug usually markets that drug under a brand name, normally initially under the protection of a patent, which prevents other manufacturers from making the drug. A generic version of a drug is pharmaceutically equivalent to the branded version, containing the same active ingredient(s), but may only be produced after the branded drug's patent has expired. Brand name drugs are normally much more expensive than generic versions of the same product, for example because of manufacturers seeking to recover research and development costs. For instance, in October 2006, generic simvastatin 20 mg (a drug that is used to treat high blood cholesterol levels) could be bought for £2.34 for a pack of 28, compared with £29.69 for a pack of 28 of the branded version. Although there are more generic than branded prescription items dispensed, the higher cost of branded drugs means that they account for three quarters of the total drugs bill by cost.[3]

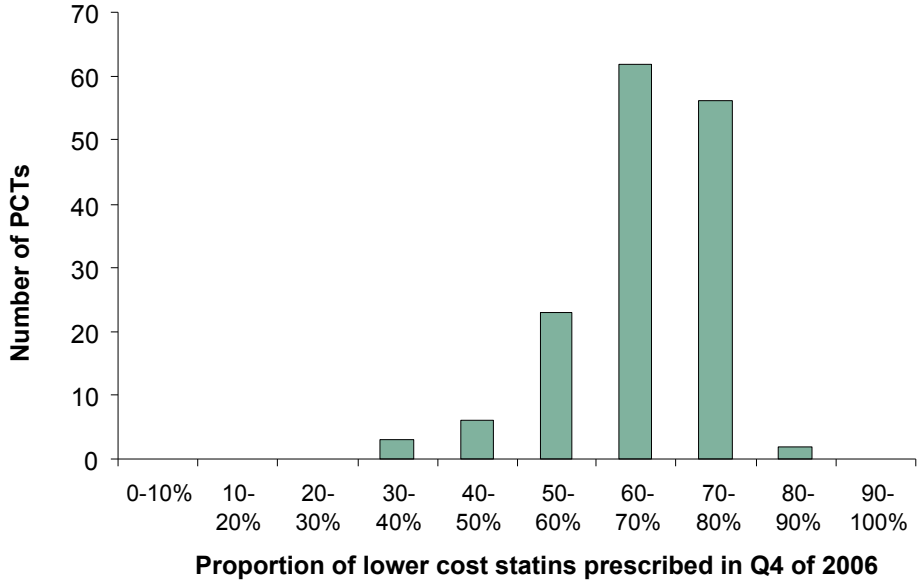
3. Increasing the use of generic drugs where appropriate offers the chance to increase the value for money which PCTs get from their expenditure on drugs. In some clinical areas it is also possible to use generic drugs in place of branded drugs, which while chemically different have equivalent clinical effects. For example, the National Institute for Health and Clinical Excellence (NICE)—the body responsible for providing guidance on the clinical and cost effectiveness of drugs—explicitly recommends that treatment is initiated with drugs of lower cost in the case of statins, which are used to treat high blood cholesterol. There is nevertheless wide variation between PCTs in the proportion of statin prescriptions dispensed as generics, as shown in **Figure 1.**[4]

2 Q17; C&AG's Report, paras 1.1–1.6

3 C&AG's Report, Figure 5; para 2.5

4 Q 4; C&AG's Report, para 2.6; Figure 6

Figure 1: Variation in the proportion of statins dispensed in generic form during quarter 4, 2006



Source: National Audit Office

4. PCTs vary in the priority they give to improving the cost-effectiveness of statin prescribing. 90% of new statin prescribing is for low cost versions; but it may be more difficult to switch patients' existing medications, and some patients will experience side effects or intolerance to some drugs. For this reason it is necessary to have a range of treatments available, and there will always be a need for some patients to receive more expensive versions of drugs.[5]

5. Generic statins have been available for three years, and NICE guidance on the use of generics has been available since January 2006. The Department's own data on statin prescribing show nevertheless that the drugs being dispensed by pharmacists are in many cases not the most cost effective. The NHS Institute for Innovation and Improvement, which aims to support the NHS by developing and spreading new ways of working and new technology, launched its 'Better Care, Better Value' prescribing indicator in September 2006. On this basis, the Department estimated that £85 million a year could have been saved by more cost-effective statin prescribing.[6]

6. The NAO considered four areas of prescribing, including statins, and found that £227 million would have been saved between August 2005 and July 2006 if all PCTs had prescribed with the same efficiency in these areas as the top 25% of PCTs. The four areas examined were for commonly prescribed drugs, representing 19% of the total primary care drugs bill; yet the NAO's analysis revealed large variations in the average price paid per dose, as shown for three of these areas in **Figure 2**. Although there could be scope for further savings on the rest of the drugs bill, the four areas considered by the NAO were the most important for achieving savings which the Department now needs to deliver.[7]

5 Qq 4, 7, 42, 44, 69

6 Qq 4, 6, 7; C&AG's Report, para 2.8

7 Qq 40–41; C&AG's Report, paras 2.12–2.13, 2.17

Figure 2: Cost per defined daily dose for drugs prescribed by PCTs in England, August 2005 to July 2006

	Lowest	Average for England	Highest
Statins (used to reduce high blood cholesterol levels)	£0.10 *(North Eastern Derbyshire PCT)*	£0.21	£0.37 *(North Norfolk PCT)*
Renin-angiotensin drugs (used to reduce high blood pressure	£0.08 *(South West Dorset PCT)*	£0.17	£0.28 *(Southport & Formby PCT)*
Proton pump inhibitors	£0.46 *(Plymouth PCT)*	£0.57	£0.70 *(North Norfolk PCT)*

Source: National Audit Office

7. One prerequisite for efficient prescribing is for GPs to prescribe generically whenever possible, writing prescriptions by chemical name rather than by brand name, so the pharmacist is able to dispense a generic version if it is available. Rates of generic prescribing have improved considerably since the early 1990s so that now the rate of 83% is the highest in Europe. Nevertheless, the price difference between branded and generic products means that even small further improvements can deliver large cash savings.[8]

8. A high generic prescribing rate, although a necessary condition for obtaining value for money from expenditure on drugs in primary care, is not however sufficient to deliver the savings identified by the NAO. For example, if a GP writes a prescription by chemical name (i.e. generically) for a statin that is still under patent, the pharmacist is obliged to dispense the branded drug; whereas a lower cost generic can be dispensed against a prescription for a statin no longer under patent, such as simvastatin. PCTs that have been successful in delivering savings have supported their GPs in starting new patients on more cost-efficient drugs when appropriate and in switching existing patients' medications when necessary.[9]

9. Another approach to controlling prescribing costs is to establish a list, or 'formulary', that limits GPs' prescribing choices to a list of recommended drugs for particular conditions. This regime already applies for hospital consultants. We asked the Department why GPs have greater prescribing freedom than consultants and why they did not allow pharmacists to dispense generic versions of brand name drugs, when available, against brand name prescriptions.[10]

10. The Department's view is that because prescriptions written by GPs could be dispensed at any community pharmacy, rather than at a hospital pharmacy as is the case for consultants' prescriptions, it would be harder to control pharmacists' enforcement of a formulary. The proportion of GPs' prescriptions written generically had increased over the last decade, which was a very effective way of ensuring that the drugs dispensed by

8 Qq 4, 11–13

9 Qq 6–7, 13; C&AG's Report, para 3.1

10 Qq 5, 10–13

pharmacists were the most clinically effective and the most cost effective. The Department needed to do more to ensure consistency between prescribing in primary and secondary care, especially as much primary care prescribing is initiated in hospital or influenced by local specialists. One of their aims in publishing their recent work on area prescribing committees was to strengthen the links between primary and secondary prescribing.[11]

11 Qq 5, 13; C&AG's Report, para 3.38

2 Influences on GPs' prescribing

11. The pharmaceutical industry spends more than £850 million annually on marketing its products to GPs. The Department provides useful information to patients and practices, and there is good partnership work between NHS organisations, general practices and the pharmaceutical industry. Nevertheless, in the NAO's survey of 1,000 GPs, one in five respondents said they felt that pharmaceutical company marketing had more influence on prescribing behaviour than official NHS prescribing advisers did.[12]

12. The industry's promotional efforts must comply with the code of practice drawn up by the Association of the British Pharmaceutical Industry, which was strengthened following the Health Select Committee's 2005 inquiry into the influence of the pharmaceutical industry. Furthermore, GPs are required to notify their PCTs of any gifts or inducements they receive from pharmaceutical companies, above a certain minimum level. Currently PCTs are not required to publish this information.[13]

13. At the time of the last renegotiation of the Pharmaceutical Price Regulation Scheme (PPRS), in 2004, the prices of branded drugs in the UK were at the top of the European range. The 7% price cut negotiated at that time brought prices 'within the range' for other European countries. The Department for Business, Enterprise and Regulatory Reform has recently stated that it will discuss options for reforms in drugs pricing with the pharmaceutical industry, following the Office of Fair Trading's review of the PPRS.[14]

14. To support GPs on prescribing issues and to spread best practice, PCTs employ prescribing advisers, specialists with pharmacy qualifications. Guidance and training for prescribing advisers is provided by the National Prescribing Centre. Most GPs report having a good relationship with their prescribing adviser, and feel that prescribing advisers have more influence over their prescribing decisions than pharmaceutical companies do. There are about 1,200 prescribing advisers employed in England. The Department quoted independent research which suggested that prescribing advisers increased clinical and cost effective prescribing and could save at least £2 for every £1 of salary costs. There has however been no work to assess the individual effectiveness of prescribing advisers or how prescribing adviser effectiveness correlates with the potential savings identified in the Comptroller and Auditor General's report.[15]

15. Other incentives for GPs to prescribe cost effectively are financial incentive schemes operated by PCTs; the 'medicines management' points in the Quality and Outcomes Framework that underpins GPs' pay; benchmarking and peer review of their prescribing patterns; and the introduction of Practice Based Commissioning.[16]

12 Q 8; C&AG's Report, para 3.19

13 Qq 52–56

14 Qq 29–32, 71–72, 89–91; Department for Business, Enterprise and Regulatory Reform News Release 2007/034, 2 August 2007

15 Qq 33–38, 63–64

16 Qq 20–26, 80

16. Individual PCTs may operate financial incentive schemes that reward practices, with extra income to be used for patient care, for staying within an agreed prescribing budget or increasing the proportion of more cost effective drugs being prescribed for certain conditions. There are two indicators in the Quality and Outcomes Framework which reward practices for meeting a prescribing adviser at least annually, and agreeing up to three actions related to prescribing. The NAO found that the vast majority of practices achieve the maximum of 4 points on these two indicators,[17] despite the large variations between PCTs in prescribing efficiency.

17. Benchmarking prescribing patterns involves comparing indicators of prescribing, such as volume and cost, across GP practices or PCTs, making allowances for differences in patient demographics. 'ePACT' (electronic prescribing analysis and cost) data is produced by the NHS Business Services Authority's Prescription Pricing Division. It is available to all PCTs to help them with benchmarking. Showing GPs how their prescribing compares with that of their peers has proved in the Department's view to be an effective way of influencing prescribing behaviour.[18]

18. Practice Based Commissioning (PBC) is the Department's initiative to give GPs more control over their PCTs' financial resources, and allows GPs to reinvest a proportion of any efficiency savings they make into their practices. By June 2007, 96% of GP practices had taken the incentive payment to become involved in PBC. The Department expects the drugs budget to be an integral part of PBC, and that PBC will bring practices together into consortia which will increase the amount of peer review and drive positive changes in behaviour. In the NAO's survey of GPs, however, 37% of respondents did not know what impact Practice Based Commissioning would have on their drugs bill, and 20% said it would not encourage their practice to make any savings. 36% said it would encourage small savings, and 8% said it would encourage significant savings.[19]

19. Dispensing doctors operate predominantly in rural areas where pharmacies are often in short supply, and are remunerated for dispensing drugs they have prescribed to their patients. The Department's data shows no evidence of higher levels of prescribing for dispensing doctors compared with non-dispensing doctors, and very little difference in average costs, except for a few cases where dispensing doctors were prescribing more expensive drugs. Recent changes to dispensing doctors' remuneration arrangements have meant that any incentives for them to prescribe expensive drugs over cheaper versions have been removed.[20]

17 Qq 24–25; C&AG's Report, paras 3.31–3.33

18 Qq 20, 25, 65; C&AG's Report, paras 3.34–3.36

19 Qq 21–23, 26, 65–66, 80; C&AG's Report, paras 3.9–3.10

20 Qq 14, 86

3 Reducing drugs wastage

20. Estimates of the extent to which drugs are dispensed and not taken, or not taken correctly, vary widely, and the Department of Health has no recent information. A cautious estimate is £100 million annually; but this figure is based only on unused medicines that are actually returned to pharmacies. There are potentially serious public health and financial implications from drug wastage, as not only do PCTs have to pay for the drugs which are unused, but they also have to pay to dispose of them and for the consequences of patients not taking their medicines correctly.[21]

21. 88% of prescription items are dispensed free to patients and the remainder for a standard charge not directly linked to actual cost. There is a risk that the patients for whom these drugs are prescribed may not be aware of how expensive medicines can be, and consequently do not realise the importance of taking them correctly and returning them for safe disposal if they are not used. The Department has done some research on whether displaying the cost of a drug on the packaging would discourage wastage. The results appeared to be inconclusive, with some patients suggesting that a high price would dissuade them from taking the drug because it was too expensive, and others suggesting that a low price would dissuade them from taking the drug, because they felt it was too cheap.[22]

22. Partly in order to reduce medicines wastage, the Department introduced medicines use reviews (MURs) in the 2005 community pharmacy contract. An accredited pharmacist undertakes a structured review with patients who are on medication for long term conditions, to ensure their medicines are being used correctly and to check if there are any problems. The number of MURs carried out in the first year of the new contract was substantially lower than expected, although it is now increasing, and there were around 60,000 MURs completed in January and February 2007. Most PCTs consider that MURs have considerable potential to reduce wastage, but recognise that progress has been slow.[23]

23. A submission from a member of the public pointed out that generic drugs are manufactured using different tablet sizes, colours and shapes, and come in different types of packaging.[24] This diversity can be confusing, particularly for elderly people who have become used to the appearance of a particular formulation, and for patients taking several different drugs. The Department saw limited scope to encourage the standardisation of appearance of generic drugs prescribed in the UK, because UK drugs sales represent only about 3.5% of the global medicines market.[25] Greater standardisation should however bring benefits wherever in the world the drugs are used.

21 C&AG's Report, paras 4.1–4.3

22 Qq 2–3

23 C&AG's Report, paras 4.9–4.11; Q 39

24 Ev 17

25 Qq 82–83

Formal Minutes

Monday 10 December 2007

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Austin Mitchell
Mr Ian Davidson	Dr John Pugh
Mr Philip Dunne	Mr Alan Williams

Draft Report (Department of Health: Prescribing costs in primary care), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Wednesday 12 December at 3.30 pm.

Witnesses

Monday 11 June 2007

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Oral evidence

Taken before the Committee of Public Accounts

on Monday 11 June 2007

Members present:

Mr Edward Leigh, was in the Chair

Mr David Curry	Mr Austin Mitchell
Mr Philip Dunne	Dr John Pugh
Ian Lucas	Mr Alan Williams

Sir John Bourn KCB, Comptroller and Auditor General, **Tim Burr**, Deputy Comptroller and Auditor General and **Chris Shapcott,** Director, Health Value for Money Audit, National Audit Office, were in attendance and gave oral evidence.

Paula Diggle, Treasury Officer of Accounts**,** was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Prescribing Costs in Primary Care (HC 454)

Witnesses: **David Nicholson CBE**, Chief Executive, National Health Service, **Professor David Colin-Thomé**, National Clinical Director for Primary Care, and **Dr Felicity Harvey**, Head of Medicines, Pharmacy and Industry Group, Department of Health, gave evidence.

Q1 Chairman: Good afternoon and welcome to the Public Accounts Committee. Today we are considering the Comptroller and Auditor General's Report, *Prescribing Costs in Primary Care*. We welcome back to our Committee David Nicholson, who is the Chief Executive of the National Health Service. We also welcome Professor Colin-Thomé, who is National Clinical Director for Primary Care, and Dr Harvey.

Perhaps, Mr Nicholson, you could start by looking at the Comptroller and Auditor General's Report. Figure 1 on page 8 tells us that: "88% of all prescription items dispensed were free to patients." That, naturally, might lead to a problem of wastage. How are you managing that risk?

David Nicholson: Obviously, if you look at the people who are entitled to free prescriptions, you see that it is quite an extensive list—people over the age of 60—

Q2 Chairman: I am not in any way questioning people's right to free prescriptions. I am just saying that if you get something free, there may be a tendency not to look after it as carefully—there is nothing wrong with that; it is perfectly natural human behaviour. I am just asking how you are managing the risk of wastage and trying to inform the public of the huge costs of medicines. For instance, figure 1 says that: "£1.9 billion (almost a quarter of the total bill) was spent on cardiovascular prescriptions" alone, and I would not be surprised if a high proportion of those were, quite rightly, delivered free. However, I am just wondering how you are getting over the message that there is a cost to them and to all of us in providing these medicines, that they should be looked after and, if they are not used, that they should be returned.

David Nicholson: They should, and there are lots of initiatives in the NHS to help us in that. We have to understand, of course, that the really important relationship here is between the general practitioner and the individual patient. Making sure that the general practitioner has all the information that they require and is able to talk through the issues with patients is the most important part of the process of enabling us to minimise waste. However, we have a whole series of initiatives, some of which are reported in the National Audit Office Report, in relation to the NHS. We have locally run publicity campaigns and a whole series of things around the medicines usage reviews. We have the medicines collaborative, where patients and clinicians come together, and initiatives around pharmacists working with general practitioners. So we have a whole range of things that enable us to make sure that waste is minimised, but we are clearly still very concerned about the issue.

Q3 Chairman: One idea that I would like to put to you is, why do you not put on boxes of medicines how much they cost the NHS?

David Nicholson: Yes, we have done some research on that, which Felicity might mention.

Dr Harvey: We did some research fairly recently on that to see whether, if we did put the cost of the medicine on a box or a bottle, it would actually influence people. Interestingly—this was from a literature research plus some focus group work—we found that many patients took the view that once they had the medicine, whether or not they had paid for it, it was theirs to do with as they wished. In terms of the medicine price being on the box specifically, we found that if the cost of the medicine was very high, some people thought that they should not take it, because it was too expensive. We also had some feedback from the groups that indicated that if the cost was very low,

people thought that they should have had a slightly more expensive drug. So rather than supporting the view that we had had originally—that putting the medicine price on the box might be quite helpful—the small piece of research that we have done so far in fact indicated the opposite. However, we will obviously be doing some further research on this in terms of waste.

Q4 Chairman: Well, I will leave it with you. It seems a fairly obvious suggestion to me. I do not find the answer that you have given entirely convincing, but everybody will no doubt have a view on that.

Can I just deal with the doctors, who are obviously the key part of this? If we look at paragraph 2.8 on page 12, we see that there is a staggering variation in the costs of medicines. For instance, we see that the proportion of the lower-cost generic versions of statins prescribed varies from 28% to 86% across primary care trusts. Why does the proportion of statins vary in that way? That seems such a high proportion.

Professor Colin-Thomé: I suppose that what has happened is that it is only three years since statins such as simvastatin and pravastatin went off patent. Before that time, statins were about equivalently priced. Many patients were put on some of the more expensive statins because they were not expensive then, and taking people off them is quite difficult. Starting people on new prescriptions is quite easy, and at the moment nearly 90% of new statin prescribing is low cost. There is no doubt that some PCTs have put more focus on this than others, and that is why, with the National Institute for Health and Clinical Excellence (NICE) and the other incentives that we have introduced, we think that the position will improve. However, it was only three years ago that the patent went, and it was only in January 2006 that NICE gave the recommendation that we should be prescribing the statin with the lowest cost. Some of it is history, but some of it is because some PCTs have focused more on that than others. We want to look at outliers and help them.

Q5 Chairman: Obviously, generic medicines are much cheaper. We read in case study 6 on page 25, at paragraph 3.40, that there are hospital limits on the freedom of consultants to prescribe drugs. Yet we know that GPs are allowed to prescribe any drug they wish. Why is this?

David Nicholson: Partly it is the different position in hospitals. I am sure you understand. One of the things about working in hospital is that when you have a formulary, which many of them do—in fact I think all of them do now—you have a mechanism for controlling that formulary, which is the hospital pharmacy. Patients can only get their drugs from one particular place, and that is the way in which you control and police a situation like that. In general practice it is quite different, of course, because patients have the right to go to any community pharmacy to get their drugs. The ability to control is much more limited in that event. Plus, of course, GPs are independent contractors and we operate with them through a contract of service, whereas we directly employ hospital consultants.

One of the issues for us is that one of the big drivers for primary care prescribing is secondary care prescribing. I think there is research in the Report that shows that every one prescription in hospital can produce 15 in the community. What is clear—and we need to do this much more—is that we need to get agreement between secondary and primary care. A primary care formulary on its own would by its nature be too extensive and difficult to police, but a primary and secondary care one would be much better. That is one of the reasons the National Prescribing Centre recently published their work on area prescribing committees, to reinforce the secondary and primary care link. It seems to me that that is the way in which we will drive costs down and quality up.

Q6 Chairman: What we read in paragraph 2.6 on page 12 is that advice from NICE is often not being followed by doctors. For instance, "NICE's Technology Appraisal 94, *Statins for the prevention of cardiovascular events*, states that: 'when the decision has been made to prescribe a statin, it is recommended that therapy should usually be initiated with a drug of low acquisition cost'." Why is that guidance not being followed adequately by doctors? There is no suggestion, is there, that patients' lives are being put at risk?

Professor Colin-Thomé: No, but if you look at new prescriptions—

Q7 Chairman: I know that you have made the point already about new ones, but surely doctors can talk patients through this and explain that there is nothing in the new generic drugs that is in any way inferior to what they have been getting up to now. But as far as the taxpayer is concerned they are massively cheaper, are not they?

Professor Colin-Thomé: But in fact I have spent a long time as a general practitioner, and it is not as easy, even though I think that we had a good, trusting relationship, because there is a view that: "I have been used to these drugs already; why would I need to change?" When patients are already on drugs, there is quite a lot of evidence on this; there is a case study in the Report about a PCT where it took two years to switch only about 1,000 patients. It is easy with new prescriptions to get NICE guidance in place. That is what we do very well, but for existing patients it is much tougher, given patients' views on prescribing.

Going back, in a way, to an earlier question about cost and charges, worldwide 50%. of people with chronic diseases do not take their medication as recommended, whether they pay for the prescription or not. One of the issues is that often the patients choose not to take them—it is not carelessness—because they have side effects and so on. The real issue is that getting concordance with patients on taking drugs is quite a difficult art, and it is not as easy when they are already on something.

Q8 Chairman: We know from paragraph 3.11 on page 20 that the pharmaceutical industry spends £850 million a year marketing its products to GPs. How do you know, Mr Nicholson, that that does not influence the decisions of GPs?

David Nicholson: The document talks about a contest. I do not believe that it is a contest, because a lot of the information is really valuable and useful. A lot of really good partnership work is going on in the NHS between organisations, general practices and the pharmaceutical industry. That gives good information to patients and practitioners. So, in that sense, I do not think that it is all bad. There is a lot of useful information.

Q9 Chairman: But you have got to be convinced that they are prescribing for the benefit of patients, and not to add to the profits of the pharmaceutical industry.

David Nicholson: Absolutely, and it is heavily regulated in the way in which it can advertise and communicate with general practitioners. However, the real way in which to do all of this is through GP training, the activities of the National Prescribing Centre, the variety of bulletins that we send out and the important work of the prescribing advisers. Those things make the difference to GP prescribing.

Q10 Chairman: Why not allow pharmacists to dispense generic medicines, even if a doctor has prescribed a brand name?

David Nicholson: My understanding is that that is illegal. It is against the law.

Q11 Chairman: Why do you not allow them to do it? Why are they not allowed to do it?

Dr Harvey: May I come in here? In fact, the generic prescribing rate in this country is 83%, which is the highest in Europe.

Q12 Chairman: Yes, but I read in the Report that the costs of brand variations are still very high. They are so much more expensive, are they not? I cannot find the reference right now.

Dr Harvey: They are more expensive, but—

Chairman: The reference is in paragraph 2.5.

Dr Harvey: Because we have such a high rate of generic prescribing—

Q13 Chairman: Three quarters of the cost comes from brand names.

Dr Harvey: Indeed. If a doctor or any prescriber prescribes generically, the patient will be given a generic product, if one is available. If a medicine is new and innovative and still in patent, the patient will get a medicine of that generic chemical entity. Actually, getting more general practitioners to prescribe in that manner—the percentage has increased from 51% in 1994—is a very effective way in which to ensure that the drug dispensed by the pharmacist is the most clinically effective and the most cost-effective.

Q14 Chairman: Are you sure that doctors who can dispense as well are not over-prescribing in rural areas?

Professor Colin-Thomé: There is no evidence that the average number prescribed by dispensing doctors differs from the average among GP prescribers. In a few cases, the more expensive drugs have been prescribed by dispensing doctors, but that is a very tiny percentage of the total cost, and even that has been reduced since we made changes to the remuneration. However, it is not true to say that it is a major cause of over-prescribing—it is a very tiny percentage.

Q15 Ian Lucas: We have heard that 88% of prescription items are dispensed free of charge. Only 12% of prescription items are paid for by the public. How much income does that 12% bring in?

David Nicholson: Just over £400 million.

Q16 Ian Lucas: Do you know the cost of administering the system and dealing with the paid prescriptions?

Dr Harvey: I do not have the costs with me, but I know that it is relatively low in comparison with the large amount of income that it brings in. Certainly, we can get that figure for you from the prescription pricing division.[1]

Q17 Ian Lucas: It would be a useful figure to have, because it would tell us whether it is worth doing.

Dr Harvey: Yes it would. We looked at it a little while ago, and it is relatively low. In fact, the cost of administering the whole of the prescription system is less than £10 million.

Q18 Ian Lucas: Right, so it brings in a net profit of about £390 million?

Dr Harvey: In fact, some £425 million should be coming in this year from prescription medicines and the money that we get back from charges. So that leaves us with £415 million.

Q19 Ian Lucas: Has any assessment been made of the impact that charging for prescriptions has on levels of prescribing?

Dr Harvey: Not specifically. We will look quite carefully with colleagues at areas in the United Kingdom that have got rid of prescription charging, such as Wales as of April, to see what sort of impact it might have. Clearly, a prescription charge might make people think twice, for example, about medicines that could be got on prescription as well as over the counter from a pharmacist. There might be some switching to prescriptions. We will be keeping an eye on that.

[1] *Note by witness*: The figure forecast for 2007–08 is £8,085,000 and covers the total cost of issuing pre-payment, medical and maternity certificates, low income scheme charges certificates and tax credit exemption certificates for England. The latter two also provide help with dental, optical and travel costs. It does not include the cost of processing prescription forms by the NHS BSA to reimburse contractors for the provision of pharmaceutical services.

Professor Colin-Thomé: I suppose that pre-payment is one way of obviating some of the rest of the impact on people who have to pay. For at least about 5% you can—

Ian Lucas: Get a discount.

Professor Colin-Thomé: Yes. It is cheaper to have got the season ticket rather than pay per item each time.

Dr Harvey: In fact, we have just brought in the ability to have that on a monthly direct debit as well as a three-month pre-payment certificate—before it was just four months or a year. We understand that that is a large amount of money for people to pay out at one time.

Q20 Ian Lucas: Turning to doctors and the cost of drugs for doctors, do they receive the information themselves on the cost of the drugs?

Professor Colin-Thomé: Our current IT system, which some 90% of general practices has, flags up the cost. When someone prescribes, the total cost comes up on their computer, so we get that feedback. We also get feedback on prescribing data analysis from something called *ePACT*. We get quite a lot of feedback. GPs often compare information with each other, and peer review is a good way of looking at costs and effectiveness.

Q21 Ian Lucas: They are allocated and prescribed in budget? Is that correct?

Professor Colin-Thomé: Only if people have practice-based commissioning, of which prescribing is an integral part. As you know, we are just developing that. It is not fully up and running, but GPs are certainly engaged and have business plans and so on. That will be a key incentive for two reasons. First, it brings the budget nearer to where clinicians are. Secondly, many people work in groups of practices and, as I have said, all the research evidence is that peer review is a far more powerful way of getting change than being told by somebody on high.

Q22 Ian Lucas: There is a financial incentive for those particular practices. Do they get 30% of the money saved?

David Nicholson: No, 70%.

Professor Colin-Thomé: But that is to provide for other services and is only to release money for other services.

Q23 Ian Lucas: I understand that. Has that had any impact on prescribing budgets?

Professor Colin-Thomé: It is too early to say. All we can say is that previous examples, such as the system in the old fundholding days, which was a similar model although not quite the same, did have an impact on prescribing.

David Nicholson: We have run prescribing incentive schemes for some time, which reflect reducing costs.

Q24 Ian Lucas: So, at the moment, there is no effective incentive for a general practitioner to use a cheaper generic drug rather than a more expensive drug? It makes no difference at all to someone's practice whether they use one or the other.

Dr Harvey: If there is a primary care trust incentive scheme for a particular package or individual switch that it is seeking—for example to increase the prescribing of generic statins—some PCTs are providing incentive schemes to practices to do that, which gives some additional income to the practice for patient care.

Q25 Ian Lucas: So, that would be an incentive for patient care rather than a direct financial incentive for doctors?

Dr Harvey: There are also quality and outcomes framework points in terms of medicines management. For example, two of the QOF (Quality and Outcomes Framework) measures—six and 10—are about having meetings with a prescribing adviser and then taking action. Evidence of at least three actions that someone is taking forward and implementing leads to QOF points for the practice.

David Nicholson: I would not underestimate the issue of peer review. Our experience is that once faced with the prescribing data of other GPs, most will move their prescribing practices in line with that.

Professor Colin-Thomé: The high percentage of generic prescribing that we have achieved without incentives is proof that there are other ways of working with GPs rather than simply offering incentives, although incentives help.

Q26 Ian Lucas: To use a crude analogy, there seems to be huge resistance to having a menu listing the prices that the practice actually pays for drugs.

David Nicholson: I do not think so. The drugs budget will be an integral part of practice-based commissioning, and 96% of GPs have signed up to do it. We were with some GPs on Friday who have signed up to do it, and they have all sorts of plans to enable them to reduce their expenditure on drugs so that they can reinvest elsewhere in health care. I think that there is a real opportunity to take this forward.

Q27 Ian Lucas: But the level of the cost of drugs in the NHS budget has rocketed—the figure is 60% in real terms over the past decade. Is that explained only by an ageing population or is a bigger issue involved?

Professor Colin-Thomé: There is a 55% increase in items, which is to do with an ageing population, but it has much more to do with conditions being diagnosed earlier. For instance, the threshold for diagnosing high blood pressure or diabetes is much lower than it was, so we are actually treating people earlier, because we know that that will produce better outcomes. Drivers include the national service framework, the ageing population and, unfortunately, the general rise in illnesses such as diabetes because of lifestyle. There are many drivers.

We want to be cost-effective, but it should be pointed out that prescribing is one of the most effective therapeutic interventions that doctors make. Things such as ACE inhibitors and statins

actually increase longevity—they do not just alleviate symptoms. The much bigger push to increase prescribing is valid.

Q28 Ian Lucas: So is it a good thing, therefore, that there has been an increase in prescribing? The Committee of Public Accounts might see it as a bad thing, from a narrow point of view.

Professor Colin-Thomé: Yes, but we need to be specific about whether prescribing is effective. That is why we have NICE and other systems, but the answer is that prescribing is a very effective therapeutic intervention. There is evidence from many places, including my own practice, that prescribing has resulted in fewer admissions to hospital, because people get better treatment through primary care.

Q29 Dr Pugh: May I start with a slightly left-of-field question? According to the NAO Report, although only 20% of the drugs that are prescribed are patented, branded drugs, they make up three quarters of the total NHS drugs budget. I wonder whether you know or could give some kind of feeling for what that cost might be, or how it might be reduced, if we were charged in the UK at the European average cost for branded drugs, as opposed to the UK cost. Has any calculation been done?

Dr Harvey: There has not been a specific calculation across the piece about what impact that would have.

Q30 Dr Pugh: Of course, the markets are different, are they not?

Dr Harvey: They are indeed. There are various analyses of the prices, some of which indicate that our prices are towards the top of the bundle of prices for all European countries.

Q31 Dr Pugh: We are towards the top of the range.

Dr Harvey: When we had the last pharmaceutical price regulation scheme negotiation in 2004, our prices were at the top of the European prices. The 7% price cut that we negotiated brought them down within the range for other European countries. We are looking at present to see exactly where we are in terms of all the European countries, but, as I have said, there are various ways of calculating that.

Q32 Dr Pugh: Can you give me an assurance that the UK is not paying top whack for branded medicines?

Dr Harvey: I do not think that we are paying top whack for branded medicines. This is something that we keep a close eye on, but we are also keen to ensure that we have innovative medicines for UK patients to use.

Q33 Dr Pugh: Okay. May I now turn to the prescribing adviser? I did not know what a prescribing adviser was before I read the Report, but there are 1,200 of them. What are they paid?

Dr Harvey: I am afraid that I do not know.

Q34 Dr Pugh: You do not know, but I would like to persist with these questions. Clearly, if there are that many advisers, there is one for every 25 doctors. We would want them to be very effective, and there are statistics in the Report that show that doctors think that they are effective. Have you done any research to find out whether they are actually effective?

Dr Harvey: There is quite a lot of evidence about prescribing advisers and the impact that they have. For example, the Report often highlights their impact on increasing clinically effective and cost-effective medicine utilisation at a local level in the PCTs.

Q35 Dr Pugh: The problem is that there could be disaggregation of other sorts of things that drive down the price of drugs, such as PCT incentive schemes, peer review and the general circulation of information. We want to know, as we want to know of the NAO, what we are paying advisers for, and how effective they are. Do you have a feel for that?

Dr Harvey: To go back to your earlier point, prescribing advisers are paid between £40,000 and £50,000 per annum.

Q36 Dr Pugh: So they are costing us quite a lot. I wonder how much they are saving us. Can we identify how much they really are saving us, as opposed to all the other things that might be saving money?

Dr Harvey: There are many examples of individual PCTs that have invested in prescribing advisers and of the sorts of savings that they have made as a result of the work that the prescribing advisers have done within the PCT. The advisers can save at least £2 for every £1 of salary.

Q37 Dr Pugh: They can? Is there independent research that says that they definitely save such amounts?

Dr Harvey: Yes.

Q38 Dr Pugh: I am comforted. The Report also says that 24% say that they visit each GP once a year, which is not too stretching a demand on them. What do the other 76% do? Do they work without seeing GPs for years on end?

Dr Harvey: I visited a prescribing adviser last week, to find out how they were working. As they described the process to me, they look at all the drugs and prescriptions in the entire area of the PCT, from which they identify particular issues that they need to take forward, and particular practices in which they feel there needs to be quite a lot of intervention. It might be that advisers do not make many regular visits to many practices on their patch, although they provide benchmarking information, for example. They might feel that spending more of their time in face-to-face meetings in a few practices will be beneficial for achieving the sort of clinical, cost-effective prescribing, and the improvements in prescribing, that they feel are needed. I therefore think that it will differ across PCTs, depending on what the advisers find from their benchmarking information.

Q39 Dr Pugh: Can I ask you about the medicine use reviews? The NAO Report also says that some academic research says that many PCTs felt that they were of limited value, or were unconvinced by their benefits. There are two methods—the advisers and the reviews—neither of which is guaranteed to work and neither of which is impressing the people it should impress.

Dr Harvey: You need to remember that the number of medicines use reviews, which are advanced services under the new community pharmacy contract, is now starting to increase. In January and February of this year, for example, there were about 60,000 medicine use reviews a month. It is still fairly early on. The intervention was initially trialled in the medicines management collaborative; Coventry PCT took it forward and found that the medicines use review had huge benefits. The review involves talking to patients about how easy they find it to take their medicines, and establishing whether there are fairly minor interventions that the pharmacist can carry forward which will have a major impact on patients. Patients can be helped to understand why they are on all their medicines and how to take them, which could mean talking to them about when to take water tablets so it is convenient for their lifestyle, for example. There are lots of similar examples of that sort of intervention. We know that pharmacists have quite a good relationship with patients, which allows them to act in that way to increase compliance—

Q40 Dr Pugh: I am sorry to interrupt you, but I have a few more questions. You have convinced me that you are doing some of the right things. The NAO Report suggests that £200 million can be saved. It says that that is for only 19% of the budget, so if we were to extrapolate from that figure, we could say that £1 billion could be saved on the whole budget. Is that fair speculation, or does the Report deal with an area in which savings can easily be guaranteed, whereas they could not be guaranteed to the same extent in other areas?

Dr Harvey: Our view is that we would agree entirely with the NAO's examples for those areas. Particularly in areas where there are generic as well as brand drugs, there is a lot of evidence that the effectiveness for patients of the medicine would not be affected by changing that medicine. In other areas that make up the other 80% of the drugs budget, such as diabetes, respiratory medicine and so on, you need to have a variety of medicines that are equally efficacious. You also need an evidence base behind that, and you need some of the medicines that have come off patent.

Q41 Dr Pugh: So £1 billion might be jumping to conclusions?

Dr Harvey: I do not think that we have any evidence at the moment that there are many other drugs that could have equal impact that are about to come off patent.

David Nicholson: We certainly need to save the £200 million.

Q42 Dr Pugh: You make some savings. I turn now to the NAO. The Committee has received criticism of the methodology for determining efficiency, describing it as: "overly simplistic, utilising low prescribing as a proxy for efficient prescribing". That has come from a drugs company. I understand that low prescribing cost in an area is not necessarily identified with low need, but has there been a further evaluation, not simply of prescribing differences between PCTs, but of clinical outcomes? Has that been taken into account in the overall assessment?

Sir John Bourn: I think that it has been taken into account. The point that I would make about the criticisms by the companies, although I can understand why they felt that they had to make those criticisms, is that, first, in the analysis that we made and the work that we did, we agreed the facts that emerged with the Department. So it was not simply a case of the NAO working this all out on its own.

The second point that I would make is that what we are advocating in our Report is not reduction in prescribing; we are advocating thoughtful prescribing, in the way that the Department seeks. We are not saying, in some kind of thoughtless cuts way, that doctors should alter their practice, but we are saying that there is information, as in the Report and as the Chief Executive said, that would help doctors to carry forward their work in a properly professional way and, as I put it, in a more thoughtful way. So I think that the analysis behind our Report stands up in that sense.

Q43 Dr Pugh: Just on the specific recommendations of the Report, I think that the Report suggests for my local PCT that it can save about £3 million on a £50 million budget. From speaking to my PCT, I understand that it has the largest projected underspend in the North West; it has already saved £2 million. Is a £5 million saving on a drugs budget a realistic expectation?

Chris Shapcott: Is the suggestion that the trust does not need to save the money because it has enough already?

Q44 Dr Pugh: No, not precisely that. I suppose you could suggest that research on statins is a relatively easy hit—the trust itself has suggested that to me—because everybody has done a lot of work on statins. Squeezing out a few more savings is a bit more complex.

Chris Shapcott: What we are saying is that, for certain drugs that we are looking at, some very substantial savings can be made by changing the prescribing practice. If you move, say, from a branded statin to a generic one, you can reduce the cost of the medicine by a factor of 10 at times; the same thing is true of some of the other drugs too.

Clearly, we are making estimates about the scope for savings; the figures that we give are not definitive, in the sense that an account might be. However, we think that that is a reasonable target to aim at, and then perhaps the savings could be recycled into increasing prescribing in more appropriate cases,

finding other people in unreached populations and so on, who would benefit from increasing use of these drugs.

Q45 Mr Mitchell: Can I deal with the NAO Report first, Mr Shapcott? We have had a memorandum from Sanofi-Aventis & Bristol Myers-Squibb,[2] and it makes several points; I would like to raise some of them with you. I shall quote from the letter: "Many of the PCTs that the NAO deem to be inefficient prescribers have successfully reduced the incidence of heart attacks and strokes through implementation of effective prescribing policies based on national guidelines. If they were to be encouraged to reduce their prescribing, this success could be jeopardised." Is there a correlation between the level of prescribing and the incidence of heart attacks and strokes?

Chris Shapcott: Sanofi-Aventis & Bristol Myers-Squibb has not given us detailed work to support that.

Q46 Mr Mitchell: Have you looked at that issue?

Chris Shapcott: That is not something that we have gone into.

Q47 Mr Mitchell: But you could look at it?

Chris Shapcott: The advice that I have had is that getting the information on the outcomes is quite difficult. We have used the approach that we did because that was what the data was available to support. We have agreed with the Department that that was an effective way of working.

Q48 Mr Mitchell: But Sanofi-Aventis & Bristol Myers-Squibb is making an assertion, rather than stating a verifiable fact.

Chris Shapcott: Yes, it is.

Q49 Mr Mitchell: Okay. I would like to make a second point. To quote from the Sanofi-Aventis & Bristol Myers-Squibb memorandum again: "The Report suggests that all patients receiving clopidogrel should have their treatment stopped after 12 months. This is inconsistent with the clinical trial evidence . . . Stopping clopidogrel therapy for all patients at 12 months may jeopardise the safety of patients who require longer-term treatment." Why did you fix on that provision, to stop at 12 months? There is another letter from the American Pharmaceutical Group,[3] which is based in Basingstoke—presumably because Basingstoke is closer to America. It says: "The NAO Report implies that the alternative anti-platelet treatment of aspirin can be substituted for clopidogrel. In fact, aspirin is not a generic equivalent of the patented medicine clopidogrel (brand name Plavix); the two are entirely different". So why did you suggest that it was stopped after12 months and aspirin substituted?

Chris Shapcott: Because we did not suggest the things that are being attributed to us there.

Q50 Mr Mitchell: Say that again.

Chris Shapcott: We did not say that you should stop clopidogrel after 12 months in every case. The guidance from NICE allows for it to continue in appropriate cases where people are aspirin intolerant, and we allow for that possibility in the Report.

Q51 Mr Mitchell: Okay. Are those appropriate cases a small minority or are they a substantial proportion?

Chris Shapcott: The estimates we have seen are that between 6% and 20% of people with the appropriate indication will be aspirin intolerant and so you would expect them to continue, but in other cases it should be stopped after 12 months.

Q52 Mr Mitchell: Returning to the Department of Health, why should doctors not register gifts, inducements and things that they get from drug companies? It is all very nice to get invited to do research on prescription for stress on yachts in the Mediterranean, but we have to register all our trips and so why should they not do so?

Dr Harvey: In fact they do.

Q53 Mr Mitchell: There is a register of what Grimsby doctors are getting from drug companies that I can consult at the PCT?

Professor Colin-Thomé: I would need to have some written evidence of this, but above a certain amount of money, which excludes *Post-its* and a few pens, you need to put into the PCT—

Q54 Mr Mitchell: And it is published?

Professor Colin-Thomé: It is up to the PCT to publish it, but the GPs have to report that they have—

Q55 Mr Mitchell: Should it not be published? I would like to go round and compare foreign trips with Grimsby doctors.

Professor Colin-Thomé: I think there is a good case for it to be published. I think you are right. But above a certain minimal level of free gifts of small things, you have to declare what you have received.

Q56 Mr Mitchell: You talk about small gifts. I do not know many doctors these days. I used to have a lot of doctor friends. Some of my best friends were doctors, indeed. But since they have got so well paid they have gone up a social class and they do not speak to me much. Should not drug companies be required to register the gifts they are sending out and their expenditure on free samples to get people hooked through inducements of every kind? Are they required to do that?

Dr Harvey: There is an Association of the British Pharmaceutical Industry (ABPI) Code of Practice and that was made far more robust in 2006 after the Health Select Committee had looked at the influence of the pharmaceutical industry. They are now extraordinarily careful about what they can and cannot do. As for inducements, hospitality and things like that, whereas 20 or 30 years ago that might have been something that the pharmaceutical industry would do, there is now a strict code of conduct in

[2] Ev 16

[3] Ev 13–15

terms of what they are and are not allowed to do. Indeed, that is policed by the Prescription Medicines Code of Practice Authority. If anybody says that they think that something has happened that is against the code of practice, it potentially means that a company could be excluded from the ABPI. It is fairly serious if they do. It is also underpinned by European regulations—the Medicines (Advertising) Regulations 1994.

Q57 Mr Mitchell: Thanks. I stop you when you say European regulations. Just to pursue the point made by the Chairman, why should not chemists be allowed to prescribe generic drugs? For instance, I get the *Daily Mail* under plain cover and it is constantly telling me that I should be taking statins. My wife is very keen that I should take statins. Why should I have to go to a doctor just because he will get a cut for prescribing it? Why should I not be able to go round to my chemist and say, "I want two and a half tonnes of statins."

Dr Harvey: In fact, as part of the changes to non-medical prescribing, we have been looking at independent prescribing by non-doctors. Recently we brought in independent prescribing rights for pharmacists.

Q58 Mr Mitchell: We are still very snotty about that in this country. I am addicted to melatonin. It makes me go to sleep in the Chamber downstairs. But in America I could just go into a supermarket and buy it. Here there is all sorts of rigmarole.

Dr Harvey: It rather depends on whether the drug is a prescription-only medicine, a pharmacist-only medicine or one that you can buy over the counter. It depends on which classification the market authorisation has as to whether it can be given only by prescription, although a pharmacist who has prescribing rights—one who is under contract with the PCT—can prescribe.

Q59 Mr Mitchell: But folk are getting it all through the internet, are they not? It is all flooding in, whatever you say about doctors prescribing; people are getting it through the internet.

Professor Colin-Thomé: You can buy statins over the counter. You can get low-dose simvastatin—

Q60 Mr Mitchell: Can I?

Professor Colin-Thomé: Yes, so you should go straightaway.

Q61 Mr Mitchell: I will.

At paragraph 3.3, the Report states: "56%. of respondents to our GP survey said that over half of their consultations result in a prescription". We are given the impression that doctors are just doling out prescriptions and drugs in order to keep people happy and quiet. Has that proportion gone up? What would that figure have been 40 years ago?

Dr Harvey: I do not know what it would have been, but David might have more information. Certainly there has been a change over time—

Q62 Mr Mitchell: But is there a greater propensity to prescribe—to give the patient something in order to get rid of them?

Dr Harvey: I think that that practice is changing.

Professor Colin-Thomé: I think it is anecdotal. Many of us have done studies over some years. I was a GP a long time ago, as well as more recently, and the figure was roughly 50%. What has changed is the number of drugs taken by people with chronic disease; there are far more items rather than more patients getting drugs. Now if you have a type 2 diabetes, you are on several drugs. The items per patient for those with chronic disease has gone up significantly. That is where the biggest rise has been. A young child still gets only about three to four drugs a year, and some of them are things like *Calpol* or paracetamol. It is because of the chronicity of the problem that the number of items has rocketed.

Q63 Mr Mitchell: I get the impression from the Report that doctors tend to like prescribing advisors for the primary care trusts. Do you keep any record or a league table of who are the most effective prescribing advisors and who are not? If I were a prescribing advisor wanting to get on in the world, what would I have to do?

David Nicholson: We certainly do not keep league tables of their performance, although PCTs do keep league tables of the performance of GP practices in prescribing. It would be straightforward to deal with. However, there is no doubt that prescribing advisors who can demonstrate significant changes in the prescribing activities of GPs get on better in the system.

Q64 Mr Mitchell: I have a lovely table from the National Audit Office, for which I am grateful. It shows that our PCT in North East Lincolnshire, which is excellent, would save £865,000 if it prescribed at the level of the most efficient authorities. Are records kept that show any correlation between the work of prescribing advisors and those potential savings?

Dr Harvey: We certainly do not use any correlation centrally. All the prescribing advisors are supported through the National Prescribing Centre, which runs quite a lot of courses and provides lots of information for all prescribing advisors. We do not benchmark the individual prescribing advisors, although we do the trusts.

Q65 Mr Mitchell: The Report indicates that there will be a lot more prescribing by nurses. What kind of problems do you anticipate will arise from that? Will it make the problem worse, or will the nurses be more diligent and better informed than the doctors?

Dr Harvey: So far, the proportion of prescriptions in primary care from nurses is only 2%, so it is very small. In fact, if you look at the sort of things that they are prescribing, there is nothing at this stage that would lead us to have any concerns. It is clearly something that we will need to look at, because every individual prescriber has a prescribing number, and that means that when the *ePACT* data—the electronic prescribing analysis and cost data—is

provided, it can be done for every individual prescriber. PCTs will therefore be aware at local level of the prescribing patterns of all their prescribers, including nurses—and, indeed, pharmacists.

Q66 Mr Mitchell: So it is to be watched. You cannot impose a discipline such as practice-based commissioning on them, can you?

Dr Harvey: They will be working as partners.

Q67 Mr Mitchell: In so far as they are working in the practice, you can, but in so far as they are not, you cannot.

Dr Harvey: It depends on the circumstances in which the nurses are working—whether they are in community teams, or part of the practice. We would expect the PCT to keep an eye on the prescribing all of its prescribers.

David Nicholson: What we do know is that nurses generally keep to guidelines much better than doctors.

Professor Colin-Thomé: Can I say also, even though I have a self-interest, that British doctors are not bad? We have the highest generic prescribing, as has been said, and we also have some of the lowest drug costs in western Europe. Even though we could always do better, and there is variation, British doctors do pretty well on prescribing.

Q68 Chairman: Professor, Mr, Mitchell was asking about statins, which is a new wonderdrug that doctors are pushing like sweeties at the moment. Does that worry you? If there is a tidal wave of fashion—at the moment it is statins—how do you try to control that, or do you think that it is not your job?

Professor Colin-Thomé: The evidence is that if you prescribe statins for people who are at high risk, you will lessen fatal and other heart attacks. The guesstimate—it has to be a guesstimate—is that we could save 3,000 lives a year of people who die of ischemic heart disease at the moment if they got statins early. Because of a particular medical condition that I have, I am on a statin and feel quite comfortable about it. They represent a huge improvement in the decrease in the mortality rate from heart disease in this country and abroad, so I have no concerns. There are some rare and spectacular side-effects, as there are other drugs; but they happen rarely and, of course, the drug will be immediately stopped. However, I think that they are an excellent drug to prescribe, which is why we have said that you can buy low-dose statins over the counter. Their side-effect profile is tiny, and saving lives and quite significant morbidity is a great bonus. I do not want to get too excited, but it is a spectacular advance in therapeutics.

David Nicholson: It is also a good example of spending more in some areas to get benefits elsewhere in the system, because the impact on hospital bed-day usage is impressive.

Q69 Mr Curry: We are fascinated by our own health, and no doubt, my wife would say that men tend to more fascinated by their health than women are about theirs. There is a huge amount of psychology in getting better from something, is there not? When we are looking at own brands against generic drugs, or branded against own label, I think that, psychologically, people think that the branded drug is better. I use two drugs from time to time. In the hay fever season, I use Ventolin. Nothing will persuade me that the generic equivalent does the job as well as Ventolin does. I have tried both, and I am convinced, on the empirical test with myself, that I breathe easier after Ventolin rather than the generic.

When I do my back in, gardening, windsurfing or being too energetic with grandchildren, I go to my toilet bag where I have a supply of Voltarol bought over the counter in France. I cannot buy it in the UK. It does the job better than any medicine that my doctor in the UK is willing to prescribe—although under pressure, with a gun at his head, he will prescribe Voltarol, or he will give me an equivalent with the same ingredients. However, the equivalent does not fix my back in the way that Voltarol does. Is there not a problem persuading people that the generic drug is actually as good as the other one? Is there not a real psychological barrier when facing, as it were, the Kelloggs against the Tesco own brand?

David Nicholson: I am sure that David will be able to tell you what turned out from what you said in terms of proof. However, it only reinforces the point that we are trying to make, which is that on one level, shifting from branded drugs to generics sounds a straightforward and simple thing to do, but it is terribly complex. It goes to the heart of the relationship between the GP and the patient, and you have just underlined that well. That is why I think that more than 80% at present is a pretty impressive result for the NHS in this country.

Professor Colin-Thomé: It comes back to the point that I made to you, Chairman, about it sometimes being hard to dissuade patients, despite having a good relationship. There is no evidence that Voltarol is better than diclofenac, which is the generic name, and so on. As a doctor of many years, I know that what is really important and makes GPs effective is having a good relationship with their patients. If it was the deal that we struck on, I would prescribe Voltarol and Ventolin for you, Mr Curry, but the majority of patients are not so obsessed about those drugs. The relationship with the patient is what makes general practice effective—in other ways as well, not just prescribing. There is more to life than simply prescribing, although it is an important part of our work.

Q70 Mr Curry: What other drugs are coming off patent soon and might well offer themselves as generic alternatives, and where are those generic alternatives likely to have been made?

Dr Harvey: In fact, the ones that have been highlighted in the NAO Report are the ones that are around. We are not expecting any other major brands to come off patent in the next year or so.

Q71 Mr Curry: The reason I ask is that in my constituency I have the principal plant of Johnson & Johnson. It does not make that sort of medicine, it makes bandages and very sophisticated wound

dressings. Its concern is that the more pressure it comes under on the price of its products, the harder it is to persuade its American parent to maintain investment in the UK.

What sort of balance do you come to when you are looking at the prices you pay for drugs and there are products, presumably often made in the far east, that are good, even if not at quite the same level of excellence, but are significantly lower in price? Is your concern a purely financial, cash-flow one for the NHS, or is there an element of considering the broader economic issues of having a vigorous pharmaceutical industry in the UK and the science base and so on that it generates?

David Nicholson: When we are involved in negotiations on pricing, a key priority is obviously what it will cost the NHS. I do not think that you would expect me to say anything else. But we are very interested in the development of a thriving pharmaceutical industry in this country—one that attracts overseas investment and is a centre for research and development. We do take that into account when we are involved in our negotiations. Settling on a price is a matter of quite tough negotiation.

Q72 Mr Curry: When a company says to you that it is faced with what it describes as an arbitrary demand to cut a price, what type of negotiation takes place? We have faced that issue.

Dr Harvey: May I give some context to that? We have a good working relationship with the pharmaceutical industry and the device industry. A shared goal between the Government and the pharmaceutical industry is to have fast uptake of NICE positively appraised drugs. We know that those are clinically effective, cost-effective, innovative drugs—the sort that help us to reduce morbidity, hospital days and so on. That is very much a shared goal. As you say, it is a balance, and we are conscious of that in the PPRS (Pharmaceutical Price Regulation Scheme) negotiations and in our work with the pharmaceutical industry.

Q73 Mr Curry: In all sorts of political areas, governments effectively model constituencies of one sort or another. What sort of modelling has been done, if any, on the right level of prescribing for a PCT, taking into account what one might describe as its sociology? You cite those in North Yorkshire, which by and large has a relatively elderly but relatively healthy population. If you looked at one of the London boroughs, you would find wholly different sociology and a wholly different structure of GP surgeries. In my constituency we tend to have big surgeries, sort of mini-factories, with perhaps a dozen GPs. London is characterised by—I was going to say poor quality, but rather a handful of small surgeries without any of that sort of polyvalence that you get in other places.

David Nicholson: There have been a number of attempts to do that sort of thing, but it has proved a holy grail in the sense that every community has its own unique history, sociology and clinical and service needs. We have tended not to try to go after that holy grail but to focus on the benchmarking information that we have had and use it as an opportunity to examine cost and prescribing habits, rather than go for a model that we genuinely do not believe is ever attainable.

Professor Colin-Thomé: There is another issue, which is fact that 70% or so of prescribing goes into six therapeutic areas, one of which is pain relief and another mental health. Some of that is about a judgment by the clinician and the patient about what drugs are used—are any needed, does the patient need antidepressants, and so on. It is hugely impossible to model that, because it is about the clinical interchange between patient and doctor. It is much easier with some things, such as statins, but I would argue that it is pretty impossible to have a package for comprehensive modelling. I am aware of nowhere in the world that has even attempted that because of its impossibility. NICE does make some assessment, but it is very much a guesstimate—a guide rather than an absolute, which would be almost impossible to produce because of the very nature of how you prescribe for individual patients.

Q74 Mr Curry: We are talking increasingly of patients dealing with their clinician electronically. Do they have to come back to the hospital for the second prescription? Cannot that be done electronically? Presumably that would make it even harder to make an assessment of what that patient really needs.

Professor Colin-Thomé: Yes, but it is up to the doctor to make a judgment about when a patient needs reviewing. It is the same in the non-electronic repeat prescribing that we do, but we have reviews to make certain that the patient is taking the drug, that their blood pressure is controlled, or whatever the treatment is for. It is a convenient way of getting drugs that are already acceptable to be prescribed with the doctor's agreement, but if the doctor, or whichever clinician is prescribing, thinks there is need for an assessment, that has got to be done. The responsibility is on the clinician to make certain that the review takes place.

Q75 Mr Curry: Is there any correlation between the size of the GP surgery and the pattern of prescription? A big surgery is likely to have more doctors coming in who are perhaps younger and more up to date with the latest technologies and new ideas. A very small surgery might have had the same GP, who is getting a bit long in the tooth, for the last 30-odd years. Has any investigation been done into that? Is there an optimal surgery, with its own pharmacy attached, of course?

David Nicholson: If you look at the data from the quality and outcomes framework the only big data that we have, it is more likely that in the bigger, combined practices you get better scores. There are some small practices that have great scores, which do really well, but you are more likely to get a better score in a bigger practice.

Professor Colin-Thomé: On the other hand, you also have a higher percentage of smaller practices in socially deprived areas, where it is much more difficult to prescribe so it is very difficult to separate. Previous work by people such as Professor Pringle at

Nottingham University suggests that the quality in small practices was not as poor as people claimed and in fact QOF is helping to narrow the gap between those areas. We have some evidence that it is already happening.

Patients love small practices because of the continuity and personal care, which is often stronger than in some of the more impersonal, big practices. There is a lot of variation in what quality means, and lots of variables. I do not have any detailed figures; the biggest issue is social deprivation, which accounts for a lot of the prescribing differences.

Q76 Mr Dunne: Mr Nicholson, in the financial year that ended at the end of March, what proportion of the reduction in deficits would you attribute to increased efficiency and savings from prescribing?

David Nicholson: I have not got that figure to hand.

Q77 Mr Dunne: Do you have a sense of it?

David Nicholson: There is a figure in my head, but I would have to check it before I said it. I have a figure.

Q78 Mr Dunne: Could you write and give us an indication of it?

David Nicholson: Yes. I will be happy to do so.[4]

Q79 Mr Dunne: The reason I asked the question is because in the reconfiguration of the primary care trusts in my area two years ago, it was set out as the holy grail—the easiest quick win for the management of the PCT to reduce the deficit in that area. My sense from talking to the GPs is that it is a great deal more difficult to effect savings than management at the centre think. Is that your experience at the centre of the NHS since you have taken over?

David Nicholson: It is always more difficult than people imagine to make savings in this area against a background of saying, "We want to improve services, so there are some things that we want to spend more money on, not less." Most of the primary care trusts that were in the turnaround group would have had a prescribing element of savings attributable to that turnaround. The ones that I have seen certainly all delivered it, but, to be frank, they were all at the end where they could have delivered it, because there were significant opportunities for saving, although I agree with you that it is often overestimated how easy that is.

Q80 Mr Dunne: The NAO Report suggests a number of areas in which GPs in particular could be encouraged to prescribe in a more cost-effective way, one of which is through financial incentives. Case study 3, on page 23, shows what happened in Bristol North and Coventry PCTs. To what extent do you at the centre look to financial incentives as another quick win to help best practice?

David Nicholson: Financial incentives are an important tool in the armoury, if you like, of financial control and for getting change to happen, and they have been effective in the primary care area. But again, it seems to me that incentives around practice-based commissioning—that is, where you can clearly show that savings in prescribing can be reinvested in improving local health services—and peer review are a much more fruitful way of moving change forward.

Q81 Mr Dunne: To pick up on one of the comments that Mr Curry made, one of the points made to me, representing a rural area, is that patients in rural areas tend to have a closer relationship with their GP and are perhaps more resistant to change than patients in an urban area. Therefore, for someone with a chronic illness on a long course of treatment who has accommodated one change, accommodating subsequent changes perhaps gets more and more difficult. Consequently, rural areas tend to have higher prescribing costs than urban areas. Is that the evidence at the centre?

Professor Colin-Thomé: I do not think that that is to do with the relationship. Many GPs, including me, worked in socially deprived areas and were there for 30-odd years. The relationship is there across many areas, rather than just rural areas. The only thing about rural areas that might have made a difference was that in many rural areas the age profile is higher than in some other parts. But many GPs in socially deprived or urban areas stay for quite considerable lengths of time. I have forgotten the exact figures, but the length of time that the average GP spends in one area is several years, so I think that the relationships are the same in many parts.

David Nicholson: What is true—it has been reinforced by the discussion today—is that switching a patient with a long-term condition from one drug to another is a big issue and involves quite a lot of discussion. Indeed, I was talking about that with someone the other day—you have to see every patient individually and talk them through the whole process, and they have to be satisfied with everything from the colour of the tablets to the packaging, which takes time.

Q82 Mr Dunne: We have had a submission from an external party in relation to generics. One of the difficulties with generic drugs is that many of them are manufactured using different tablet sizes, colours and shapes and come in different types of packaging. That can be very confusing, particularly for elderly people who have got used to a particular look and where patients are taking more than one drug. Is there anything that the NHS can do to encourage the standardisation of the generic drugs that are prescribed here in terms of appearance?

Dr Harvey: I do not think that we can do anything on that, because it is up to the individual manufacturer to come forward.

[4] *Note by witness*: We believe measure to control prescribing expenditure has played a significant role in the financial recovery of the NHS. We have introduced a number of initiatives to support more efficient prescribing practice—such as performance indicators published by the NHS Institute on the generic prescribing of statins, and the negotiation of a price reduction on generic drugs. The precise impact of these measures is difficult to measure, but overall we believe there has been a net saving of around £150m. This is based on a comparison of the provision outturn figures for drug expenditure and the level of drug expenditure that NHS bodies believed would be needed at the start of 2006/07.

Q83 Mr Dunne: But are you not one of the manufacturers' largest customers in the world?

Dr Harvey: We are about 3.5% of the global medicines market, which is not a huge proportion. Nevertheless, we have a very active generics market here. What we are finding, however—this is about the importance of the relationship between the pharmacist and the patient—is that some pharmacies, if they are dispensing a generic, will find out what form of it the patient had last time, so that their patients do not have to go through changes where the generic that they have one month looks different the next month. This is an issue that some pharmacies are looking at. However, there is nothing that we can do centrally, because we are one purchaser, as it were, within the global market for generic medicines.

Q84 Mr Dunne: We have had evidence from the chair of the Royal College of General Practitioners that GPs are often hampered by the lack of clear information on best choices, which is one of the issues that is touched on in the NAO Report. Prescribing advisers are there to provide that information. If there is one prescribing adviser and 25 GPs, and given the reaction from the Royal College, does not that suggest that they are not doing their job properly?

Professor Colin-Thomé: Yes—well, not that they are not doing their job properly, because they are only one facet. Every GP funded by the Department of Health receives the "British National Formulary", which is superb, because it gives both clinical guidelines as well as NICE recommendations and the range of drugs that can be offered. As Dr Harvey mentioned, it is not just about prescribing advisers as they might well focus on practitioners who need special attention.

Q85 Mr Dunne: Can I just pick you up on that point? I am aware of it, but table 16 on page 25 indicates that the "British National Formulary" is cited by only 3% of high prescribers and 0% of low prescribers as their main influence in prescribing.

Professor Colin-Thomé: It is one of many, but what I am saying is that GPs have ready access to information. There is evidence that older GPs like face-to-face consultations with advisers, which is why we have a menu of options. If GPs say that they do not have ready information, I would argue that they should not be able to use that excuse, because one cannot get much better than what is available.

Q86 Mr Dunne: Those GPs that also operate as dispensing practices generate quite a significant proportion of their remuneration from dispensing activities. Is there not an inherent conflict for them in seeking to reduce the cost of prescribing with their own remuneration? How do you deal with that?

Professor Colin-Thomé: There is a risk. However, if you look at the evidence from dispensing doctors, their average costs match those of non-dispensing GPs, as I have said. There is a small percentage of very expensive drugs that might seem to be more common in dispensing practices, but even that number is declining. In any event, we changed the remuneration to create a flat rate instead of having payments linked to the drug cost. Dispensing doctors provide an excellent service where pharmacies are not available. In fairness, the average costs and prescribing patterns were very similar, and there were only one or two small examples in which that was not the case.

Q87 Mr Dunne: Turning to pharmacists rather than dispensing practices, is there any specific incentive on them to be supplied by either the branded drug producers or by the generics? My sense is that they have more flexibility with generics than with the branded drug suppliers, because they can negotiate better deals. Is that fair? One would then be inclined to get a higher proportion of such drugs from pharmacists.

Dr Harvey: They can certainly negotiate their deals. On reimbursement, they are reimbursed at the category M reimbursement price for generics and in relation to branded drugs they are reimbursed at the PPRS price. It is important that they purchase well, which is why the remuneration system incorporates a degree of permitted retention of received discounts, so as to ensure that prices and markets are kept buoyant.

Q88 Mr Dunne: I have a final couple of questions on NICE and new drugs. The Report mentions that few drugs are coming off patent during the next year or so. With medical advances, what sense can you give the Committee of how many drugs you anticipate that NICE will approve during the next 12 months or so? If there is an accelerating drug discovery pattern, what pressure will that put on the prescribing budget?

Dr Harvey: I cannot remember the exact number, but I know that NICE is conducting many appraisals at the moment. From memory, I believe that it is approximately 26, although that might not be correct and we might need to come back to you with the correct figure.[5] A lot of new drugs are being processed at the moment. The new single technology appraisal mechanism means that the NICE process begins much earlier, as the licence dossier for the drug is submitted to NICE and the regulator. That means that the NHS has information within a couple of months of a drug having market authorisation.

In terms of what has been happening to date in respect of pressure from NICE, since NICE came into being in 1999, there has been huge growth in NHS finances. The overall increase in the drugs budget[6] due to NICE recommendations on drugs has been about £1.2 billion. That comes from huge growth of many, many billions within the NHS.

[5] *Note by witness*: NICE's Business Plan indicates that it expects to publish around 32 Technology Appraisals in 2007/08, though some of these will include guidance on more than one drug or technology. A small number of NICE appraisals relate to non-drug technologies. The exact number of pieces of guidance published will depend on factors such as drug licensing timescales and whether or not appeals are lodged against particular appraisals.

[6] *Note by witness:* This relates to total estimated drug spending, in both primary and secondary care, not just the area of expenditure studied in the NAO Report which focuses only on primary care.

Professor Colin-Thomé: Some £40 billion.

Dr Harvey: There has been £40 billion worth of growth in the NHS. When we put drugs into the work programme for NICE, we look carefully at the cost implication that we will see down the line for PCTs. That is factored into the finances for primary care trusts. We consider that very carefully.

However, it is fair to say that as novel medicines get more and more innovative and specific for people, we may find down the line that we want to spend a greater proportion on drugs, because of the impact that that would have on changing patient pathways—having more care out of hospitals and at home, which is very much the direction of the White Paper. Clearly, we need to look at that for the long term, in terms of horizon scanning for the sort of impact that medical advances can have.

Chairman: The final question comes from Mr Mitchell.

Q89 Mr Mitchell: In answer to an earlier question, David Nicholson said that when negotiating prices with the drugs firms, you had to bear in mind that they make up a major British industry and a very effective competitor. That must mean that you are giving them a soft deal—that you are subsidising them.

David Nicholson: I do not think that that is the case.

Q90 Mr Mitchell: Why say that, then?

David Nicholson: We have to take it into account. Our current arrangements are being reviewed in the light of the OFT report on the drugs industry. We are reviewing those, and the Government will at some stage come forward with their proposals on that. One of the benefits of the arrangements that we have at the moment is price stability, which is beneficial to us in terms of planning and also as far as the industry is concerned.

Q91 Mr Mitchell: Prices should be coming down. These are big multinationals, and there is no need for them to be subsidised in this country.

David Nicholson: Prices are coming down. Two and a half years ago, we agreed a 7% reduction with them as part of the 2005 PPRS.

Q92 Chairman: Thank you very much, Mr Nicholson. The fact remains that although we constantly read of the NHS being short of resources, £200 million a year could be saved if doctors prescribed generic drugs, which are just as effective as branded ones. My colleague Mr Dunne referred to the case study in Bristol. I am not convinced that you are being sufficiently energetic in encouraging GPs to prescribe generic drugs. Our job in this Committee is to protect the interests of the taxpayer, and I am sure that our Report will reflect that, Mr Nicholson.

David Nicholson: May I say two things about that?

Chairman: You may have the last word.

David Nicholson: First, we have the highest generic rates in Europe.

Q93 Chairman: So what? You could always do better.

David Nicholson: Of course, but we are doing extraordinarily well compared with other health systems across Europe. Secondly, prescribing is about not just cost, but quality.

Q94 Chairman: Of course. But I specifically said that we could save £200 million by prescribing drugs that are just as effective as branded ones.

David Nicholson: But the quality of the relationship between the GP and the individual patient is important to us in that regard.

Chairman: Thank you very much, Mr Nicholson and colleagues.

Memorandum submitted by the American Pharmaceutical Group

I am writing on behalf of the American Pharmaceutical Group to share with you our comments on the NAO's recent Report on prescribing costs in primary care. I hope that this will be useful ahead of the Committee's discussion of the Report on 11 June.

The APG welcomes this scrutiny of primary care prescribing and we strongly support the goal of efficient and effective prescribing. The Report notes that the average cost to the NHS of a prescription is £11. However it is also important to note that a day in an NHS general ward costs up to £400 a day, and £1,200 or more in an intensive care unit. The Report highlighted that there are areas of under prescribing, where people are not accessing medicines which could improve their quality of life and save money by preventing hospital stays. We welcome this recognition.

We also welcome the Report's recommendations for an evaluation of medicines use reviews and further research into medicines wastage. Wastage of drugs and inappropriate use of medicines costs the NHS money with no benefit to the patient.

The Report gives great emphasis to the potential of generic medicines to save money, and the APG supports the use of generics when consistent with the best care for patients. Such savings can create headroom to fund innovative new medicines. However it is crucial to understand that replacing a branded medicine with a different molecule—albeit from the same therapy class—is not replacing like-for-like and that small differences in medicines can have significantly different outcomes for different people. There are

strong pharmaco-genomic reasons for needing a number of different compounds within a therapeutic class. Individuals metabolise and react to medicines in different ways, and it is crucial to have a broad spectrum of medicines from which a prescriber can chose the most suitable.

Decisions to change a medication on which patients are stabilised must be undertaken with care and in consultation with the patient, and must be closely monitored to ensure the best patient outcome. We have provided more detail about this below.

Another factor to consider when switching medicines is the effect on patient concordance. Research shows that changing a patient's medicine often has an adverse affect on concordance causing more wastage of medicines, but more importantly, negative consequences for patient care.

The NAO Report goes on to note that GPs benefit from information support. Our research shows that doctors value the information provided by the pharmaceutical industry. Central to this relationship is the strict industry code of practice which includes limits on the number of times GPs can be contacted, and with serious sanctions for companies who breach this code. We would draw your attention to this code of practice, which we firmly support, and which can be found at: www.abpi.org.uk/links/assoc/PMCPA/pmpca—code2006.pdf.

The Report makes the important point that the definition of "value for money" in prescribing must include quality of outcome and not just economy. It is right that patients have access to more effective, more expensive drugs when this is clinically appropriate.

Finally, I would like to reiterate our support for the NAO's aim of improving value for money in primary care prescribing. We very much support this goal and we would be delighted to provide further information if that would be helpful to the Committee.

Detailed Notes

The NAO Report suggests an ACE/AIIA target ratio of 84% / 16%. This is contradictory to the joint British Hypertension Society/NICE guidance which recommends an 80% / 20% ratio. The 4% differential, if implemented, would deny a significant number of patients the opportunity to receive the proven clinical benefits of an AIIA. No consideration is given in the Report to the BHS/NICE guidance and what this differential means to patient care.

The Report mentions clopidogrel, a treatment used to prevent patients who have had a heart attack or stroke from having a further event. The NAO Report implies that the alternative anti-platelet treatment aspirin can be substituted for clopidogrel. In fact, aspirin is not a generic equivalent of the patented medicine clopidogrel (brand name Plavix); the two are entirely different medicines with different modes of action, and the two treatments are frequently used in combination with one another. There is detailed NICE guidance that specifies when clopidogrel should be used; however national audit data suggests that 40% of patients who should receive clopidogrel do not in fact get it.

The largest single area of savings the Report claims to have identified relates to statins. The newer statins still under patent protection have greater efficacy and different levels of tolerability (particularly at higher doses) to the older, generic statins. At the levels of generic prescribing the Report appears to endorse, a significant number of patients would fail to reach agreed national clinical targets for cholesterol management, putting their cardiovascular health at unnecessary risk. Calculations show that only 68% of patients eligible for statin therapy would meet the national target of total cholesterol = 5 mmol/l using 40mg simvastatin.

Analyses such as that conducted by the NAO, which downplay clinical considerations and focus only on spending, are accelerating the switching of medication patients receive. As noted above, switching a patient's medication needs to be conducted with care and be guided by good clinical practice. Unfortunately, this is not always in evidence: the National Prescribing Centre (NPC) statin campaign (www.npc.co.uk/statins.htm), published December 2006, implies that a rise in cholesterol of 0.5 mmol/l is of little clinical consequence. However, a 0.5 mmol/l increase in LDL-cholesterol can lead to an 11% increase in major vascular events and a 6% increase in all cause mortality. [Cholesterol Treatment Trialists' Collaborators (2005) Lancet 366: 1267-78]

The Report also fails to capture many of the changes to statin prescribing that have taken place since the significant price differences between generic and on-patent statins emerged (May 2005):

— 90% of new patients are now initiated on generic statins.

— Total cash market for statins (£685m) is down £229m compared with its peak in Dec 04 (£914m).

— At the same time that the budget has fallen by £229m, the number of patients taking statins has risen from 3 million to over 4 million—ie the total statins budget has fallen by 25% as the number of patients has risen by 35%.

Andrew Hotchkiss
Chair
American Pharmaceutical Group

6 June 2007

Memorandum submitted by Merck, Sharp and Dohme (MSD)

As you know the Public Accounts Committee is meeting on 11 June to consider the National Audit Office Report *Prescribing Costs in Primary Care*. As MSD is a leading supplier of branded medicines to the NHS, I thought I would write to draw a number of points about the Report to your attention.

MSD agrees with the NAO that savings can be made through more efficient prescribing, and we support the NAO view that value for money is a function of both quality and economy. However, we believe the NAO's conclusions must be approached with a number of caveats, principally because the concept of switching patients from one medicine to another is not straightforward and it is erroneous to assume that medicines in the same class always have the same clinical effect.

The NAO Report conclusion that GPs can prescribe lower cost clinically effective medicines without affecting patient care is misleading. It states that this could save primary care trusts (PCTs) more than £200 million a year. The NAO also state that their report examines how the DH and NHS can seek to influence prescribing decisions where different drugs have: "the same clinical effect but different prices". MSD would like to draw the Committee's attention to the fact that there are important differences in medicines which treat the same condition.

For instance, replacing angiotensin-II receptor antagonists with ACE inhibitors as suggested by the NAO is not replacing like-for-like. Both medicines are for high blood pressure but have different pharmacological properties. This is also the case with medicines which are more closely related, where medicines can have the same pharmacological properties yet still be different chemical substances. For example in the statin class, an area currently targeted for efficiency gains, it is vital to understand that simvastatin and atorvastatin are chemically different and therefore will affect different people in different ways. It is inappropriate to assume all patients can be switched with no effect on clinical outcomes.

The assertion that PCTs could match the prescribing of low cost drugs achieved by the "best" PCTs without affecting clinical outcomes is therefore open to question. There is no proper measure of clinical outcomes vs. prescribing available in the UK.

An additional yet important point which must be taken into consideration is that there are costs associated with switching patients from one medicine to another, which takes time and effort on behalf of clinicians and may have adverse consequences for patient compliance.

On the prices and costs of medicines generally, it should be noted that primary care medicines accounted for 11% of NHS costs in 2005—the same proportion as ten years ago. It is also important to note that prices of branded medicines are 21% lower in real terms than ten years ago.

I should finally like to comment on the NAO's observations on pharmaceutical industry marketing activity, where it has quoted from the Health Select Committee's 2005 report on the Influence of the Pharmaceutical Industry.

The NAO repeats the Committee's unsubstantiated statement that industry promotion is "relentless" and aggressive, and there seems to be a tacit acceptance that promotion is somehow inappropriate. However as the industry pointed out when the HSC report into the Pharmaceutical Industry was published in 2005, the evidence did not match their assertion. In fact, most doctors receive only a handful of representative visits in a month and the NAO lists 17 other influences on GP prescribing (page 19). Also, the NAO's research points to the fact that 26% of doctors do not see representatives in their surgery, and the vast majority only see representatives between once per week and once every three months. According to industry research the majority of GPs say they value the clinical and product information provided.

Nor is there is any mention of the strict standards of regulation imposed on our marketing activity by the MHRA, in addition to the industry's own rigorously enforced Code of Practice which sets limits on the amount of marketing information that can be sent to GPs and the number of visits that can be made by representatives

7 June 2007

Memorandum submitted by Sanofi-Aventis & Bristol-Myers Squibb Pharmaceuticals Ltd

Introduction

The National Audit Office recently published a Report, *Prescribing Costs in Primary Care*. The PAC is due to take evidence from David Nicholson, Chief Executive of the NHS, on 11 June in relation to the Report's findings. We thought it important to point out to the Committee that we have a number of significant concerns about the report with regard to its analysis and findings relating to our product clopidogrel. We have set out these concerns in detail in a letter to Sir John Bourn, the Comptroller and Auditor General, requesting that the mistakes in the report be rectified. This letter can be shared with PAC Members on request. Our specific comments on the Report follow below.

Comments on the NAO Report

1. The NAO Report claims that the NHS could achieve more efficient prescribing by ensuring that 75% of Primary Care Trusts reduce the volume of their clopidogrel prescribing. This methodology for determining efficiency is overly simplistic, utilising low prescribing as a proxy for efficient prescribing and taking no account of the clinical need of the population. Encouraging PCTs to reduce prescribing to meet this flawed definition of efficiency could have a negative impact on patient safety and clinical benefit.

2. Many of the PCTs that the NAO deem to be inefficient prescribers have successfully reduced the incidence of heart attacks and strokes through implementation of effective prescribing policies based on national guidelines. If they were to be encouraged to reduce their prescribing, this success could be jeopardised.

3. The report suggests that population-based medicines reviews can be used to reduce prescribing. In light of the complexity and severity of the diseases that patients receiving clopidogrel are suffering from, any approach to medication review should be based on a clinician reviewing the patient in an individual face-to-face consultation.

4. The Report suggests that all patients receiving clopidogrel should have their treatment stopped after 12 months. This is inconsistent with the clinical trial evidence supporting the use of clopidogrel and national guidance issued by NICE. Clopidogrel is indicated to treat patients with a range of cardiovascular related conditions—principally unstable angina, heart attack, stroke and peripheral arterial disease. There are two separate pieces of NICE guidance that apply to these indications, one of which recommends a treatment duration of 12 months (TA80 on Acute Coronary Syndromes) and one which makes no specific recommendation on treatment duration (TA90 on Occlusive Vascular Events). Stopping clopidogrel therapy for all patients at 12 months may jeopardise the safety of patients who require longer-term treatment.

5. The NAO considers only the potential to stop therapy and does not address the significant issue currently facing the NHS that patients who, according to NICE guidance, could benefit from treatment with clopidogrel but are not receiving it. National audit data suggest that 40% of patients with ACS do not receive clopidogrel. The potential £39 million saving claimed by the NAO's report fails to take into account the additional spending that would be required to treat these patients according to national guidelines.

In putting these points, we wish to make clear that we agree with the NAO that clopidogrel should be prescribed appropriately so as to maximise the cost-effective use of resources as well as the benefit to patients. NICE is charged with issuing guidance that ensures efficiency and cost-effectiveness in prescribing practice and it has been very clear as to where and when clopidogrel should be used. We support NHS activity aimed at achieving the full and equitable implementation of the guidance—a policy that would ensure that money spent by the NHS on clopidogrel is spent effectively and efficiently.

Our concern is that the shortcomings in the report could lead the Department of Health to pursue policies that have a negative impact on patient safety and care. Anecdotal evidence suggests that many PCTs are already carrying out population-base reviews of clopidogrel usage, and in some instances stopping therapy for patients against the clinical judgement of the treating GP. It is critical that the Department does not encourage this financially driven approach to patient care.

The right way to for the Department to pursue efficient spending on clopidogrel is to promote robust, clinically-driven audit processes that seek to ensure the right patients are treated with clopidogrel—initiating therapy for patients who are not currently treated as well as stopping therapy for those who no longer require it. We remain open to dialogue with the Department to support the development of tools and processes that can help achieve this objective.

4 June 2007

Further memorandum submitted by Sanofi-Aventis & Bristol Myers Squibb Pharmaceuticals Ltd

Further to our earlier submission and to the 11 June PAC evidence session relating to the NAO Report, *Prescribing Costs in Primary Care* we thought it appropriate to draw to the attention of the Committee some additional points relating to our product Plavix that may inform the publication of the Committee's report into this subject.

1. There was discussion at the evidence session of the switching of patients from branded medicines onto generic medicines. We would like to emphasise to the committee that aspirin is not a generic version of Plavix and that there is in fact no licensed generic alternative to Plavix. Plavix has a pharmacologically different mode of action to aspirin and has been shown in extensive clinical trials to have a clinical benefit over and above that of aspirin when used in its licensed indications. It should also be noted that Plavix is used *in combination with* aspirin in patients with acute coronary syndromes (some forms of heart attack and angina), and that this use is endorsed by NICE.

2. We reiterate to the committee that there is evidence that many NHS patients who according to the 2004 NICE guidance[1] should receive Plavix but do not in fact receive it. An audit of NHS hospitals carried out by Innovex Health Management Solutions showed that 40% of heart attack (NSTEMI) patients and 61% of unstable angina patients were discharged from hospital without receiving Plavix. More detailed briefing on this evidence has been sent to the National Audit Office and is enclosed.

3. It is important that patients on Plavix who are identified as potentially appropriate for a switch to aspirin are properly assessed and reviewed on an individual basis by their clinician. The importance of any change of medication being led by the patient's doctor was stressed to the committee in evidence from Dr David Colin-Thomé. Many patients who have been treated with Plavix for 12 months will require longer-term therapy, for example if they remain at high risk of a further event or if they are aspirin intolerant.

August 2007

Memorandum submitted by W A Smith

I wish to draw attention to a problem which must affect many thousands of NHS patients throughout the country. I enclose a draft leaflet which we are developing to draw attention to a problem which must affect many thousands of NHS patients throughout the country.[2]

Ultimately the Health Service is there to maintain and improve the well-being of patients, and the present system of supplying medicines to patients causes much difficulty for those patients who need to take many tablets every day. Thus, effectiveness is reduced, and NHS funds are misused.

The essential problem is that a patient prescribed a generic medicine cannot rely on receiving the same brand every time, so that the tablets, the foil strips, and the packet can all look quite different for the same medicine. In addition, the brands all have different names so that a patient cannot always be sure that he is getting the same medicine, and it is very easy to get tablets mixed up.

This clearly impedes the effectiveness of the medicines, causing inadvertent underdosing or overdosing, however careful the patient is, and may also indeed cause hazard.

Of course, there is no problem for a patient who needs to take only a single medicine for a short period.

This is a serious problem which is little recognised by politicians, administrators, and health professionals, perhaps partly because it is seen to be too difficult and complex to tackle. The problem relates to competition policy within this country and throughout the EEC, where patients in other countries may have more choice of brand of medicine.

The problems are greater with items manufactured in other countries of the EEC, and in many cases even the same brand appears quite different if manufactured abroad. Often the label in English pasted on obscures other important information in another language.

One approach might be to find ways of achieving a uniform appearance in all respects for all brands of a single general medicine, with the generic name larger and more prominent than the brand name. This could be difficult, but should not be shirked as it would solve the problem, no doubt other solutions could also be found.

I believe that patients should be informed of the NHS cost of their medicines and it could be helpful if the price was printed on the pharmacist's label.

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[1] NICE Technology Appraisal 80; Clopidogrel in the treatment of non-ST-segment-elevation acute coronary syndrome; July 2004.

[2] Leaflet not printed.

Incidentally, why is it cheaper to produce medicines in other parts of the EEC than here, and who eventually gets the profit from doing this?

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