Annex B: Overview of the proposed community pharmacy reimbursement reforms

Proposed reform		Issue	Proposal
1.	Changes to the determination of reimbursement prices of generic medicines in Category A	Reimbursement prices are based on the weighted average of the list prices of AAH, Alliance Healthcare (Distribution) Ltd, Teva UK and Actavis. List prices do not reflect selling prices and some list prices are based on the Category A reimbursement prices.	The proposal is to move from reimbursement prices based on weighted list prices to actual sales data obtained under the Information Regulations including margin. This will ensure that Category A reimbursement prices better reflect selling prices.
2.	Changes to the distribution of margin added to generic medicines in Category M	Some suppliers of branded generics price their products below the Category M reimbursement price. Because the branded version then appears cheaper, this encourages prescribers (encouraged in turn by their CCG) to prescribe the product by brand rather than generically. In reality however, the branded medicine is more expensive to the NHS because it does not contribute (as much) to the £800m medicine margin under the CPCF.	The proposal is to reduce the amount of margin added to Category M generics with branded competitors that appear to cost less because no margin is added to brands. This, together with the proposal for changes to the deduction scale, will make it less attractive for CCGs to encourage GPs whose practices are members of the CCG to prescribe by brand.
3.	Changes to the determination of reimbursement prices of branded medicines with multiple suppliers in Category C	Category C reimbursement prices are in the main based on the brand originator's list price. Where there is competition this means that reimbursement prices do not reflect actual selling prices which are much lower.	The proposal is to move from reimbursement prices based on the originator's list price to either basing them on average weighted list prices of suppliers as published on the Dictionary of medicines and devices (dm+d) or actual sales data obtained under the Information Regulations. This will ensure that Category C reimbursement prices for these products better reflect selling prices.
4.	Inclusion of products treated as drugs (i.e. products other than licensed and unlicensed medicines that are treated as "drugs" for the purposes of NHS pharmaceutical services) in Part VIII of the Drug Tariff with a listed reimbursement price.	Only some "drugs" that are not licensed or unlicensed medicines but that have been prescribed for medical purposes, such as commercially available food supplements, have been included with a reimbursement price in Category A or C in Part VIIIA of the Drug Tariff, but there is scope to extend the practice.	The proposals for "drugs" that are not (un)licensed medicines but are prescribed for medical purposes, such as commercially available food supplements, are to a) include more of them with a reimbursement price in Part VIIIA; b) move some products from reimbursement prices in Part VIIIA based on the price of the

Proposed reform		Issue	Proposal
			reference product to either average weighted list prices of suppliers as published on dm+d or actual sales data obtained under the Information Regulations; c) adopt the reimbursement of non-Part VIIIA drugs as per proposal 5.
5.	Changes to the determination of reimbursement prices for non-part VIIIA drugs.	Non-Part VIIIA drugs are those not listed with a reimbursement price in Part VIIIA of the Drug Tariff. We aim to include as many products as possible with a reimbursement price in Part VIIIA. However, it is not possible or practical to list every drug available. Currently, non-Part VIIIA drugs are reimbursed at the list price of the supplier that the pharmacy contractor has sourced the drug from which can be the manufacturer or wholesaler. As a consequence, pharmacy contractors will source drugs with the biggest discount and not the drug that has the lowest list price. Because pharmacy contractors are reimbursed the list price of their supplier, the NHS/CCGs pay more for those products than necessary.	The proposals are to: a) base non-Part VIIIA reimbursement price of single source products on the manufacturer's list price as published on dm+d (instead of, as now, the pharmacy contractor's supplier's list price); b) base non-Part VIIIA reimbursement price of multi-source products on average weighted list prices of suppliers as published on dm+d (instead of the pharmacy contractor's supplier's list price). The weighted average of the supplier's list prices from the previous month as published on dm+d would provide an indicative reimbursement price to pharmacy contractors.
6.	Changes to the arrangements for reimbursing and procuring unlicensed medicines ('specials')	The most commonly prescribed specials are listed with a reimbursement price in Part VIIIB of the Drug Tariff. Reimbursement prices are based on quarterly information from suppliers obtained under the Health Service Products (Provision and Disclosure of Information) Regulations 2018 and until 31 July under the Specials MoU from some manufacturers. Any special not listed in Part VIIIB of the Drug Tariff is reimbursed at the invoice price (less any discount or rebate). The scope of Part VIIIB is currently restricted to manufactured non- solid dosage forms (e.g. liquids, creams and lotions) whilst 40 percent	The first proposal is to include tablets and capsules (40 percent of current spend on specials) with a reimbursement price (including margin) in Part VIII based on actual sales data obtained under the Information Regulations. The second proposal is to introduce alternative arrangements for non-Part VIII specials. The consultation will list several options: a) Require pharmacy contractors to seek three quotes b) Set up a central approvals service and require pharmacy contractors to seek approval for all non-part VIIIB product quotes

Proposed reform		Issue	Proposal
		(about £26m) of our expenditure on specials is on tablets and capsules, the majority of which are imported. For non-Part VIIIB specials there is no incentive for pharmacy contractors to source at the cheapest price possible because they are reimbursed the invoice price. As a consequence, the prices paid for those specials vary enormously and, in some instances, pharmacy contractors appear to have been charged excessive prices that do not reflect the cost of manufacturing/importing the special.	c) Procure either the central supply of specials or a central service that sources non-Part VIIIB specials and require pharmacy contractors to go through a central point for the procurement of non-Part VIIIB specials.
7.	Changes to the reimbursement of generically prescribed appliances and drugs dispensed as 'specials'	There are instances where a pharmacy contractor dispenses a special (unlicensed medicine) against a generically written prescription when they could have dispensed an appliance or a drug (i.e. products other than licensed and unlicensed medicines that are treated as "drugs" for the purposes of NHS pharmaceutical services). The cost of dispensing a special is considerably higher than dispensing an appliance or a drug. Specials are generally more expensive than appliances and drugs and in addition pharmacy contractors are paid a fee of £20 every time they dispense a special. Every time a pharmacy contractor chooses to dispense a special in this type of situation, this costs the NHS more than if they had dispensed the appliance or drug.	The proposal is to reimburse for the cost of appliance or drug and not cost of the special regardless of what has actually been dispensed against the generically written prescription.
8.	Changes to the deduction scale to reflect different levels of discount for branded and generic medicines	Pharmacy contractors are paid monthly for the items they dispensed in a given month. Every month a deduction is made to their payments, known as 'deduction scale. This is an assumed amount of discount received to avoid pharmacies having to calculate and declare discount received on each item dispensed. The	The proposal is to split the current deduction scale into one for generics and one for brands. This, together with the proposal for changes to category M (see proposal 2) will make it less attractive for CCGs to encourage GPs whose practices are members of the CCG to prescribe by brand.

Proposed reform		Issue	Proposal
		deduction scale does not take into account whether a pharmacy contractor dispenses brands or generics. As a consequence, pharmacy contractors that dispense more branded medicines than average do not have equitable access to margin. And, CCGs in areas where more branded medicines are prescribed are not paying their fair share of margin.	