

M is for mayhem, madness or mischief

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With the recent criticism levelled by the Office of Fair Trading at the Pharmaceutical Price Regulation Scheme (*PJ*, 24 February, p208), it looks likely that attention will once again revisit the mechanisms used to set NHS drug prices. It is to be hoped that any review will have a remit wide enough to embrace the whole picture — not just brands — because the recent overhaul of generic pricing mechanisms leaves a great deal to be desired, especially in respect of category M.

Although the “M” is intended to reflect the link with manufacturers’ prices, alternatives could be mayhem or, perhaps, even madness or mischief, because from whatever standpoint taken it is difficult to see who has gained from its creation. Essentially a mechanism to divert resources from drug reimbursement to new services in the new community pharmacy contract, it appears to have created more problems than it has solved.

The Drug Tariff defines category M as: “Drugs which are readily available, where the Department of Health calculate the reimbursement price based on information submitted by manufacturers. Endorsement of pack size is required where more than one pack size is listed. Broken Bulk may be claimed if necessary.” One does not have to look far to find examples where category M bears absolutely no relation to real life trade prices and thus its definition is immediately undermined. Among the most startling is the category M price for a pack of 32 paracetamol tablets, currently £1.90, when the going rate for over-the-counter pharmacy sale is less than half this and supermarkets sell smaller packs at prices as low as a penny a tablet. To think that the NHS, which spends over £10 billion per annum on medicines, is willing to pay almost six times more than Joe Public for such a widely used medicine beggars belief.

Although this may be an extreme example, it amply demonstrates that the current arrangements need to be challenged. Communications on this subject with the Department of Health, via my member of Parliament, recently introduced me to the formula which the DoH uses to set category M prices: it is reproduced in the Panel. Now, although I am no great mathematician, I think it is fair to say that this is complex and the idea that such a formula justifies the current arrangements is of concern.

While the NHS has benefited from price reductions in generic statins, calcium antagonists and bisphosphonates, among others, there has been a rise in the cost of many long-standing traditionally cheap drugs. Phenytoin is a classic example, with the price of 100mg tablets rising to the dizzy heights of £62.29. The impact of this is so significant that the

drug now frequently appears in the top 20 drugs by cost for many in general practices.

However, not only do we have a situation whereby the state pays grossly excessive amounts for common drugs, but we have an increasing issue with generic prescribing no longer reliably offering best value for money for the NHS. The humble tube of hydrocortisone cream 1 per cent illustrates the point better than anything, with the generic costing the state over £10, while GlaxoSmithKline’s Efcortelan comes in at a mere 75p.

There are many other examples of this and these extend beyond the realm of modified release preparations, where this situation has been common for years. As if the situation was not bad enough already, the fact that the Drug Tariff frequently includes more than one pack size, with a huge variation in unit cost, accentuates the issue. Enteric-coated sulfasalazine is a good example: packs of both 100 and 112 are included in category M, but a prescription dispensed from the former will cost the NHS around four times more than one dispensed from the latter, and almost nine times more than if the brand Salazopyrin EN has been prescribed.

We also have the bizarre situation where inflicting a higher tablet burden on patients helps

reduce NHS expenditure. The doubling of simvastatin 40mg tablets, rather than prescribing 80mg tablets, is a prime example. Although a regimen of two tablets at night is unlikely to be detrimental to compliance, it is against what is intuitively logical in terms of best practice in medicines management.

Prescribing budgets have, with good reason, been milked as a cash cow for many years, often by switching to less expensive generic equivalents. As a direct result of the category M arrangements, the boot is on the other foot and many primary care organisations are recommending switches to brands — a total reversal of what for many was a mantra of best practice. For some, such moves are a step they are not willing to contemplate. Reasons often cited for not following such recommendations include a view that it is someone else’s problem, concerns centred on the patient’s understanding, worries about the longevity of savings from such changes, reliance on single suppliers and the impracticality of prescribers adhering to mixed messages about brand and generic prescribing. For others, however, the opportunity to make savings that may run into the millions is too attractive a proposition to pass over and in some areas prescribing support staff working in general practice are engaged in making mass switches, both to and from generic medicines, according to current pricing arrangements. At the same time, dispensing contractors are increasingly using small pack sizes to maximise their profit margins, routinely filling prescriptions for 100 tramadol capsules with packs of 30 and the like.

Although both primary care organisations and contractors are, of course, permitted to manipulate the arrangements to their own advantage, I perceive an increasing frustration from those on both sides of the fence and a growing recognition that there is something wrong with the current arrangements.

It is impossible to estimate the amount of time that is being spent by primary care organisations calculating the potential savings, then getting agreement from prescribers and implementing such switches, just as quantifying the time spent by dispensing contractors to select, label and package multiple small packs would be a challenge. Nonetheless, it is clear to someone who operates within both environments that considered nationally it must be significant.

If only the DoH could step back from the mayhem it has given birth to in the form of category M; then prescribers, their advisers and dispensing contractors could get on with the job of improving patient care through effective medicines management, rather than playing a shambolic system which is little short of a national scandal.

Category M price setting

The reimbursement prices of category M medicines are set quarterly in accordance with the following equation:

$$\sum_{i=1}^{i=n} m_i v_i = \left[\sum_{i=1}^{i=n} a_i v_i \right] - \theta$$

where

n is the number of medicines in category M contributing to savings;

m_i is the category M reimbursement price of the i th medicine;

v_i is the cardinal volume of the i th medicine;

a_i is the original category A reimbursement price of the i th medicine;

θ is the target savings uplifted by the pre-existing discount clawback; where

$$m_i = \alpha + \beta i + \eta \cdot \chi_i$$

where

α is an undisclosed fixed cost;

βi is a random element for the i th medicine;

η is a dimensionless factor;

χ_i is an index of the factory gate price of the i th medicine (which is the harmonic mean of the volume weighted arithmetic and geometric means of the factory gate prices of the i th medicine)