



National Audit Office

# Prescribing costs in primary care

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# SUMMARY

**1** The National Health Service spends £8 billion a year on prescription drugs in primary care in England. Expenditure on primary care drugs has increased by 60 per cent in real terms over the last decade, and the number of items dispensed has increased by 55 per cent. The continued development of new drugs for use in the NHS, the identification of new applications for existing drugs, and England's ageing population, mean that further growth can be expected.

**2** There are, however, ways in which the Department of Health (the Department) and NHS bodies can help make growth more affordable without affecting patient care, and hence enable more people to be treated or expensive treatments to be made more widely available.

They can seek to influence doctors' prescribing decisions, for example where different drugs have the same clinical effect but different prices; and they can seek to control the prices the NHS pays for drugs.

**3** This report examines the first of these approaches: supporting doctors and other prescribers in their prescribing decisions. We looked at the scope for improving the efficiency of prescribing, issues involved in assessing prescribing effectiveness, and the influences on prescribing behaviour. We also examined the extent of drugs wastage, due, for example, to patients not taking drugs they were prescribed, or being given repeat prescriptions for medicines of which they already had a sufficient stock.

**4** The Department's main mechanism for controlling drugs prices is the Pharmaceutical Price Regulation Scheme, an agreement negotiated every five years with the pharmaceutical industry, that aims to ensure that the health service can obtain drugs at fair prices, whilst promoting a strong industry capable of developing new and improved medicines. This scheme has recently been the subject of a review by the Office of Fair Trading, which has made recommendations for reform of the scheme (summarised in Appendix 1), which the Government is currently considering.

**5** The main strands of our methodology were: a survey of 1,000 general practitioners (GPs); a survey of prescribing advisers in Primary Care Trusts (PCTs); case studies of good practice across the country; an analysis of the NHS database of all primary care prescriptions written for the period August 2005 to July 2006; an in-depth study of practice in two PCTs with different prescribing outcomes, involving focus groups and interviews with GPs and PCT staff; consultation with an expert panel of academics, GPs, pharmacists and other stakeholders; and interviews with representatives of the industry, relevant professional bodies and other organisations. Appendix 2 sets out our methods in more detail.

**6** Although there has been progress in some areas in recent years, for example an increase in the proportion of prescriptions written that allow drugs to be dispensed in cheaper, 'generic' form, the Department acknowledges that there is scope for improving value for money in primary care prescribing. In September 2006 the NHS Institute for Innovation and Improvement launched its 'Better Care, Better Value' indicator for the prescribing of statins (drugs used to lower blood cholesterol levels and reduce the risk of heart attacks and strokes). The Department estimated that £85 million could be saved by more systematic prescribing of lower cost, generic forms of these drugs.

**7** We examined four groups of drugs, including statins, that account for 19 per cent of the total primary care drugs bill and which are used to treat conditions where there are several suitable drugs available at differing prices. We found large variations between PCTs in the extent to which local GPs prescribed lower cost drugs for these conditions, meaning that there is scope for most PCTs to increase efficiency, without affecting clinical outcomes, by increasing the proportion of low costs drugs used. We estimated that as a result PCTs could save more than

£200 million a year, for example, if all PCTs achieved at least the standard of the most efficient 25 per cent. We also found there were variations in the volume of prescribing which did not match variations in indicators of clinical need, such as local disease prevalence. An unusually low volume of prescribing may indicate unmet need, and an unusually high volume may indicate excessive prescribing, both of which represent poor value for money.

**8** Practice Based Commissioning, the Department's initiative that gives individual GP practices more control over their PCTs' financial resources, allows GPs to reinvest a proportion of any efficiency savings they make into their practices. It therefore could be a lever for improving value for money in prescribing, but its potential has yet to be tested. Only eight per cent of GPs responding to our survey said it would encourage significant savings. GPs will therefore continue to need support from PCTs in managing their prescribing.

**9** GPs have to update their prescribing knowledge continuously, but we found that it was difficult for GPs to assimilate all the information they received on prescribing. Both official NHS prescribing advisers and the pharmaceutical industry influence GPs' prescribing decisions, with the industry spending more than £850 million annually marketing its products to GPs. Two thirds of the GPs we surveyed said that PCTs' prescribing advisers have more influence on their prescribing behaviour than the pharmaceutical industry, but one in five GPs indicated they felt that pharmaceutical companies have more influence than prescribing advisers.

**10** Another influence on GPs' prescribing is the secondary care sector, as around a fifth of primary care prescribing is initiated in hospital, and drug choices in general practice are often guided by local specialists. Hospitals limit consultants' prescribing options to drugs approved by the hospital's expert drugs and therapeutics committee as a cost-effective subset of the large range of medicines available. GP practices are not subject to such a committee, but GPs should review prescriptions originating in secondary care at regular intervals to see if they are still required or should be changed. However, only a quarter of respondents to our GP survey mentioned that they would routinely review consultants' prescriptions when asked what arrangements they had in place for managing prescriptions that originate in hospital but are dispensed in the primary sector.

**11** Our analysis showed that several mechanisms are effective in improving value for money in prescribing, and can be adopted by PCTs. These include personalised communication with GPs from local experts, providing financial and practical incentives, and involving the whole prescribing community, across primary and secondary care, in decisions on local drugs policies. Currently PCTs currently vary considerably in their approaches to medicines management, and the extent to which they are employing these strategies.

**12** We found that drugs wastage is a significant cost for the NHS: at least £100 million a year, and perhaps considerably more than this, although the lack of robust data, and the wide range of reasons for waste, makes quantification difficult. There are local examples of anti-wastage practices in place, such as limiting the initial time period of new prescriptions, or of the length of time between repeat prescriptions, and information campaigns to raise public awareness about the cost of medicines to the NHS. The Department recognises that wastage is a serious problem, and has introduced medicines use reviews for patients with long term conditions, and repeat dispensing schemes that allow patients to collect repeat prescriptions directly from pharmacists, who can check whether they are still taking their medicines or experiencing difficulties with them, in an attempt to tackle some of the causes of waste.

**13** Uptake of these initiatives, however, has been low since their introduction in 2005. In the year to September 2006 less than 0.5 per cent of dispensing was done by repeat dispensing. By December 2006 about 500,000 medicines use reviews had been conducted in total. Academic research suggests that many PCTs remain to be convinced of the value of medicines use reviews, and that further action is needed to support and embed the medicines use review service. It will be important to evaluate the effectiveness of these initiatives after the electronic prescription service comes fully online.

## Conclusion on value for money

**14** There is scope to improve the efficiency of prescribing in primary care. Improving efficiency frees up money, without affecting clinical outcomes, which can then be used to pay for treatments for other patients. We found over £200 million of potential efficiency savings by looking at just 19 per cent of the primary care drugs bill. The areas we examined offer the most significant savings opportunities, but further savings may be possible in other areas of primary care drugs expenditure.

**15** Wastage of drugs, under-prescribing, and over-prescribing, whenever they occur, represent poor value for money. The Department of Health does not currently monitor levels of drugs wastage, so it is difficult to form a view on whether its current anti-wastage measures are proportionate. Assessing whether local prescribing volumes are consistent with clinical need is complex. However, combining prescription data with local prevalence data can provide benchmark information for PCTs and GP practices to help identify opportunities for improving the value for money they get from their prescribing.

## Recommendations

**16** We make the following recommendations on the basis of this examination.

### The Department of Health should

- a** Build on the 'Better Care, Better Value' statin prescribing indicator to develop further metrics, across a larger proportion of the primary care drugs bill, that PCTs can use to quantify achievable improvements in areas of high prescribing volume and against which they can assess themselves.
- b** Commission the NHS Business Services Authority and the Information Centre (Prescribing Support Unit) to collaborate in developing prescribing benchmarking tools for PCTs that improve on the currently available electronic prescribing analysis and cost data by incorporating local prevalence information.
- c** Actively promote their prescribing benchmarking tool to PCTs and seek PCTs' feedback to improve its accessibility and functionality for producing reports that prescribing advisers can use directly with GP practices.
- d** Evaluate the effectiveness of medicines use reviews and repeat dispensing schemes after the electronic prescription service comes fully online.
- e** Update the 1996 survey of residual medicines to come up with a more robust estimate of the scale of medicines wastage in England, and better information on why patients don't take their drugs.

### Strategic Health Authorities should

- f** Ensure that PCTs integrate approaches to prescribing across primary and secondary care, so that patients discharged into primary care have their medicines reviewed regularly, that drugs are not continued for longer than necessary, and that there is consistency between GPs' and consultants' choices of drugs.

### All Primary Care Trusts should

- g** Assess the value for money they are getting from prescribing by benchmarking themselves against other PCTs, and identify areas where improvement is necessary.
- h** Make more active use of the medicines management indicators in the Quality and Outcomes Framework to promote more efficient prescribing, where this is an issue of importance as part of the local prescribing strategy, with appropriate performance management by Strategic Health Authorities.
- i** Use GP practice-level information about prescribing in the areas identified for improvement to identify practices whose prescribing behaviour is significantly different from that of their peers. Ensure that prescribing advisers maximise their face-to-face contact time with these practices, and gain commitment to improvements in prescribing, develop practice-level action plans, and monitor and follow up performance.
- j** Support prescribing advisers in seeking to influence GPs' prescribing behaviour in targeted areas by:
  - keeping messages clear and simple, focused only on a small number of key prescribing priorities;
  - emphasising that value for money in prescribing includes quality of outcome as well as economy, and that there remains scope for practices to use more expensive drugs when that is clinically appropriate; and
  - backing up key messages with endorsement from senior management and local clinical opinion leaders.
- k** Identify the costs associated with possible PCT-wide ways of improving prescribing such as additional financial incentives or practice-based pharmaceutical support for GPs, and the potential 'return on investment' in terms of prescribing cost savings; and implement such programmes when they would be cost effective.