



# Community pharmacy drug reimbursement reforms

## Consultation

July 2019

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# 1. Introduction

- 1.1 The Department of Health and Social Care is seeking views on proposals for a number of changes to the way it reimburses community pharmacy contractors in England for the drugs they dispense against NHS prescriptions.
- 1.2 In 2018, 1.1 billion prescription items (drugs, appliances and other items) were dispensed by community pharmacy contractors and dispensing doctors in England with a total value of £8.8 billion. The Department wants to ensure that the money spent on those items represents value for money to the NHS and tax payers and that pharmacy contractors are paid appropriately and fairly for the items they dispense.
- 1.3 Pharmacy contractors are private businesses that provide NHS pharmaceutical services under the community pharmacy contractual framework (CPCF). The core NHS pharmaceutical service provided by pharmacy contractors is the dispensing of NHS prescriptions. CPCF funding is delivered through fees and allowances paid to pharmacy contractors and medicine margin. Medicine margin is the difference between the purchase price paid by the pharmacy contractor and what they have been reimbursed by the NHS for dispensing the product against an NHS prescription.
- 1.4 In broad outline, the payment arrangements for pharmacy contractors are set out in a publication known as the [Drug Tariff](#). The fees and allowances to be paid to pharmacy contractors for the services they provide under CPCF, such as the single activity fee (which partly relates to the cost of dispensing) are for historic reasons referred to as "remuneration". None of the proposals that are being consulted upon relate to service "remuneration". Instead they all relate to what for historic reasons is referred to as "reimbursement".
- 1.5 The Drug Tariff also sets out the "reimbursement" arrangements for products that are dispensed as part of NHS pharmaceutical services. For present purposes, the key "reimbursement" cost is the amount that pharmacy contractors are paid by the NHS for the drugs, appliances and other product they dispense. This is known as the "reimbursement price". For most products that are dispensed, the reimbursement price is actually listed in the Drug Tariff, but if no price is listed, the Drug Tariff instead sets out how the reimbursement price is to be determined.
- 1.6 The Department believes that the reimbursement arrangements generally work well and to the benefit of both businesses at each point in the supply chain and the NHS. However, that improvements can be made to ensure that the following principles are adhered to, in so far as this is possible and practical:

- the entirety of the arrangements provides value-for-money to the NHS and tax payers;
- all pharmacy contractors have equitable access to medicine margin;
- reimbursement prices better reflect market prices to improve pharmacy contractors' cash flow; and
- the addition of medicine margin to reimbursement prices does not make medicines look more expensive than they really are and influences prescribing patterns.

1.7 This consultation document contains a range of proposals to improve the current reimbursement arrangements. Chapter Two provides further background on the community pharmacy drug reimbursement arrangements. Chapter Three explains the overarching rationale for the proposed changes and the subsequent chapters provide the detail for each of the proposals.

## Consultation

1.8 Consultation on changes to the Drug Tariff is a statutory requirement and a normal part of CPCF negotiations. Under section 165(1)(a) of the NHS Act 2006 the Secretary of State is required to consult the body representing pharmacy contractors before making Drug Tariff changes that are known as "determinations". The Secretary of State has recognised the Pharmaceutical Services Negotiating Committee (PSNC) as the representative body of pharmacy contractors for these purposes.

1.9 Section 165(1)(b) goes on to state that the Department may consult such other persons as the Secretary of State considers appropriate. On this occasion, the Secretary of State has decided to hold a public consultation, but with an important caveat. It is a generally recognised principle of public law that public authorities can and sometimes will conduct consultations in stages<sup>1</sup>. That is what is happening on this occasion. It is recognised that some of the proposals impact either directly or indirectly on others, apart from pharmacy contractors, in the supply chain, including manufacturers and wholesalers, and more widely on the NHS, in particular Dispensing Doctors, and Clinical Commissioning Groups who pay for the cost of prescribed products in their areas. We have therefore decided on this occasion to seek a wider range of views on the high-level issues of principle that underpin the proposals - and in particular the views of some other

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<sup>1</sup> See for example R (Breckland District Council) v Boundary Committee for England [2009] EWCA Civ 239 @ paragraph 49.

representative bodies that we will specifically target as part of this particular consultation exercise. However, rather than simply go out to particular organisations, we have chosen to broaden and simplify the consultation process by doing a public consultation on the high-level principles of the proposed changes. That will in particular allow businesses or individuals that feel that the representative bodies for the sector do not adequately represent their views to have their say.

- 1.10 When it comes to the second stage of the consultation process, which will cover the detail and the mechanics of how we reimburse pharmacy contractors (for example the formulas used to calculate reimbursement prices), we will revert to our normal consultation practice and conduct a follow-up consultation with the PSNC only.
- 1.11 It is important also to be clear that this package is by no means an "all or nothing" set of proposals. The merits of each of the proposals will be looked at afresh after the first stage of the consultation process is ended - and there is no pre-conceived commitment to taking any of them forward. Equally, there is no set timetable for taking any forward that are adopted in principle. A series of target dates is included in Chapter 12, but the target date that the Department has generally in mind for implementing measures is 1st April 2020. This is to allow sufficient time to conduct the next stage of the consultation in the usual way. However, it is possible that specific proposals that are to go forward will be implemented earlier, or later, if discussions with the PSNC lead in that direction.
- 1.12 A draft impact assessment has been prepared and should be read alongside this consultation document. Views can be submitted by 17 September. How to respond to this consultation is outlined in Chapter 13.

## 2. Reimbursement: context and background

### Prescribing practice

- 2.1 When writing prescriptions, prescribers can prescribe a medicine by brand (i.e. a proprietary name) or by the generic name, (i.e. the approved and registered active pharmaceutical ingredient name). If the generic name is written on the prescription, the dispenser can dispense any version of that product with that generic name, but she/he would most typically dispense a version of the product that was labelled with that generic name and not with an invented or brand name. The shorthand description for such a product is a “generic medicine”.
- 2.2 The alternatives open to a dispenser would be to dispense a “branded generic” (i.e. a product labelled with the brand name in a way that means it can be identified without reference to the generic name but that competes with 'generic medicines' with the same active pharmaceutical ingredient') or a branded medicine sometimes referred to as "full branded medicines" (i.e. branded medicines with the sort of labelling given to products while the active ingredient is still patent protected, with the intention of establishing the brand name rather than the generic name in the minds of purchasers and patients).
- 2.3 Conversely, if a brand name is written on the prescription, the dispenser has to dispense that branded version of the product, even if there is an alternative version that is identical in all respects to the branded version, except for the labelling.
- 2.4 This fundamental principle - a generic prescription can be fulfilled by any version of the product that meets the specifications of the prescription, but a prescription written by brand can only be dispensed by that particular brand - underpins a lot of what follows.
- 2.5 It also feeds into another fundamental principle, which is the starting point of any consideration of prescribing practice: clinical freedom. It is the prescriber's choice whether they prescribe by brand or generically. Nevertheless, prescribers are encouraged to prescribe generically where this is clinically appropriate. Generic prescribing is at a high level (77.7% in 2016 in primary care in England according to the latest relevant annual statistical bulletin published by NHS Digital [“Prescriptions Dispensed in the Community: England 2006-16”](#)).

## **Generic prescribing**

- 2.6 There are good reasons to support generic prescribing. Even if there is only one brand of a product on the market, prescribing generically supports prescriber understanding of the treatment they are giving and the nature of the product they are prescribing. It tends to give greater certainty amongst healthcare professionals treating a patient when, for example, patients move between care providers – e.g. on discharge from hospital – as to the patient’s treatment regime. Prescribing generically also tends to remind clinicians of the therapeutic action of the drug, so they are less likely to prescribe a drug of similar action – unintentionally causing duplication – or to prescribe a second medicine which is incompatible with the first.
- 2.7 There are also advantages in terms of dispensing flexibility. If a prescription only medicine is prescribed by brand, the dispenser has to dispense that particular brand of the medicine to avoid breaching regulation 214 of the Human Medicines Regulations 2012. As noted above, this principle is followed more generally, even if the dispensed product is not a prescription only medicine. As a consequence, prescribing generically provides pharmacists with greater flexibility in relation to the products they are able to dispense to patients. It also facilitates patients obtaining their medicines more quickly, and less stock has to be held by the pharmacy (i.e. they do not have to keep supplies of every supplier’s version of the product). This in turn leads to savings for the NHS.
- 2.8 If generic prescribing is established while an active pharmaceutical ingredient is in patent, this makes it easier for competitor products to launch once the product is out of patent – which has an obvious benefit in terms of reducing the costs paid by the NHS for that particular drug. There are therefore both clinical and financial reasons to support generic prescribing.

## **Reimbursement of pharmacy contractors**

- 2.9 Given that more than 1 billion prescription items are reimbursed each year under the community pharmacy contractual framework and there are 11,619 community pharmacies (2017/18) providing NHS pharmaceutical services in England, it is not practical to reimburse community pharmacies the exact amount they paid to purchase each product dispensed on an NHS prescription. Thus, at an individual prescription item level, community pharmacies may sometimes be reimbursed less than they paid for the product. However, at a national level, because of the medicine margin system, on average the reimbursement arrangements cover the cost of the product plus the target medicine margin (see below), meaning that NHS dispensing should be a profitable activity overall.



- 2.10 This encourages community pharmacies to stock a range of medicines so they can supply patients' NHS prescriptions promptly. The medicine margin system also incentivises efficient procurement by community pharmacies, yielding value for money for the NHS. This is because medicine margin is calculated based on average prices, so community pharmacies that achieve higher discounts than the average get a bigger share of the £800 million margin.
- 2.11 This system ensures that the NHS is getting the best deal for the tax-payer, whilst at the same time also ensuring that community pharmacies are rewarded for their services.

## Community Pharmacy Contractual Framework

- 2.12 Pharmacy contractors are the private businesses that own the community pharmacies that provide NHS pharmaceutical services under the community pharmacy contractual framework (CPCF). As noted above, the core NHS pharmaceutical service is the dispensing of NHS prescriptions, but it also covers a range of other services also provided by pharmacy contractors such as promotion of healthy lifestyles and support for self-care.
- 2.13 Under the CPCF, pharmacy contractors are paid for NHS pharmaceutical services through a combination of (i) fees and allowances and (ii) medicine margin. Funding for 2019/20 is £2.592 billion, with £1.792 billion from fees and allowances (paid by NHS England) and £800 million from medicine margin (paid for by clinical commissioning groups as part of drug costs).

## Medicine margin

- 2.14 At its simplest, medicine margin is the difference between the purchase price paid by the pharmacy contractor for a product and what they have been reimbursed by the NHS for the product. The amount of medicine margin being made by pharmacy contractors is assessed by a rolling annual medicine margin survey. The survey identifies, from sale invoices supplied by a sample of independent pharmacy contractors confidentially, the actual price they paid for a sample of drugs, appliance and borderline substances, and compares this to the amount the pharmacy contractors are reimbursed for those products by the NHS. This data is used to calculate the average amount of medicine margin retained during the year. Given the commercial sensitivities, the pharmacy contractors submitting sale invoices do not know the products within the sample and DHSC does not publish this information.

- 2.15 The difference between the medicine margin found in the margin survey and the medicine margin as part of the CPCF (£800 million for 2018/19) determines whether there needs to be any adjustments to payments made to community pharmacies. If too much medicine margin is being delivered, downward adjustments are needed and, if not enough medicine margin is being delivered, upwards adjustments are needed. The adjustments usually (but not always) are made to the reimbursement prices of products in Category M.

## **The Drug Tariff**

- 2.16 The Drug Tariff sets out the fees and allowances to be paid to pharmacy contractors for services they provide under CPCF. As mentioned above, the service element of the amounts paid (such as the single activity fee) is referred to as "remuneration", but none of the proposals under discussion in this consultation document relate to service "remuneration". The Drug Tariff also sets out the "reimbursement" arrangements for products i.e. the prices that pharmacy contractors are paid for the drugs, appliances and other products they dispense. For most products that are dispensed, the reimbursement price is listed in the Drug Tariff, but if no reimbursement price is listed, the Drug Tariff instead sets out how the reimbursement price is determined.
- 2.17 The proposals in this consultation largely relate to the reimbursement of drugs, as opposed to reimbursement of other products that are dispensed as part of NHS pharmaceutical services. "The term "drugs" has a meaning in the context of NHS pharmaceutical services that is both different to and broader than the popular understanding of what constitutes a "drug". In a pharmaceutical services context, "drugs" covers licensed medicines, unlicensed medicines (specials) and other products that are not medicines but which have recognised health benefits and have been prescribed for medical purposes. This includes, for example, medical foods, commercially available food supplements or certain dermatological products, for example creams. In other contexts, these products that are treated as "drugs" are sometimes known as "borderline substances", being in the grey area between medicines and foods or medicines and cosmetics.

## **Reimbursement of licensed medicines**

- 2.18 If a medicine is prescribed by brand name, then as noted above, a pharmacy contractor must dispense that branded version of the product, and subject to limited exceptions, a pharmacy contractor dispensing that medicine in England will be reimbursed for it by the NHS Business Services Authority ("BSA") by reference to the list price for the medicine of the manufacturer, wholesaler or supplier from

which the dispensing contractor sourced the medicine (Part II, Clause 8, of the Drug Tariff).

- 2.19 If a medicine is prescribed generically and the medicine is listed in Part VIIIA of the Drug Tariff, a pharmacy contractor in England will be reimbursed for it according to the price listed in Part VIIIA. There are essentially three Categories of drugs listed in Part VIIIA of the Drug Tariff, referred to by the letters A, C and M.
- 2.20 Category C products are the products not generally available as a generic. Category C reimbursement prices are based on the price of a particular product. The Secretary of State determines the reimbursement price as the price listed by the manufacturer or supplier (whether it is a proprietary or a non-proprietary product) on or before the 8th of the month being reimbursed.
- 2.21 To be in Category A or M, the medicine must be available as a generic. The decision as to whether or not to move a product from Category C to Category A or M is taken by the Secretary of State, after consultation with the Pharmaceutical Services Negotiating Committee (PSNC).
- 2.22 Part VIIIA explains how Category A prices are calculated. In relation to Category A, Part VIIIA says: “The Secretary of State determines the prices for Category A drugs to be the average of the price calculated for the pack size listed in the Drug Tariff weighted by the following four manufacturers and suppliers; AAH, Alliance Healthcare (Distribution) Ltd, Teva UK and Actavis/Accord on or before the 8th of the month being reimbursed. In the weighted formula, AAH and Alliance Healthcare (Distribution) Ltd prices have a weighting of 2, the prices from the other suppliers have a weighting of one (Either Actavis or Accord’s list price is used in the weighted formula; in circumstances where a product is listed by Actavis and Accord, then Accord’s list price is used in the weighted formula).”
- 2.23 A product has to score 4 in the weighted formula to be considered for Category A. That is, the product has to be available from both AAH and Alliance Healthcare (Distribution) Ltd, or from one of those companies plus both of the other suppliers, in order to prompt a discussion with PSNC over the possibility of the product moving into Category A.
- 2.24 Category M prices are calculated based on quarterly information provided by all manufacturers and suppliers. This information is obtained under the [Health Service Products \(Provision and Disclosure of Information\) Regulations 2018](#).
- 2.25 Drugs are included in Category M when there is more than one manufacturer and the drug fulfils minimum spend and/or volume requirements.

- 2.26 These criteria and calculation methods are indicative only. What is fundamental to the process is the discussion with PSNC. For example, simply because a product fulfils the Category A or M criteria does not mean it will be moved from Category C to Category A or M. It will prompt a discussion with PSNC but the outcome of that discussion cannot be predicted in advance.

## **Reimbursement of unlicensed medicines ('specials')**

- 2.27 "Specials" are products which have been specially manufactured or imported for the treatment of an individual patient after being ordered by a doctor, dentist, nurse independent prescriber, pharmacist independent prescriber, supplementary prescriber. An unlicensed medicinal product of this sort may only be supplied in order to meet the special needs of an individual patient. An unlicensed medicinal product of this sort should not be supplied where an equivalent licensed medicinal product can meet the special needs of the patient.
- 2.28 The most commonly prescribed specials are listed with a reimbursement price in Part VIII B 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 2019 under the Specials MoU from some manufacturers. Specials will be included in Part VIII B of the Drug Tariff when they fulfil the minimum spend and/or volume requirements.
- 2.29 Any special not listed in Part VIII B of the Drug Tariff is reimbursed at the invoice price (less any discount or rebate).

## **Reimbursement of other drugs (neither licensed nor unlicensed medicines)**

- 2.30 There are the products treated as "drugs" that are not medicines but that have been prescribed for medical purposes such as medical foods, commercially available food supplements and some dermatological products.
- 2.31 Some of these products have been included with a reimbursement price in Category A or C of the Drug Tariff. Drugs of this sort that are not listed with a reimbursement prices in Part VIII of the Drug Tariff are reimbursed under the non-Part VIII arrangements, i.e. the reimbursement price is the list price of the manufacturer, wholesaler or supplier from which the dispensing contractor sourced the medicine.

## Non-Part VIII reimbursement

- 2.32 If no reimbursement price is listed for a drug in Part VIII of the Drug Tariff, then as just mentioned, pharmacy contractors are reimbursed the list price of the manufacturer, wholesaler or supplier from which the dispensing contractor sourced the medicine.

## Deduction scale

- 2.33 Pharmacy contractors are paid monthly in arrears for the items that they have dispensed in a given month. Every month a deduction is made to their payments, on the basis of what is known as the "deduction scale". This is an assumed amount of discount received to avoid pharmacy contractors having to calculate and declare discount received on each item dispensed.
- 2.34 Currently, the deduction scale is based on the monthly total of reimbursement prices with a minimum of 5.65% and a maximum of 11.5% deducted from the total monthly reimbursement.

## Dictionary of medicines and devices (dm+d)

- 2.35 Some of the proposed reforms rely on information about list prices published on the Dictionary of medicines and devices (dm+d). The dm+d is a terminology reference source that contains unique identifiers and associated textual descriptions for medicines and medical devices. The dictionary is provided in electronic form to enable rapid updating of systems in response to new products being made available. Its purpose is to enable interoperability of all systems that record and communicate the prescribing and administering of medicines and devices. As well as being used by the Electronic Prescription Service (EPS) it is available to systems that need to record information about medicines and devices in a standard format. It is publicly available through the [dm+d browser](#).

## Apportionment of product reimbursement costs to CCGs

- 2.36 Reforms introduced by the Health and Social Care Act 2012 meant that NHS England and Improvement were given powers to apportion the costs to the NHS of providing to NHS pharmaceutical services to Clinical Commissioning Groups (CCGs). The arrangements for these apportionments are set out in Schedule 12A to the NHS Act 2006.

- 2.37 The apportionments are due to take place annually. For present purposes, the critical apportionment is the apportionment of the reimbursement costs of products dispensed under NHS pharmaceutical services. These reimbursement costs are apportioned to the CCG of the prescriber, regardless of where the product is dispensed.
- 2.38 So if a patient who lives in Enfield has a prescription written by a GP at a practice in Enfield dispensed near their office in Central London, it is the CCG that includes the GP practice of the prescriber in Enfield that has allocated to its budget the reimbursement cost of the product that prescriber prescribed - not the CCG of the area of Central London where the product is dispensed. As a consequence of this, the CCGs monitor the behaviour of their member practices' prescribers to see that they are prescribing appropriately.

## 3. Rationale for the proposed changes to drug reimbursement

3.1 The pharmacy contractor reimbursement arrangements described in Chapter Two generally work well but the Department believes that some improvements can be made to ensure that the following principles are adhered to, in so far as is possible and practicable:

- the entirety of the arrangements provides value-for-money to the NHS and tax payer;
- reimbursement prices better reflect market prices to improve pharmacy contractors' cash flow;
- all pharmacy contractors have equitable access to medicine margin; and
- the addition of medicine margin to reimbursement prices does not make medicines look more expensive than they really are and influences prescribing patterns.

### Value for money

3.2 The existence of medicine margin helps to create value for money to the NHS for tax payers by encouraging pharmacy contractors to source products as cheaply as possible which leads to competition putting downward pressure on selling prices which in turn leads to lower NHS reimbursement prices. However, for medicines not listed in the Drug Tariff and without a reimbursement price, this incentive mechanism does not operate as effectively, as pharmacy contractors are reimbursed based on the actual cost of the medicine that they endorse on the prescription. As a result, there is no incentive for pharmacy contractors to seek to source these products at the lowest possible cost.

3.3 The Department is considering a number of options to address this lack of incentive to purchase products at the lowest possible cost, including:

- Where possible, adding more of these products to the Drug Tariff;
- Where this is not practical, introducing other rules to make the reimbursement prices of these products more reflective of the market and create incentives for better purchasing by pharmacy contractors;

- For specials and unlicensed medicines not listed in the Drug Tariff, considering alternative mechanisms outside of the normal Drug Tariff mechanisms to incentivise better purchasing.

3.4 For products that are already in the Drug Tariff, it is recognised that these existing incentive mechanisms are most likely to be effective when the reimbursement prices listed in the Drug Tariff are reflective of the actual selling/purchase prices in the market. As a result, the Department also wishes to consult on a number of measures designed to change the methodology for setting listed reimbursement prices to make greater use of market data.

## **Improving pharmacy contractors' cash flow and medicine margin distribution**

3.5 Under the current product reimbursement arrangements, pharmacy contractors are encouraged to source as cheaply as possible in order to maximise the amount of medicine margin they can make. As described in Chapter 2, the medicines margin survey is a rolling annual survey which seeks to measure the total amount of medicines margin made by pharmacy contractors. Where this survey finds that there has been under or over delivery of medicine margin against the currently agreed annual total of £800 million, reimbursement prices are subsequently adjusted to make up the difference.

3.6 Although this system is designed to deliver the right level of funding to pharmacy contractors overall, there are disadvantages to the need to make adjustments to reimbursement prices.

3.7 There will inevitably be a delay between when medicine margin is earned, when it is measured in the survey and when appropriate adjustments to reimbursement prices are made. There is a very real risk that this delay can mean that reimbursement prices need to be adjusted downwards to account for previous over-delivery of medicine margin at a time when market conditions have worsened. This may have significant negative effects on pharmacy cashflow.

3.8 Since any subsequent adjustments to correct for over or under delivery of medicine margin will be made by adjusting Category M reimbursement prices, this creates a risk that the pharmacy contractors who benefited most from previous over-delivery of medicine margin are not those who are most affected by any subsequent downwards adjustment to reimbursement prices.

3.9 As a result, the Department's preferred position is that reimbursement prices should be set in a way that is most accurate and as reflective of the market as possible, in order to minimise the need for subsequent adjustments to correct for



over or under delivery of medicine margin and improve cash flow for pharmacy contractors. As such, the Department wishes to consult on a series of options to:

- Change the methodology for setting reimbursement prices to make greater use of market data to ensure that reimbursement prices are as reflective of the market as possible.
- Propose changes to the methodology for setting reimbursement prices for specific products where issues have been identified that mean that reimbursement prices are not reflective of market prices.

## **Distorting effect of medicine margin on prescribing and ensuring all contractors have equitable access to medicine margin**

- 3.10 Some suppliers and manufacturers of branded medicines, including branded generics, price their products below the Category M reimbursement price. This can have a distorting effect on prescribing decisions because the branded version then appears cheaper, which encourages CCGs and prescribers to prescribe the product by brand rather than generically. To take the simplest example of how this might work in practice, when a GP prescribes a medicine, the software that they use will generally inform them of the Drug Tariff reimbursement price of the medicine. It will also generally inform them of branded versions of the medicine that are available and their prices. It may therefore look to the GP that a branded version represents good value to the NHS because its list price is significantly below the Drug Tariff reimbursement price.
- 3.11 In reality, however, the branded medicine may well be more expensive to the NHS because it does not contribute (or contributes very little) to the £800 million medicine margin under the CPCF. This in turn leads to a shortfall in medicine margin that will need to be factored elsewhere into reimbursement prices. This also leads to an unequal distribution of medicine margin amongst pharmacy contractors, and it also means that the NHS overall will lose money because some reimbursement prices will have to be set higher than it would have done - to the ultimate detriment of CCGs as a cohort.
- 3.12 In addition, where CCGs recommend prescribing the branded product because they see it as cheaper to them, pharmacy contractors in the CCGs' catchment area do not have equitable access to medicine margin as they do not retain medicine margin on brands. This also means that not all CCGs contribute equally to the £800 million medicine margin under the CPCF. So, an individual CCG may

benefit from the amount apportioned to it in relation to a particular transaction, but CCGs as a cohort and the NHS overall will lose out.

- 3.13 These issues are also exacerbated by the application of a single deduction scale to cover brands and generics. When pharmacy contractors are reimbursed for the drugs and appliances they have dispensed, a deduction is made to their payments, based on what is known as the "deduction scale", described in Chapter Two. This is an assumed amount of discount received to avoid pharmacy contractors having to calculate and declare discount received on each item dispensed.
- 3.14 Currently, the deduction scale does not take into account whether a pharmacy contractor dispenses brands or generics. However, the Department knows from the information it receives that, generally, branded medicines do not attract as much discount as generic medicines. Pharmacy contractors, on average, dispense branded medicines at a loss. As a consequence, pharmacy contractors that dispense more branded medicines than average do not have equitable access to medicine margin. Additionally, CCGs in areas where more branded medicines are prescribed are not paying their fair share of medicine margin.
- 3.15 To address these issues the Department is proposing to consult on two measures, that will help improve the distribution of medicine margin amongst pharmacy contractors, to
- Change the distribution of medicine margin added to generic medicines in Category M to ensure that the generic medicine does not look more expensive than the branded version and the reimbursement price better reflects the actual purchase price.
  - Change the deduction scale to split it into two separate scales, one for generic medicines and one for branded medicines.

## 4. Changes to the determination of reimbursement prices of generic medicines in Category A

### Current reimbursement arrangements

- 4.1 If a medicine is prescribed generically and the medicine is listed in Part VIIIA of the Drug Tariff, a pharmacy contractor in England will be reimbursed by the NHS for it according to the price listed in Part VIIIA. As explained above, there are essentially three Categories of drugs listed in Part VIIIA of the Drug Tariff, referred to by the letters A, C and M. Category C products are the products not generally available as a generic.
- 4.2 To be in Category A or M, the medicine must be available as a generic. The decision as to whether or not to move a product from Category C to Category A or M is taken by the Secretary of State, after consultation with the PSNC.
- 4.3 Part VIIIA explains how Category A prices are calculated. In relation to Category A, Part VIIIA says: "*The Secretary of State determines the prices for Category A drugs to be the average of the price calculated for the pack size listed in the Drug Tariff weighted by the following four manufacturers and suppliers; AAH, Alliance Healthcare (Distribution) Ltd, Teva UK and Actavis/Accord on or before the 8th of the month being reimbursed. In the weighted formula, AAH and Alliance Healthcare (Distribution) Ltd prices have a weighting of 2, the prices from the other suppliers have a weighting of one (Either Actavis or Accord's list price is used in the weighted formula; in circumstances where a product is listed by Actavis and Accord, then Accord's list price is used in the weighted formula).*"
- 4.4 A product has to score 4 in the weighted formula to be considered for Category A. That is, the product has to be available from both AAH and Alliance Healthcare (Distribution) Ltd, or from one of those companies plus both of the other suppliers, in order to prompt a discussion with PSNC over the possibility of the product moving into Category A.

### The problem with the current arrangements

- 4.5 Manufacturers' and wholesalers' price lists do not reflect actual selling prices and do not take into account any discounts and rebates given to pharmacy contractors by the manufacturers and wholesalers. Because of this, reimbursement prices for generic medicines in Category A do not reflect selling/purchase prices. In some

instances, we have seen reimbursement prices in the Drug Tariff that are ten times the price that the pharmacy contractor paid for the medicine.

- 4.6 We are also aware of instances where the supplier has multiple price lists, does not produce price lists or uses the Category A reimbursement price in the Drug Tariff as their list price.
- 4.7 The Department believes that, in principle, Drug Tariff reimbursement prices should reflect actual selling prices so that no more medicine margin than intended is retained and pharmacy contractors would be encouraged to source below the Drug Tariff reimbursement price which would then be based on averages. Whilst any medicine margin above the anticipated medicine margin will be found in the medicine margin survey and clawed back, excessive medicine margin on some products means that not all community pharmacies have equitable access to medicine margin. In addition, high reimbursement prices that do not reflect actual purchase prices may deter prescribers from prescribing a medicine, potentially to the detriment of a particular patient.

## **Our proposal for reform**

- 4.8 To address the problem outlined above we propose that we use actual purchase, sales and volume information already obtained in the quarterly collection under the Health Service Products (Provision and Disclosure of Information) Regulations 2018 to set Category A reimbursement prices. This would ensure that reimbursement prices better reflected selling prices. The reimbursement prices that would be set would include medicine margin to allow pharmacy contractors to earn medicine margin on the Category A generic medicines they dispense. If this proposal goes ahead, we anticipate that unlike the medicine margin on Category M medicines, the medicine margin on Category A medicines would not be adjusted to achieve the annual amount of medicine margin under CPCF (£800 million).

## **Further follow-up consultation with the PSNC on detail**

- 4.9 Subject to the views expressed on this proposal, if it were to go ahead, we would consult the PSNC on the methodology for calculating Category A reimbursement prices using quarterly information obtained under the Health Service Products (Provision and Disclosure of Information) Regulations 2018. The transitional arrangements, i.e. the gradual introduction of Category A reimbursement prices based on actual selling price, would also be part of the discussion with PSNC.

## Questions

Question 1: Do you agree with the proposed reform?

Question 2: Do you have any comments on the proposed reform?

## **5. Changes to the distribution of medicine margin added to generic medicines in Category M**

### **Current reimbursement arrangements**

#### Category M

- 5.1 If a medicine is prescribed generically and the medicine is listed in Part VIIIA of the Drug Tariff, pharmacy contractor in England will be reimbursed for it according to the price listed in Part VIIIA. As explained above, there are essentially three Categories of drugs listed in Part VIIIA of the Drug Tariff, referred to by the letters A, C and M. Category C products are the products in the main not generally available as a generic.
- 5.2 Category M prices are calculated based on quarterly information provided by all manufacturers and suppliers. This information is obtained under the Health Service Products (Provision and Disclosure of Information) Regulations 2018.
- 5.3 To be in Category M, a drug must be available as a generic. The guideline criteria for Category M are that the drug is available from more than one manufacturer and the drug fulfils minimum spend and/or volume requirements.
- 5.4 Category M reimbursement prices are based on quarterly information provided under the Health Service Products (Provision and Disclosure of Information) Regulations 2018 from suppliers. The reimbursement prices include medicine margin allowing pharmacy contractors to earn medicine margin on the medicines they dispense. Category M is also the main tool for the Department to support the delivery of the £800 medicine margin.

#### Branded generics

- 5.5 In some instances, branded versions of generic medicines are available that are priced below the Category M reimbursement price. If they are prescribed by their brand name, those branded medicines are reimbursed under non-Part VIII arrangements i.e. the list price of the manufacturer, wholesaler or supplier from which the dispensing contractor sourced the medicine. Unlike the Category M reimbursement prices, reimbursement prices of branded medicines are not adjusted to deliver the £800 million medicine margin and as a consequence, the branded version may appear cheaper than the generic in Category M.

## The problem with the current arrangements

- 5.6 Some suppliers of branded manufacturers price their products below the Category M reimbursement price. Because the branded version then appears cheaper, this encourages CCGs and prescribers to prescribe the product by brand rather than generically. To take the simplest example, of how this might work in practice, as mentioned above, when a GP prescribes a medicine, the software that they use will generally inform them of the Drug Tariff reimbursement price of the medicine. It will also generally inform them of branded versions of the medicine that are available and their prices. It may therefore look to the GP that a branded version represents good value to the NHS because its list price is significantly below the Drug Tariff reimbursement price.
- 5.7 In reality however, the branded medicine may well be more expensive to the NHS because it does not contribute as much to the £800 million medicine margin under the CPCF. Pharmacies do not earn any or very little medicine margin when they dispense the branded product which leads to a shortfall in medicine margin that will need to be recovered elsewhere from pharmacies and ultimately CCGs.
- 5.8 In addition, where a CCG recommends prescribing the branded product because they see it as cheaper to it, pharmacy contractors in the CCG's catchment area do not have equitable access to medicine margin as they do not retain medicine margin on brands. This also means that not all CCGs contribute equally to the £800 million medicine margin under the CPCF. So, that particular CCG may benefit as a consequence of a smaller amount being apportioned to it in relation to a particular transaction, but CCGs as a cohort and the NHS overall will lose out.

## Our proposal for reform

- 5.9 To address the problem outlined above we propose that we change the distribution of medicine margin added to generic medicines in Category M. We propose to add less medicine margin to those generic medicines for which branded equivalents are available and that are priced below the generic medicine, and as a consequence add more medicine margin on all other Category M medicines. This will help address the problem that some generic medicine appear more expensive than the branded version.

## Further follow-up consultation with the PSNC on the detail

- 5.10 Subject to the views expressed on this proposal we will consult the PSNC on the detailed methodology for calculating the medicine margin added to generic medicines in Category M in order to give effect to the principle outlined above.

## Questions

Question 1: Do you agree with the proposed reform?

Question 2: Do you have any comments on the proposed reform?



## **6. Changes to the determination of reimbursement prices of medicines in Category C which are prescribed generically but have multiple suppliers**

### **Current reimbursement arrangements**

- 6.1 Part VIIIA of the Drug Tariff is about generically prescribed medicines. As has been noted, there are essentially three Categories of drugs listed in Part VIIIA of the Drug Tariff, referred to by the letters A, C and M. Category C products are the products in the main not generally available as a generic. However, generic medicines without any competition, or with very limited competition may also be in Category C.
- 6.2 Category C reimbursement prices are based on the price of a particular product. The Secretary of State generally determines the reimbursement price as the price listed by the manufacturer or supplier on or before the 8th of the month being reimbursed
- 6.3 This means that although reimbursement arrangements for Category C medicines assume that there is no competition for what, mostly, will be branded medicines, in reality there are Category C products that compete with each other - and this is not currently reflected in the pricing mechanism.

### **The problem with the current arrangements**

- 6.4 Where a Category C product is prescribed generically but more than one version product is available, there may also be discounts on offer to pharmacy contractors. This means that the current reimbursement prices for medicines with competition in Category C will not reflect actual selling/purchase prices and as a consequence contribute to cash flow issues.
- 6.5 This being so, effectively the reimbursement price listed in the Drug Tariff will be too high, having regard to the market overall. As a consequence, the NHS/CCGs pay more for Category C medicines in general and branded medicines in particular than it needs to, where there is competition.

## Our proposal for reform

- 6.6 To address the problem outlined above we are proposing two options for generically prescribed products in Category C:

### Option 1

- 6.7 Under option one, for branded medicines in Category C with multiple suppliers, we would determine the reimbursement price by using the weighted average of the relevant suppliers' list prices as published on the Dictionary of medicines and devices (dm+d, explained in Chapter 2), adjusted for prescribing volume, instead of the supplier's list price. The basket of prices would reflect the products in dm+d that could have been supplied to meet a generic prescription for the product in question.
- 6.8 We would work with the PSNC to introduce a process for pharmacy contractors to appeal a list price published on the Dictionary of medicines and devices (dm+d) which then fed into the weighted average calculation.

### Option 2

- 6.9 Under option two, for branded medicines in Category C with multiple suppliers, we would determine the reimbursement price using actual sales and volume data from suppliers. This would mean that those medicines would need to be included in the quarterly collection of sales and purchase information from manufacturers and wholesalers. Initially, as a quarterly ad-hoc request under Part Four of the [Health Service Products \(Provision and Disclosure of Information\) Regulations 2018](#). However, the Department would then consult on amending the Regulations to include these medicines in quarterly collection arrangements that parallel those under Part Three of the Regulations.

## Further follow-up consultation with the PSNC on the detail

- 6.10 Subject to the views expressed on this proposal we will consult the PSNC on the detailed methodology for calculating the Part VIIIA reimbursement prices for Category C medicines with multiple suppliers as well as any transitional arrangement for a gradual introduction of the change - and any additional appeals mechanisms as mentioned above.

## Questions

Question 1: Do you agree with the proposed reform?

Question 2: Do you have a preference for option 1 or option 2?

Question 3: Do you have any comments on the proposed reform?

## **7. Inclusion of drugs (other than licensed and unlicensed medicines) with a reimbursement price in Part VIII**

### **Current reimbursement arrangements**

- 7.1 There are products treated as "drugs" that are not medicines but that have been prescribed for medical purposes such as medical foods, commercially available food supplements and some dermatological products.
- 7.2 Some of these products have been included with a reimbursement price in Category A or C in Part VIIIA of the Drug Tariff. Drugs not listed with a reimbursement price are reimbursed under the non-Part VIII arrangements i.e. the list price of the manufacturer, wholesaler or supplier from which the dispensing contractor sourced the medicine.

### **The problem with the current arrangements**

- 7.3 Not many drugs which are not medicines are currently listed with a reimbursement price in Part VIIIA of the Drug Tariff. Because most of these products are currently reimbursed under the non-Part VIII arrangements i.e. the list price of the supplier (manufacturer or wholesaler), pharmacy contractors will source products with the biggest discount and not the drug that has the lowest list price. As a consequence, the NHS/CCGs pay more for those products than is necessary.
- 7.4 Because of the disparity in reimbursement, the amount paid for essentially the same products varies across CCGs and within CCGs.

### **Our proposal for reform**

- 7.5 To address the problem outlined above we are proposing to include more "drugs" that are not medicines with a reimbursement price in Part VIII.
- 7.6 We are proposing two different options for the reimbursement of these particular drugs:

## Option 1

- 7.7 Under option 1, for drugs that are not medicines but which are to be listed with a reimbursement price in the Drug Tariff, we would determine the reimbursement price by using the weighted average of the relevant suppliers' list prices as published on the Dictionary of medicines and devices (dm+d) (explained in Chapter Two). The basket of prices would reflect the products in dm+d that could have been supplied to meet a generic prescription for the product in question.
- 7.8 We would work with the PSNC to introduce a process for pharmacy contractors to appeal a list price published on the Dictionary of medicines and devices (dm+d) which then fed into the weighted average calculation.

## Option 2

- 7.9 Under option 2, for drugs that are not medicines but which are to be listed with a reimbursement price in the Drug Tariff, we would determine the reimbursement price using actual sales data from suppliers. This would mean that the drugs in question would need to be included in the quarterly collection of sales and purchase information from manufacturers and wholesalers. Initially, as a quarterly ad-hoc request under Part Four of the [Health Service Products \(Provision and Disclosure of Information\) Regulations 2018](#). However, the Department would then consult on amending the Regulations to include non-medicines in quarterly collection arrangements that parallel those under Part Three of the Regulations.

## Further follow-up consultation with the PSNC on the detail

- 7.10 Subject to the views expressed on this proposal we will consult the PSNC on the detailed methodology for calculating the reimbursement prices for drugs which are not medicines but which are to be newly listed in the Drug Tariff, as well as any transitional arrangement for a gradual introduction of the change - and any additional appeals mechanisms as mentioned above.

## Questions

Question 1: Do you agree with the proposed reform?

Question 2: Do you have a preference for option 1 or option 2?

Question 3: Do you have any comments on the proposed reform?

## 8. Changes to the determination of reimbursement prices for non-part VIIIA drugs

### Current reimbursement arrangements

8.1 Non-Part VIIIA drugs are those "drugs" whose non-proprietary name is not listed with a reimbursement price in Part VIIIA of the Drug Tariff which are not reimbursed as unlicensed medicines under Part VIIIA. As explained earlier, this includes products prescribed for a medical purpose such as medical foods, food supplements and some dermatological products. The Department aims to include as many products as possible with a reimbursement price listed 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.

### The problem with the current arrangements

- 8.2 If the prescription is written generically for a non-Part VIIIA product, pharmacy contractors will source drugs with the biggest discount and not the drug that has the lowest list price. Because pharmacy contractor are reimbursed the list price of their supplier, the NHS/CCGs pay more for those products than is necessary.
- 8.3 Because of the disparity in reimbursement, the amount paid for essentially the same products varies across CCGs and within CCGs.
- 8.4 If a prescription is written by brand, then the pharmacy contractor, as explained above, has to dispense that branded version of the product, even if there would have been other alternatives available if the product had been prescribed by brand.

### Our proposal for reform

- 8.5 To address the problems outlined above we propose that:
- 8.6 For **single source products** we base the non-Part VIIIA reimbursement price for prescriptions written generically, on the manufacturer's list price as published on the Dictionary of medicines and devices (dm+d).

- 8.7 For **multi-source products** for prescriptions written generically, we base the non-Part VIII A reimbursement price on average weighted list prices of suppliers as published on the Dictionary of medicines and devices (dm+d). The weighted average of the supplier's list prices from the previous month as published on the Dictionary of medicines and devices (dm+d) will be published to provide an indicative reimbursement price to pharmacy contractors.
- 8.8 For single and multi-source products for prescriptions written by brand the reimbursement price will be the manufacturer's list price on the Dictionary of medicines and devices (dm+d).
- 8.9 We would work with the PSNC to introduce a process for pharmacy contractors to appeal a list price published on the Dictionary of medicines and devices (dm+d).

## **Further follow-up consultation with the PSNC on the detail**

- 8.10 Subject to the views expressed on this proposal we will consult the PSNC on the methodology for calculating the reimbursement prices for non-part VIII A drugs. We will consult the PSNC on the detailed methodology for calculating the non-Part VIII A reimbursement prices, as well as any transitional arrangement for a gradual introduction of the changes

## **Questions**

Question 1: Do you agree with the proposed reform?

Question 2: Do you have any comments on the proposed reform?



## **9. Changes to the arrangements for reimbursing and procuring unlicensed medicines ('specials')**

### **Current reimbursement arrangements**

- 9.1 'Specials' are products which have been specially manufactured or imported for the treatment of an individual patient after being ordered by a doctor, dentist, nurse independent prescriber, pharmacist independent prescriber, supplementary prescriber. An unlicensed medicinal product of this sort may only be supplied in order to meet the special needs of an individual patient. An unlicensed medicinal product of this sort should not be supplied where an equivalent licensed medicinal product can meet the special needs of the patient.
- 9.2 The most commonly prescribed specials are listed with a reimbursement price in Part VIII B 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. Specials will be included in Part VIII B of the Drug Tariff when they fulfil the minimum spend and/or volume requirements.
- 9.3 Any special not listed in Part VIII B of the Drug Tariff is reimbursed at the invoice price (less any discount or rebate).
- 9.4 Part VIII B was introduced in 2011 and as a consequence the average reimbursement price of a special has gone down from £192 in 2010 to £116 now. The average cost of a specials listed with a reimbursement price in Part VIII B is currently £62 and the average cost of a non-part VIII B special is £182. The introduction of Part VIII B, together with a reduction in prescribing of specials, reduced NHS expenditure on specials in the community from £136 million in 2010 to £66 million in 2018.

### **The problem with the current arrangements**

- 9.5 The reimbursement arrangements for specials listed with a reimbursement price in Part VIII B work well but the scope of Part VIII B is currently restricted to manufactured non- solid dosage forms (e.g. liquids, creams and lotions) whilst 40 percent (about £26 million) of our expenditure on specials is on tablets and capsules, the majority of which are imported.

9.6 For non-Part VIII B specials there is no incentive for pharmacy contractors to source at the cheapest price possible because they are reimbursed the invoice price (less any discount or rebate). 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 the special.

## **Our proposals for reform**

9.7 To address the problem outlined above we propose that, where possible, we include tablets and capsules with a reimbursement price in Part VIII of the Drug Tariff. Manufacturers and wholesalers are already providing information about approximately 100 tablets and capsules (covering 95 percent of our expenditure on special capsules and tablets).

9.8 For those specials for which we cannot introduce a reimbursement price in Part VIII we are seeking views on four possible solutions:

- Require pharmacies to obtain three quotes for non-Part VIII specials ('quotes')
- Set up or procure a central approvals service for non-Part VIII ('central approvals service')
- Procure the central supply of non-Part VIII specials and then supply on to pharmacies ('central supply') or procure a service that sources specials on behalf of the NHS ('central procurement service')

9.9 Once we include capsules and tablets with a reimbursement price in Part VIII of the Drug Tariff, we expect any of these solutions to cover a maximum of 100,000 items representing about £22 million in expenditure.

### **Option 1: Quotes**

9.10 We would require pharmacy contractors to seek three quotes and to submit those quotes to the NHS BSA. Pharmacy contractors would be reimbursed the price of the cheapest quote but would also continue to be remunerated the £20 SP fee.

9.11 Whilst this would be a relatively straightforward option we believe that this option is unlikely to address the problem as the three quotes may not be the cheapest options available.

## Option 2: Central approvals service

- 9.12 DHSC or NHSE&I would set up or procure a central approvals service for quotes for non-Part VIII B specials.
- 9.13 We would require pharmacy contractors to seek approval from the central approvals service for every quote for a non-Part VIII B special. The central approval service then either approves or declines the quote. If the quote is declined then the service would provide the pharmacy contractor with an indication of what would be an acceptable price. We believe that the majority of quotes can be dealt with relatively easily based on historic purchase prices.
- 9.14 A more dressed up central approvals service could also liaise with pharmacies and GPs where specials have been prescribed for which either a licensed alternative is available or a special listed with a reimbursement price in Part VIII B.
- 9.15 Pharmacy contractor would be reimbursed the invoice price of the special that is dispensed and would also continue to be remunerated the £20 SP fee.
- 9.16 Alternatively, each CCG could set up their own approvals service but we believe it would be preferable to centralise this task to ensure an efficient service and central knowledge about pricing of specials.

## Option 3: Procurement

- 9.17 DHSC/NHSE&I would procure non-Part VIII B specials for pharmacy contractors. There are two options for this:
- a) central supply of non-Part VIII B specials
  - b) a central procurement service for non-Part VIII B specials

### Option 3a: Central supply

- 9.18 DHSC/NHSE&I would procure the central supply of non-Part VIII B specials to pharmacies. This could be one or multiple (regional) contracts, with the expectation that the contractor who won the contract might sub-contract some supply that it could not fulfil itself.
- 9.19 Pharmacy contractors would be required to contact the central service for each prescription for a special. The central supply service then provides the pharmacy with the special, either directly or indirectly via a sub-contractor.

9.20 Pharmacy contractors would not be reimbursed but they would continue to be remunerated the £20 SP fee.

### Option 3b: Central procurement service

9.21 DHSC/NHSE&I would procure a central procurement service for non-Part VIII B specials. The contract would be for a service that sources specials at the cheapest possible price by sourcing from across the industry (but the service does not directly supply or pay for the special). NHSE&I would then pay the company supplying the special directly.

9.22 Pharmacy contractors would be required to contact the central service for each prescription for a special. The central supply service would then seek the cheapest supplier who will provide the special to the pharmacy.

9.23 Pharmacy contractors would not be reimbursed but they would continue to be remunerated the £20 SP fee.

### Further follow-up consultation with the PSNC on the detail

9.24 Subject to the views expressed on these proposals we will consult the PSNC on the detailed methodology for calculating the reimbursement prices for tablets and capsules for which we are able to include a reimbursement price in the Drug Tariff.

9.25 We will also work closely with the PSNC on implementing the solution for non-Part VIII specials. Depending on the option that will be progressed, we will also work on implementation with the relevant industry bodies including the Association of Pharmaceutical Specials Manufacturers (APSM).

### Questions

Question 1: Do you agree that DHSC should include tablets and capsules with a reimbursement price in the Part VIII of the Drug Tariff?

Question 2: Do you have any comments on the proposal to include tablets and capsules with a reimbursement price in the Part VIII of the Drug Tariff?

Question 3: Which is your preferred option for the procurement and reimbursement of specials that cannot be listed with a reimbursement price in Part VIII of the Drug Tariff?

Question 4: Do you have any comments on the options and/or do you think there are additional options that should be considered?

## 10. Changes to the reimbursement of generically prescribed appliances and drugs dispensed as 'specials'

### Current reimbursement arrangements

- 10.1 There are instances where a pharmacy contractor dispenses a special (i.e. an unlicensed medicine - see the previous chapter) against a generically written prescription when they could have dispensed an appliance or, in other cases, a drug that is not a special.
- 10.2 If an appliance is dispensed, the pharmacy contractor will be reimbursed the reimbursement price listed in Part IX of the Drug Tariff. If a drug other than a special is dispensed, unless there is a reimbursement price listed in the Drug Tariff, the pharmacy contractor is reimbursed the list price of the supplier that the pharmacy contractor has sourced the drug from, which may be a manufacturer or wholesaler.
- 10.3 If a special is dispensed, the pharmacy contractor will be reimbursed either the Part VIIIB reimbursement price or the invoice price (less any discount and rebate) and will be remunerated the £20 SP fee.

### The problem with the current arrangements

- 10.4 If a product is listed as an appliance in Part IX of the Drug Tariff it cannot also be considered a medicine.
- 10.5 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 where other options were available, this costs the NHS, because it pays more than when it would have done if instead the pharmacy contractor had dispensed an appliance or drug. This means that the NHS is not getting good value for money from its spend on these products.

## Our proposal for reform

- 10.6 To address the problem outlined above we propose that pharmacy contractors are reimbursed the price of the appliance in Part IX of the Drug Tariff for a generically written prescription that can be fulfilled by an appliance or a special, regardless of whether they dispensed an appliance or a special.
- 10.7 We also propose that pharmacy contractors that, in response to a generically written prescription that can be fulfilled either by a drug (non-medicines that have been prescribed for medical purposes) or a special, regardless of whether they dispensed the drug or the special, are reimbursed either the reimbursement price for the drug in Part VIII or, if there is no reimbursement price in Part VIII, are reimbursed under the new non-Part VIII reimbursement arrangements for drugs (i.e. weighted average list prices of suppliers as published on dm+d or the manufacturer's list price as listed on dm+d). This proposal does not impinge on the clinical freedom of healthcare professionals as they still will be able to indicate on the prescription that a special is required for their patient, but what it does it provides transparency around reimbursement in situations where both type of products are available on the market.

## Further follow-up consultation with the PSNC on the detail

- 10.8 Subject to the views expressed on these proposals we will consult the PSNC on the detailed methodology for the implementation of these proposals.

## Questions

Question 1: Do you agree with the proposed reform?

Question 2: Do you have any comments on the proposed reform?

# 11. Changes to the deduction scale to reflect different levels of discount for branded and generic medicines

## Current reimbursement arrangements

- 11.1 Pharmacy contractors are paid monthly for the items they dispensed in a given month. Every month a deduction is made to their payments, based on a scale known as the 'deduction scale'. This is an assumed amount of discount received to avoid pharmacy contractors having to calculate and declare discount received on each item dispensed.
- 11.2 Currently, the deduction scale is based on the monthly total of prices paid to the pharmacy contractor with a minimum of 5.63% and a maximum of 11.5% deducted from the monthly total. The amounts within this maximum and minimum are set out in a Table in the Drug Tariff.<sup>2</sup>

## The problem with the current arrangements

- 11.3 We know from information obtained from pharmacy contractors as part of the medicine margin survey that branded medicines do not attract as much discount as generic medicines. Pharmacy contractors, on average, dispense branded medicines at a loss. Currently, as indicated above, the 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 medicine margin. Additionally, CCGs in areas where more branded medicines are prescribed are not paying their fair share of medicine margin.

## Our proposal for reform

- 11.4 To address the problem outlined above we propose that the deduction scale is split into two separate scales, one for generic medicines and one for branded medicines. This will on average improve equitable access to the medicine margin

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<sup>2</sup> See Part V of the Drug Tariff

for community pharmacies and it will improve the deduction scale apportionment to CCGs.

- 11.5 Separately, NHSE&I would need to consider amendments to the CCG apportionment arrangements with a view to making them more equitable.

## **Further follow-up consultation with the PSNC on the detail**

- 11.6 Subject to the views expressed on these proposals we will consult the PSNC on both the detail of and operationalising the proposed changes to the deduction scale.

### **Questions**

Question 1: Do you agree with the proposed reform?

Question 2: Do you have any comments on the proposed reform?



## 12. Implementation of the reforms

12.1 The detail of implementation of the reforms will be subject to consultation with the PSNC. We are however aiming to introduce the reforms from April 2020. The table below provides an indication of the timetable for each reforms.

Proposal		Page	Indicative timeline
1.	Changes to the determination of reimbursement prices of generic medicines in Category A	20	Gradually from April 2020. To be completed by January 2021.
2.	Changes to the distribution of medicine margin added to generic medicines in Category M	23	April 2020.
3.	Changes to the determination of reimbursement prices of branded medicines with multiple suppliers in Category C	26	Earliest April 2020 (depending on the option DHSC decides on). Gradual implementation.
4.	Inclusion of drugs (other than licensed and unlicensed medicines) with a reimbursement price in Part VIII	29	Earliest April 2020 (depending on the option DHSC decides on).
5.	Changes to the determination of reimbursement prices for non-part VIIIA drugs	32	April 2020.
6.	Changes to the arrangements for reimbursing and procuring unlicensed medicines ('specials')	34	Earliest January 2020 for the inclusion of capsules and tablets in Part VIII of the Drug Tariff.  January 2021 for non-part VIII arrangements.
7.	Changes to the reimbursement of generically prescribed appliances and drugs dispensed as 'specials'	38	Earliest January 2020.

8.	Changes to the deduction scale to reflect different levels of discount for branded and generic medicines	40	April 2020.
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## 13. Responding to the consultation

- 13.1 Responses to this consultation are invited by 17 September 2019.
- 13.2 The preferred method of receiving your response is via the [online consultation questionnaire](#).
- 13.3 Alternatively, you may wish to email your responses to:  
[pharmacyreimbursement@dhsc.gov.uk](mailto:pharmacyreimbursement@dhsc.gov.uk)
- 13.4 If you do not have internet or email access, then please write to:

Department of Health and Social Care

Pharmacy Team

c/o Matthew DiClemente

North Wing, Floor 2

Quarry House

Leeds LS2 7UE

### Comments on the consultation process itself

- 13.5 If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact the Consultations Coordinator at:

Department of Health and Social Care

Quarry House

Leeds LS2 7UE

e-mail: [consultations.co-ordinator@dh.gsi.gov.uk](mailto:consultations.co-ordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address.**

## Confidentiality of information

- 13.6 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.
- 13.7 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
- 13.8 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.
- 13.9 The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

# Annex A: Impact assessment

An economic impact assessment has been produced and has been published together with this consultation document.

## Questions

Question 1: Do you have any comments on the impact assessment (not already provided under any of the previous question)?

# **Annex B: Overview of the proposed reimbursement reforms**

An overview of the proposed reimbursement reforms has been published together with this consultation document.

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Prevention, Community and Social Care

Medicines and Pharmacy Directorate

Pharmacy Team

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