Our Health
Our Money
Our Say

Iseult Roche

2020health.org

2020health.org

Our Health, Our Money, Our Say
Iseult Roche

The Author:
Iseult Roche has an Arts background and is now a student completing her Medical Degree. She has particular interests in Public Health, Health Economics , Humanitarian Aid and Crisis Management. Iseult will be supplementing her studies with MERLIN (Medical Emergency Relief International) and plans to persue to her interests in these inreasingly important areas.

Series Editor:
Julia Manning studied Optometry and Visual Science at City University, graduating in 1990. She was a founder member of the British Association of Behavioural Optometrists, and both past visiting lecturer at City University and visiting clinician at the Royal Free Hospital, London. She is a Director of the Institute of Optometry and runs a domiciliary Optometry practice in South East London. Her clinical interests are in diabetes and multiple sclerosis. Julia is a founder and the Director of 2020health.org which launched at the end of 2006.

With thanks to Andrew Burns, Gail Beer and the ABPI for their assistance.

2020health.org
2020health.org is a centre-right Think Tank for Health and Social Care. It exists to improve the way health is delivered by promoting genuine partnership between patients, professionals, government and the business sector to achieve the highest quality, most productivity and best outcomes in care.

2020health.org
C/o Professor Lord McColl [Patron]
House of Lords
Westminster
London SW1A 0PW
T + F: 020 7708 0683
E admin@2020health.org
www.2020health.org

Printed by 2020health.org

Contents

Executive Summary

Current Top-Up consultations are based on a false premise – there isn't enough money in the NHS to pay for new drugs.

Yet closer scrutiny of the NHS finances would suggest otherwise:

Medicines waste: Up to £800million this year and roughly 10% of the NHS spend on medications year on year is wasted. It could have been spent on new medications and treatments for NHS patients all along.

Budget Surplus: The NHS now has a surplus of £1.7Bn, which will be boosted by the 5% savings on the current pricing of medication through the renegotiation with the pharmaceutical industry of the pricing scheme PPRS.

Future savings: Over the next 4 years, it is estimated that 7 out of 20 of the most branded prescribed medicines will be going off patent. The predicted cost saving to the NHS could be billions - over £3Bn according to internal analysis by the ABPI. This is nothing new, the Government have been well aware of savings on generics in the past, but these savings should be passed on to the patient inthe form of new medications.

There are many repercussions to the UK not making the latest medication available to the public:

- *People die or become disabled before they should, and arguably have their suffering exacerbated.*
- *Investment and innovation in the UK are jeopardized as confidence is lost by industry in uptake of new drugs.*
- *Clinical trials depend on having the existing 'gold standard' to compare to – but if these drugs are not being widely used in the NHS, the trials cannot take place in the UK.*

This report sets forth some ideas for helping to reduce medicines waste, and argues that the budget surplus and money saved should be used to fund new therapies in the UK.

Introduction

The amount of money wasted on prescription drugs in primary care remains an extremely high burden on an already fiscally strained NHS. Indeed, unused medicines are conservatively estimated to cost the tax payer over £800 million, or effectively 10 per cent of the £8.2 billion total expenditure on primary care prescription medication, per annum.[i, iv] While the introduction of NHS top ups, following the recent House of Lords ruling in the Ross caseii, has been largely accepted by the public and many healthcare professionals as necessary, this paper strongly suggests that this action is premature and should only be accepted when the treatment that is requested is beyond the remit of the NHS. We acknowledge that the NHS budget is not limitless, but we also are concerned that NHS top up payments would produce an inequitable health system and that this concept is a far cry from the original ideals upon which the NHS was founded.

It must be restated as well that the UK proportionally spends less on medications per capita than many other countries including many of our European neighbours. In the UK in 2007 we spent on average £195 per head while in France the figure was £322[iii].

While undoubtedly NHS top ups should be allowed in a situation where no alternative is available, to ensure that Health Care is not inequitable or socially divisive, life-saving and rejuvenating treatments should be available to all.

Top ups should not be necessary if prudent management of budgets were implemented, for example reducing wastage of medication. This is just one area where money could be saved and finances better allocated. This report will highlight that if the allocation of drugs was more efficient, sufficient savings could be made to fund new and effective medicines as needed for patients and so would prevent, or at least limit, the need for top ups.

In addition, to these potential savings, it must also be remembered that there is currently an NHS surplus of £1.7 billion[iv] that could be utilised, and more popular drugs are coming off patent each year enabling cheaper generic alternatives to be prescribed.

To put this surplus in to context, £1.7 billion voted to the Health Service, by the tax payers' elected representatives, is not being used to ensure patients get the medical treatments they need. This has been particularly highlighted in recent Court cases where legal challenges have had to be mounted in order for patients to access to life-saving treatments that NICE has failed to approve on their cost-benefit analysis protocol.

At a time when the Health Service is coming under increasing pressure and justifiable scrutiny by the press and the public, then it is clear that the stewardship of our money needs to improve and it should be spent on our health, if a tax-funded NHS is going to retain the Public's confidence.

Overview

The Wasted Funds

The NHS currently spends over £8.2 billion each year on prescription drugs in primary care in Englandv. The Department of Health estimates that about 10 per cent of annual prescriptions – thus some £800 million, is wasted each year [i]. This is indeed a significant amount of the NHS budget that could, potentially, be utilised to fund medication not currently available through the NHS.

Interestingly, the National Audit Office (NAO)'s recent report on Prescribing Costs in Primary Care, (which focussed on savings by the introduction of prescribing and patient compliance strategies), identified potential savings in this area of £200 million after looking at just 19 per cent of the primary care drugs budget[iv]. Indeed, the NAO also estimated that if the standards of the top 25 per cent of PCTs examined could be achieved nationally, that then the saving could be £300 million[iv]. Presumably if the remaining 81 per cent was also subjected to equal scrutiny even greater savings could be identified and implemented, thus making a significant contribution to reduce the possible £800 million that is thought to be lost annually.

In addition to the potential savings identified by the NAO, there are also the costs borne by the NHS on disposal of wasted medicines that are returned to Pharmacists and that have to be destroyed, this is estimated to be at least £100 million per annum[vi]. Some sources suggest the figure that could be saved is closer to £200 million each year[vii]. Despite some improvements in prescribing guidelines, stringent PCT targets for changes to GP prescribing, patient education, the increased availability of less expensive generic versions of medication and the newly negotiated Pharmaceutical Price Regulation Scheme [from 1 September 2008 a 5%[viii] price reduction was agreed, albeit only until 31 December 2008, in the cost of medication sold to the NHS] - there is still a considerable scope for further savings and investment in healthcare.

Although the number of prescriptions has increased by 55 % - from 485 million in 1996 to 752 million in 2006[iv] - the proportion of spend on medication remains generally constant. The drugs bill has in fact increased by 60% over the last 10 years, whereas the NHS budget has risen 100% [iv] for the same period, and the UK still prescribes less medication per capita than most of the rest of the EU.

The cost to the NHS of prescriptions is rising and consequently the issue of unnecessarily prescribed or un-used prescriptions becomes an ever more important issue. If the savings estimated were achieved, there would be funds available without any proportional increase in the drugs budget to spend on new licensed drugs. These drugs which are licensed are currently denied to patients via the NHS as they have not yet been fully approved by the National Institute for Health and Clinical Excellence (NICE)'s cost-benefit analysis. It seems rather harsh to be already saying to the public that the value of their lives have been reduced to a 'cost-benefit' analysis. We wonder if this 'cost-benefit' appraisal was extended to limit other areas of medical intervention such as acute, high risk cardiac surgery, whether there would be an outcry.

Unintended Costs

The price of medication bought by the NHS is set by the PPRS[vii] [Pharmaceutical Price Regulation Scheme] negotiations. While the PPRS agreements are negotiated by the Government in consultation with the pharmaceutical industry representatives, it must be remembered that the effect of negotiating lower prices with the UK pharmaceutical industry has led to them having to cut more than 10 per cent of its workforce, or 8,000 employees, over the past three years, and may even threaten the research and manufacture of new and improved drugs.[ix]

For a Government to indirectly but deliberately lead to higher unemployment at a time when the UK may be heading for a recession, would seem to be extremely short-sighted. Although it must be acknowledged that the Pharmaceutical industry has a vested interest in maintaining price levels and sales volume, nevertheless, it would be irresponsible to completely ignore the analysis and contributions from this sector.

Overview

Unallocated Funds

The NHS surplus currently stands at £1.7 billion[iii]. Extreme measures and huge pressures were placed on all Primary Care Trusts to ensure that the Government could report that the NHS was in the Black this year. Ministers had declared it would be, so Primary Care Trust Chief Executives had to make sure it would happen. This was achieved by various means including service cuts, top-slicing of PCT budgets, postponing operations from one fiscal year end to the start of the next, and a moratorium on prescribing new medications.

While this might look on the surface like good stewardship, we need to remember this is tax-payers money which has been taken from earnings and been left in the bank rather than spent on health. It is no wonder then that some members of the public have been prepared to fight and go to court in order to receive licensed, life-extending or rejuvenating drugs, bewildered and distressed at the denial of therapy while money sits 'on deposit'.

Future Cost Savings

Over the past 4 years [to March 2008] at least 35 drugs prescribed by the NHS have come off-patent[x]. These included 'block-buster' frequently prescribed drugs such as Lansoprazole, Lisinopril+ Thiazide, Pravastatin, Fluticasone, Alendronate and Risperidone. Every branded medication that comes off-patent means that a generic equivalent can then be developed and sold at a lower price to the NHS. This has been a standard way for the NHS to anticipate an area of savings to its drugs budget year on year[xi].

Figures from the Association of British Pharmaceutical Industry now indicate that 62.2% of prescriptions dispensed by chemists in England were generics[xii], although in Wales the figure for 2006-7 for generics is 84%.[xiii] However pharmaceutical companies have been analysing data based on the expiration of drug patents over the next 4 years. Unpublished data from two of the organisations we contacted suggested that many more millions could be saved by generic prescribing from drugs coming off-patent in the next 4 years, with some estimates of over £3Bn of potential savings [xiv, xv]. This is because it is estimated that 7 out of the 20 most prescribed branded drugs [but accounting for more than half of the total sales of these 20] in the NHS will be coming to the end of their protected period during which they cannot be copied. Once this period is over, the drugs can be bought at usually 20-80% less than their branded counterpart. This tallies with the world-wide figures of medicines valued at $150Bn coming off patent by 2015 compared to the total worth of the current drugs market of $550Bn[xvi].

The figures we have already quoted from the NAO have demonstrated the savings to the NHS of drugs coming off patent. If competent management both in Government and in Health Trusts is in place, we suggest that the savings made through efficiencies should be reinvested in new medications coming on-line for UK residents.

Overview

Analysis of the Waste

The following is an analysis and evaluation of the recent (2006/2007) data available from Department of Health, National Audit Organisation, Binleys and the NHS information Centre; representing current prescription trends and allocation issues and suggests some basic examples of alternative medication use, and summarises recommendations to limit the number of un-used prescriptions written.

One essential remit towards targeting this is that it is necessary to have a set definition of wasted medicines clearly defined in order to achieve this result. There is no nationally agreed definition of wasted medicines, however, the NAO defined this as 'medication which is dispensed but not taken by the patient'. The number of Prescriptions written has increased in the past decade, with the cost figure now at £8.2 billion[iv]. Although much of this increase can be explained by an increased variety and cost of new medication available and an aging population, some however can be directly attributed to unnecessary prescribing and un-used medication.

Wasted prescriptions are a nationwide issue and an area that has been targeted by some individual Primary Care Trusts to be addressed at a local level. However, data on medication wastage is not currently evaluated extensively by the Department of Health [iv].
The last detailed research to consider wastage was carried out over a decade ago in 1996 indicating that 11% of people in England had medication not being used [xviii], and it is considered that this figure is out - dated and excessively underestimates the real cost of this waste to the NHS.

In 2007 the National Audit Office undertook a detailed investigation and made recommendations regarding ways to minimise prescription wastage, these were comprehensive and focussed towards primary health care modifications and improvements and have been summarised and included in the recommendations section below.

One key factor was that too many prescriptions are written unnecessarily, and that tighter guidance on prescribing could reduce waste, by minimising issues of erratic prescribing and ensuring that quality of prescribing and follow up of patient's medication reviews are maintained and improved. However, simply limiting prescription numbers whole scale is not the answer, as it is vital to recognise that suitable prescribing can prevent further morbidity and reduce secondary care costs.

It is estimated by the Department of Health (DoH) that £85 million could potentially be saved by increased prescribing of less expensive, generic forms of medication, rather than brand names. However, the National Audit Office (NAO) estimated that if all the PCT's in England, adopted the practices of the top 25% of PCTs they examined, then around £300 million could be saved. While the cost of disposal of wasted medicine is estimated to be as much as £10 million each year.[vi]

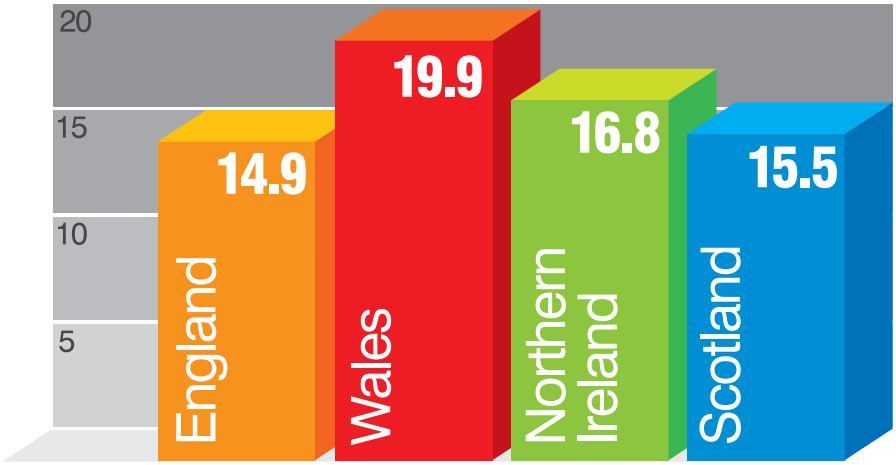
Approximately £8.2 billion is spent by the NHS in England on prescription drugs - about £22 million pounds each day – or around 25 % of the total expenditure on primary care.[iv] Considering that 98 per cent of all community prescriptions are written by GP's, it is essential that in an environment where an increased variety of medications are available, where biotechnology is the driving mechanism for newer medications[xix], that measures are in place to counter any increased potential for more prescribing due to the vast array of medications available.

Overview

Key figures for prescription expenditure in England

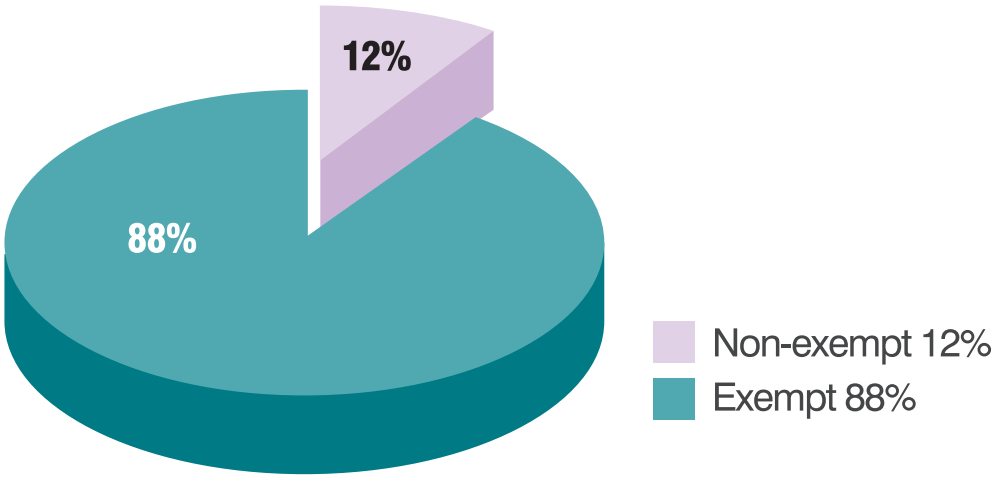
Data from 2006 – 2007 shows significant variation within the UK for the mean number of items prescribed per capita – (figure 1) - this suggests variation in prescribing habits.

Figure 1: The number of prescription items in the UK per capita



The average cost of a prescription item to the NHS has risen by 31% from £8.26 to £10.90 between 1996 and 2006[iv] and prescriptions will continue to increase per annum possibly due to the increased price of newer effective medication, thus if wastage is not addressed this too will increase in value. As the majority of prescription costs are met by the NHS (figure 2) – this further highlights the necessity to reduce waste. In 2006 in England the percentage of prescriptions that were non-exempt (i.e. paid for by the patient) represented only 12% of all prescriptions dispensed. The burden of wastage is a heavy price.[iv]

Figure 2: The percentage of exempt and non-exempt prescriptions in England in 2006



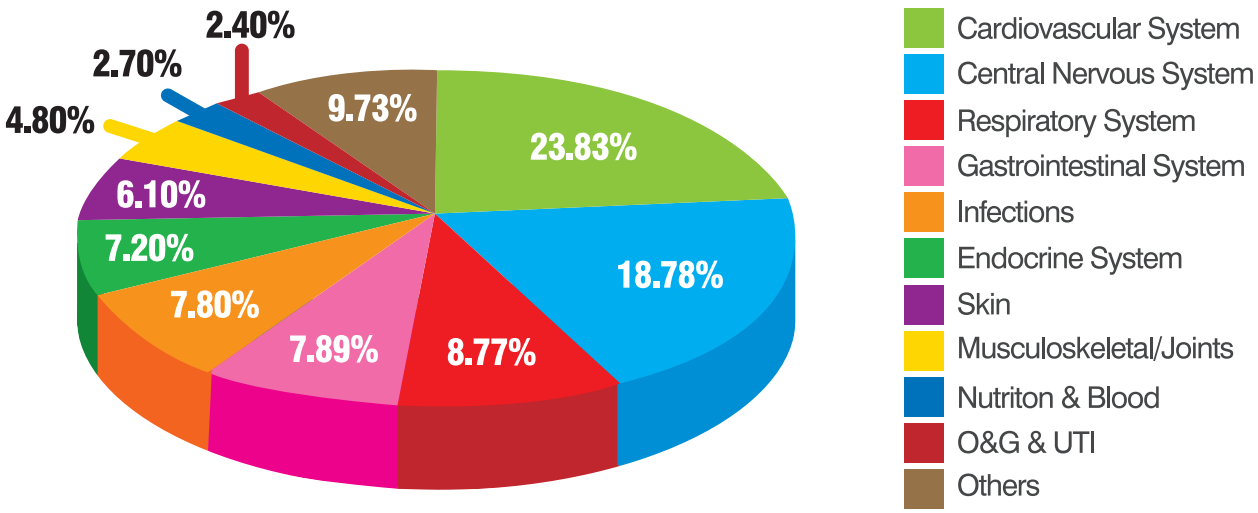
Overview

With population demographics changing – an increasingly older population will result in an increased number of prescriptions. On average, patient's aged over sixty years obtained 38 prescriptions per year, compared to only 4 prescriptions per year in those under sixteen years[iv].

Accordingly, it will be seen that a reduction in the cost of medication purchased from the pharmaceutical industry combined with the prescription of less expensive generic medications is vital. Cardiovascular class medication is responsible for nearly a quarter of all prescriptions (figure 4), and with an ageing population and insufficient public health measures to reduce obesity it is likely that this figure will continue to increase.

For example, Statins - a medication used to lower cholesterol and reduce the risk of heart disease – now account for approximately 19 % of the total primary care drugs bill in England.[iv] This is an example of an area where generic and less expensive versions of medication are readily available.

Figure 3: The percentage total of each class of medication prescribed in 2007 (based on raw data from the Prescription Cost analysis data from 2007[xx])



What our money could have been spent on

Examples of three medications so far rejected by NICE:

Alimta, a medicine which is used in mesothelioma and non small-cell lung cancer, was approved for use in 2005 in Scotland, by the Scottish Medicines Consortium. This medication was rejected as not cost effective by NICE. Alimta costs about £8,000 per patient – however, it has been suggested that the side effects of other drug alternatives prolong the length of stay in hospital[xxi], and would lead to further nursing bills, which could be off-set against the cost of Alimta treatment. The estimated £800,000,000 could pay for 100,000 treatments.

Figure 4: Potential number of new Alimta treatments available per annum

Estimated treatment cost per patient (£) / annum	8,000
Estimated money wasted (£)	800,000,000
Number of new treatments potentially paid for / annum	100,000

Tarceva is another anti-cancer medication available in Scotland, and yet not accepted by NICE. Tarceva costs about £1,700 a month and comes in tablet form, rendering alternative chemotherapy treatment, which has significant side-effects and detrimentally affects quality of life, unnecessary. Potentially 470,588 months of treatment could be funded by £800,000,000

Figure 5: Potential number of extra months of Tarceva treatments

Estimated treatment cost per patient (£) / annum	1,700
Estimated money wasted (£)	800,000,000
Number of new treatments potentially paid for / annum	470,588

Sutent used for first-line therapy for advanced renal cancer. Research shows that this can increase life expectancy for up to 2 years. This drug is a gold standard treatment elsewhere in the world. The cost equals approximately £2,000 per month on average.

Figure 6: Potential number of new treatments available per annum

Estimated treatment cost per patient (£) / annum	24,000
Estimated money wasted (£)	800,000,000
Number of new treatments potentially paid for / annum	33,336

The above are each examples of drugs that have not been prescribed due to not being deemed 'cost-effective' rather than 'effective' and highlights what could have been afforded by the NHS just from the amount of money that currently goes down the drain in wasted medication.

What our money could have been spent on

Lucentis - too little too late?

While effective treatments are being delayed or denied to patients this could serve to increase the burden on society, where the lack of effective treatments leads to further morbidity or disability.

One such example is the recently approved sight-saving drug Lucentis (used for the treatment of WET macular degeneration) by (NICE) - which took 18 months to gain full approval. The first 14 injections will now be funded for by the NHS. If further treatment is required then Novartis, the manufacturer, will pay for any additional doses.

Prior to this ruling the previous draft guidance was that patients would have to go blind in one eye before receiving Lucentis. Indeed in 2007 the Royal National Institute for the Blind (RNIB) commented that this decision would condemn 26,000 people each year in the UK to blindness, despite sight-saving drugs being available. Lucentis costs approximately £10,000[xviii] per eye treated, when placed in the context of the millions that are lost through waste in primary care and the £1.7 billion NHS surplus, then one wonders how allowing even one person to go blind could ever be economically, or morally, justified in our supposedly enlightened society.

Figure 7: Potential number of new Lucentis treatments available using 14 treatments per patient, if £800,000,000 was saved annually.

Estimated treatment cost per patient (£)	10,000
Estimated money wasted (£)	800,000,000
Number of new treatments potentially paid for / annum	80,000
New cases diagnosed per annum	26,000

This identifies that more than three years worth of new patients annually diagnosed with WET MD could be treated effectively, if more was done by the Government to limit wasted finances on wasted medication. The savings associated with a potentially reduced economic burden would be more significant and potentially save longer term social welfare funding and further costs to society.

The high costs of delayed decisions

The RNIB estimates that the cost to the State of a person who has gone blind who has retired is £10,000 per annum, but if the person is still of working age that cost rises to £30,000 per annum[xxii].

Complete treatment programmes can vary but, currently in use by the Oxfordshire PCT take between two to three years, thus at estimate costing between £24,000 - £36,000[xxiii] respectively. Using this costing basis the £800,000,000 wasted if reallocated simply to this area could pay for at least 22,222 full three year treatment plans or 33,333 full two year complete treatments.

Recommendations to reduce prescription wastage in Primary Care

Area: Patient Accountability

Since 1952, some people have had to pay towards their prescription medicines, although there are now so many exceptions over 88% of people pay no extra on top of what they have already contributed in tax and National Insurance Contributions. In Wales, since 2007 all prescriptions have been free, which has led to the situation where people living on the England / Wales border travel into Wales to have their prescriptions prescribed for no charge!

There is evidence in many fields to suggest that if people are not involved in a commercial transaction and are under the impression that they are getting something 'for free', then the item obtained is valued less. We previously published an article looking at the issues facing patients [New Prescription for prescribing, Dr Paul Charlson, 2007[xxiv]]. However there is a case to be made for everybody having to pay a nominal fee of £1 towards the cost of medication. Even for someone over the age of 60 on an average of 38 prescriptions a year, this would work out at only 70per week and would not be a disincentive to healthcare. Added to this the exemptions list is unfair – it doesn't include cancer, multiple sclerosis, arthritis and HIV/AIDS – nor does it take any account of the ability to pay.

Having a small, affordable, flat-rate charge might well help people to stop and think before accepting a repeat prescription when they have unused medication remaining. Currently the treasury receives £435 million from prescription sales[xxv]. At just £1 per item, that would rise to over £752 million [number of items dispensed in 2006 priced at £1 each], be fairer, more straightforward and an incentive for patients to decline repeat prescriptions that are not, at the time, actually needed.

The other opportunity for patients to take control is through personally-held records. Despite the failure of the NHS IT project to deliver any joined up patient record centrally, a programme such as Microsoft's Healthvault[xxvi], enables a individual to record all personal interactions with health professionals – and is under the control of the patient. This could be used by the individual to record not only prescribed medication but medication bought over the counter as well. This shared knowledge would also help to reduce adverse medication interactions.

Recommendations:

- ***A fixed fee of £1 is introduced for all prescriptions in the whole of the UK.***
- ***Introduction of electronic patient-held records to record all medication, repeat prescriptions and healthcare interventions.***

Recommendations to reduce prescription wastage in Primary Care

Area: Non-compliance

This is where patients stop their medication regimen partly through their prescribed course or do not ever take it. Poor compliance is usually linked to lack of patient understanding, a poor Doctor-Patient relationship and the side effects of the drug. This is an important area, as a Canadian study from 1995 that investigated non-compliance only, found significant results of £8 billion dollars wasted annually.[xxvii] Repeat prescriptions for chronic or long-term medication was thought to be the primary source of waste, compared to prescriptions for acute situations, where duration of compliance was shorter.

As a general management model this could indicate that an increased number of medication reviews might well be economically viable.

Recommendations:

- ***Patient questionnaires.*** *These could be designed to assess levels of non-compliance that could then be used as a marker for patients to have further medication management education.*
- ***An increased number of medication reviews*** *– so doctors and patients discuss when the medication is being taken and patients can be offered alternatives where necessary.*
- ***Medication review at an earlier stage*** *in association with smaller quantities initially prescribed, thus if side-effects are genuinely intolerable or other non-compliance issues are present they can be dealt with at an early stage and decision to continue with the prescription can be decided. Indeed further secondary costs could also be prevented if side-effects that result from medication intolerance were identified early.*
- ***Smaller amounts of initially prescribed medication.*** *This may help to enable any initial genuine side-effects that could contribute to non-compliance, to be identified before very much medication is dispensed which if it was not taken would be wasted. (This 'trial prescription' model has been used in parts of Canada)[iv]*
- ***Patient education.*** *Patients should be encouraged to understand how and when to re-order medication – and should be educated into the real likelihood of side effects in order to promote compliance.*
- ***Patient expectation.*** *Receiving a prescription rather than taking initiative for their own health improvements should also be addressed at an earlier stage.*

Recommendations to reduce prescription wastage in Primary Care

Area: Repeat prescriptions

Recommendations:

- ***Computer systems at GP practices unified.*** *This is particularly related to repeat prescriptions for non-essential items, as some practices have a 'prescription now due' option with set dates – this can encourage patients to collect a repeat prescription although they still have sufficient left. Other practices have a policy to say that medication has a date until which medication is 'authorised' until the review date.*

- ***An increased number of medication reviews.*** *These could be carried out by the patient's GP, a nurse prescriber or pharmacist thus ensuring repeat prescriptions are warranted.*

- ***Longer consultation appointments.*** *This would help ensure doctors and patients have time to decide if all prescriptions are still necessary. The average consultation time has been reduced to seven minutes, this lack of time erodes the patient-doctor relationship, where good communication is crucial and can benefit waste prevention, by confirming if repeat prescriptions are necessary.*

- *GPs to consistently update their prescribing knowledge - to ensure that the most cost-effective medication is prescribed.*

Area: Over prescriptions / unnecessary prescribing

Recommendations:

- ***Increase consultation times.*** *The increased number of prescriptions could be due to doctors having insufficient time in consultation to check if the medication is still needed and being taken, e.g. Prescription of antihistamines.*

- ***Utilise other services.*** *Lack of other appropriate services that could be used instead – e.g. the use of counselling services instead of prescription of antidepressant medication.*

- ***Use of less expensive generic brands of medication.*** *This can significantly reduce wastage costs (as above).*

- ***To ensure that sufficient information is available to GPs.*** *This would help to ensure the appropriate combination of medication is prescribed and to reduce unnecessary over –prescription. For example Clopidogrel can be overprescribed if patients are incorrectly thought to have an aspirin intolerance.*[iv]

- ***Increased information between Hospital Consultants and GPs.*** *Duplication of medication, changes to drugs made in one location but not communicated well to another can cause confusion and stock-piling.*

Recommendations to reduce prescription wastage in Primary Care

Summary Table of Recommendations to reduce prescription wastage in primary care

Area	Recommendations
Patient accountability	A fixed fee of £1 for all prescriptions Personally-held electronic records to document all medication transactions
Non-compliance *This is where patients stop their medication regimen partly through the course or do not ever take it.*	An increased number of medication reviews; A medication review at an earlier stage Smaller amounts of initially prescribed medication Patient questionnaires / education Increasing a good patient/ Doctor relationship
Repeat prescriptions	Computer systems at GP practices unified An increased number of medication reviews by GP Longer consultation appointments
Over prescribing	To increase consultation times Utilise other services. e.g. the use of counselling services instead of prescription of antidepressant medication The use of less expensive generic brands of medication To ensure that sufficient information is available to GPs Increased information between Hospital Consultants and GPs

Conclusion

Top up fees appear set to be introduced at a time when over £800 million pounds is potentially being lost to the NHS though wasted medicines. This in an unacceptable squandering of public funds and is a lack of duty and good management to the tax payer and those patients desperately seeking drug treatments not currently approved by NICE who deems some medications as 'uneconomic'.

The £1.7 billion surplus has been misdirected and is not being used to fund medical treatment and medication, although this money was voted for Healthcare by Parliament[iii]. This represents a failure to direct these funds where they are most needed in the NHS and is an issue which the Government has yet to satisfactorily explain or rectify.

Indeed, over the last 10 years, the Government has missed an opportunity to investigate the real cost implications of waste and to explore and implement specific measure to correct these on a primary care level.

While NICE continues to delay in approving key new drugs, opposition and discontent is growing in the population. There are growing numbers of legal challenges of the decisions of individual PCTs. The legal system and Courts are effectively considering what drugs ought to be funded by the PCT. Such as, the High Court ruling in early September of this year, which directed the PCT to fund treatment with Revlimid. Judicial reviews are costly to the NHS and are also damaging as it causes the public to lose confidence in the judgement of the PCTs and NICE.

The above recommendations are basic interventions, but which could have considerable benefit if recognised and implemented. Any practicable potential recommendation that could reduce waste should be considered.

Final concerns

We recognise that NICE is the body that currently undertakes the assessment of new medications that have been licensed. However we have a concern that the public servants at NICE, who are supposed to be undertaking unbiased, rational, neutral drug reviews have been coming out publically and criticizing the base-line cost of medications that are still under review. This seems to us to jeopardize equitable assessments of those drugs, which undermines the very function of NICE.

Secondly, clinical trials for new drugs depend on having the existing 'gold standard' to compare to. Individuals are recruited for trials on the new, licensed product and compared to those on current therapy regimes. This is an essential part of the appraisal process and vital if to demonstrate the any increase in efficacy of new products. However if these new drugs are not being widely used in the NHS, the trials cannot take place in the UK. Both the health and economic repercussions could be significant.

i Department of Health, Management of Medicines: A resource to support implementation of the wider aspects of medicines management for the National Service Frameworks for Diabetes, Renal Services and Long-Term Conditions, July 2004, available at: http://www.dh.gov.uk/assetRoot/04/08/87/55/04088755.pdf

ii http://www.telegraph.co.uk/news/newstopics/politics/health/2778184/Dying-cancer-patient-wins-High-Court-Revlimid-drug-challenge.html [accessed 16.9.08]

iii http://www.abpi.org.uk/statistics/section.asp?sect=1#2 [accessed 15.9.08]

iv BBC News Online, 6 June 2008, NHS £1.7bn surplus spending row, available at: http://news.bbc.co.uk/1/hi/health/7440519.stm [accessed 16.9.08]

v National Audit Office Prescribing costs in primary care 2007, available at: http://www.nao.org.uk/publications/nao_reports/06-07/0607454.pdf

vi House of Commons Committee of Public Accounts – Department of Health: Prescribing costs in primary care – Second Report of Session 2007-8.

vii Report by Grant Shapps MP, June 2007, A Bitter Pill to Swallow: A report into the cost of wasted medicine in the NHS. Available at http://www.shapps.com/reports

viii The Department of Health, The Pharmaceutical Price Regulation Scheme August 2008, available at: http://www.dh.gov.uk.en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_087021

ix Telegraph – UK Drug firms to slash workforce by 10pc – 21/03/2008 http://www.telegraph.co.uk/core/Content/displayPrintable.jhtml;jsessionid=2252NIM

x http://www.sehd.scot.nhs.uk/mels/HDL2005_39.pdf annex C [accessed 15.9.08]

xi http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5026916

xii ABPI library

xiii Letter, BMJ, September 13th, Have dispensed items really risen with free prescriptions? Tony Jewell, CMO Wales

xiv xv http://www.ims-global.com/insight/news_story/0209/news_story_020919.htm

xvi Pfizer internal document

xvii http://www.guardian.co.uk/business/2008/jul/27/glaxosmithklinebusiness.pharmaceuticals [accessed 16.9.08]

xviii http://www.independent.co.uk/life-style/health-and-wellbeing/health-news/pharmageddon-the-prescription-pill-epidemic-463043.html

xix Residual medicines A report on OPCS Omnibus Survey data produced on behalf of the Department of Health available at. https://www.nihr-ccf.org.uk/site/docdatabase/prp/prp_wm_docs/PRP%20Waste%20Medicine%20-%20Research%20Brief.doc

xx The future of science and technology. http://humanitieslab.stanford.edu/2/200

xxi http://www.ic.nhs.uk – Prescription cost analysis 2007, Summary of the number of prescription items dispensed by therapeutic classification based on BNF. Pg1.

xxii Times Online, 11 March 2007, English denied cancer drug given to Scots, available at: http://www.timesonline.co.uk/tol/news/uk/health/article1496854.ece

xxiii RNIB in conversation with editor

xxiv Oxfordshire PCT, available at: http://www.oxfordshirepct.nhs.uk/about-us/how-the-pct-works/trust-board/board-papers/2007/july/documents/chiefexecutivesreport.pdf

xxv http://www.2020health.org/forum02.html [accessed 15.9.08]

xxvi http://www.politics.co.uk/reference/issue-briefs/health/nhs/nhs-prescription-services/nhs-prescription-charges-$366605.htm [accessed 16.9.08]

xxvii http://www.healthvault.com/Personal/index.html [accessed 16.9.08]

xxviii http://www.napra.org/practice/toolkits/toolkit9/wastecost.pdf

About 2020health.org

2020health.org works with Policy makers to improve the way health outcomes.

Our key Themes are:

- ***Public Health***
- ***Science in Health***
- ***Sustainable Health [national and international]***

Our key Messages are:

- ***Demonstrate respect for the experience of front line professionals, looking at ways power can be devolved to them.***
- ***Focus on therapeutic & rehabilitation outcomes as success indicators.***
- ***Encourage continuity of care to promote excellent treatment and underpin the patient-professional relationship.***
- ***Improve access and reduce health poverty.***
- ***Empower communities to get involved with their local health providers.***
- ***Promote creation and analysis of health technologies.***
- ***Sustainable funding and financial stewardship.***

2020health.org