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SUPPLY AND DEMAND FOR MEDICINES
ROYAL SOCIETY OF EDINBURGH RESPONSE

Summary

The inquiry from the Health and Sport Committee comes at a critical time for primary care in Scotland; one in which technological development is creating new opportunities, while growing challenges are presented from an ageing population and an increasing prevalence of multi-morbidity.

The health service faces immense pressure on resources and has seen a decrease in the number of GPs, both in total number and Whole Time Equivalent. This is coupled with increases over the last decade in both the quantity of medicines prescribed and the total cost of supplying these.

The decision not to cover advice on the clinical and cost-effectiveness of new medicines in the Committee's inquiry may reduce its impact.

In order to ensure that patients receive the most clinically and cost-effective treatments, it is vital that drugs are prescribed on the strongest possible evidence base.

The issue of drug wastage – through unused and expired drugs, and changes in prescriptions – could partly be addressed through testing expired drugs to potentially extend their life for further use. Research into drug wastage could also provide a stronger evidence base for deciding the most appropriate supply length period for chronic medicines prescription.

Polypharmacy is increasingly a major issue for the National Health Service and the RSE recognises that it is an area in which NHS Scotland is highly active in seeking to identify best practice. NHS Scotland and Scottish Government have invested to provide both guidance to clinicians and informatics tools to support polypharmacy review in this area.

In some circumstances the prescription of medication may be replaced with a social prescription, particularly in cases of certain chronic conditions. Moving towards such a system would likely prove a long process of change and social prescribing must be held to the same evidential standards as medicines when determining its benefits.

International comparisons suggest that overall drug spending, in the UK as a whole, is lower than most other European Union counties.

Cultural drivers exist when prescribing medication, with many patients holding the expectation that they will always be prescribed drugs to deal with their medical complaint. For this to change there needs to be a culture change across Scotland around what we, as patients, expect from appointments and primary care services.

Summary

Poor adherence to certain treatment regimes by patients is common, with adherence particularly poor for chronic conditions without symptoms. Additional time for clinicians to explain the importance of prescribed medication, coupled with the emergence of new technology to prompt patients, could improve this.

There is not a strong culture of "de-prescribing" – whereby the time a patient will be on medication and the effects of them ceasing this treatment are carefully considered – across the healthcare professions. A change in culture – starting with the training of young doctors – is required as is a need to conduct research to fill the evidence gap in when to stop chronic medicines.

In general, the current structure of local drug and therapeutic committees, is robust, provides for a strong system of checks and balances, with these committees also delivering local education and ownership of prescribing decisions.

Important limitations to best prescribing practice do remain, however, and are often caused by lack of joined up systems between different parts of secondary care, and between secondary care and primary care. This is a major issue in Scotland that NHS Education Scotland's Digital Service can play a role in addressing.

For NHS Scotland to be as efficient as possible, it must take a data-driven approach to ensuring that patients are being given the most appropriate drugs to suit their diagnosis. Analysis must look at a range of data, at a variety of spatial scales, not simply at the health board level, as there are also important variations by drug, by practice and by locality.

Scotland is a leader in collecting and integrating healthcare data and substantial opportunities exist to utilise this data to make the system more efficient and allow health professionals, practices and boards to better understand the roles required within the system. Problems currently exist around the inability of health professionals to access this data and the quality of feedback must improve to allow clinicians and health boards to access actionable data to analyse and improve performance.

It is difficult to draw definitive conclusions on the impact on prescribing of abolishing prescription charges in Scotland in 2011.

Making certain drugs available over-the-counter to patients could result in savings for the health service in Scotland, although the way they are recategorized could affect how effective such a decision may be in terms of improving convenience and accessibility.

One of the key aspects of an effectively running and efficient system is the cohesiveness of a team of professionals working to their respective strengths. For the system to work optimally, the right professional is required at the right time while working as part of integrated multi-disciplinary team.

NHS Scotland is under immense strain both from an ageing population and decrease in the number of GPs. Short, often ten-minute, slots apportioned to patients are generally inadequate to allow doctors sufficient time to diagnose patients and recommend treatment and so clinician-patient time must be increased as part of a wider reorganisation of the team providing care.

Introduction

1 As Scotland's National Academy, the Royal Society of Edinburgh (RSE) welcomes the opportunity to respond to the consultation from the Scottish Parliament Health and Sport Committee on the Supply and Demand for Medicines. This response was produced drawing upon the expertise of a working group of RSE Fellows comprising a diverse range of backgrounds including general practice, clinical pharmacology, primary care and academia. We would be pleased to discuss further the issues raised in our response with members of the Health and Sport Committee. Our recent response to the Committee's earlier consultation on The Future of Primary Care is also of relevance to the present consultation.[1]

2 The RSE possesses a wealth of health expertise within our Fellowship. We plan to formalise our engagement in this area in order to fully realise the contribution that the RSE is able to make to support the development and scrutiny of health-related policy in Scotland. We should be pleased to discuss our plans in this area with the Health and Sport Committee.

General Comments

Importance of Primary Care

3 The Royal Society of Edinburgh would like to recognise the outstanding work of those involved in the primary care sector. This inquiry comes at a critical time for primary care in Scotland; one in which technological development is creating new opportunities, while growing challenges are presented from an ageing population and an increasing prevalence of multi-morbidity (multiple medical conditions). The immense pressure on resources, including on staffing, and the need to find the correct balance of funding between generalist and specialist services is also noted.

4 General Practitioners – who are responsible for the vast majority of prescribing in general practice – continue to do an admirable job in increasingly difficult circumstances. According to the Primary Care Workforce Survey, the estimated total number of GPs working in Scottish general practice decreased slightly between 2013 and 2017 from 4,465 to 4,453. More concerningly, the estimated number of Whole Time Equivalent (WTE) GPs fell from 3,735 in 2013 to 3,575 in 2017; a decrease of over 4%.[2] This fall in GP numbers risks causing increased costs through a range of mechanisms: medicines could be prescribed that may not have been, had the regular doctor attended; reduced time for consultations may lead to the issuing of a prescription rather than exploration of non-pharmacological interventions; insufficient medication reviews for people on repeat prescriptions; or insufficient attention to medicines reconciliation upon hospital discharge (this is a particular issue for patients presenting with concerns over their mental health).

5 This decrease in GP capacity has occurred simultaneously with a rise in the number of prescriptions across Scotland. The Audit Scotland report on 'Prescribing in general practice in Scotland', highlighted by the Health and Sport Committee in its call for evidence, shows that while the quantity of drugs prescribed increased by 33% between 2004/5 and 2011/12, spending on primary care prescriptions actually fell by 11% in real terms. This decrease in costs was largely as a result of drug patents expiring and cheaper generic drugs becoming available.[3]

6 More recent statistics, however, suggest that both number of prescriptions and total costs have increased in the last decade. Between 2009/10 and 2018/19 the total (net) cost of reimbursing medicines and appliances, and providing services increased by 20% while the total number of items dispensed and reimbursed increased by 15.8%.[4]

New Drugs

7 While the RSE welcomes the consultation from the Health and Sport Committee, and the opportunity to respond to it, the decision not to cover advice on the clinical and cost-effectiveness of new medicines may reduce the inquiry's impact. Several of the new medicines that will become available in the next few years will compete for resources and have significant cost implications e.g. the newer anticoagulants (DOACs) prescription costs are >£50 per month replacing warfarin where prescription costs are <£1 per month (although warfarin has other costs relating to blood testing, highlighting that the true costs of treatment cross budget boundaries).

1 https://www.rse.org.uk/wp-content/uploads/2019/09/AP19-10.pdf

2 NHS Scotland, Primary Care Workforce Survey Scotland 2017, p8 https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Report.pdf

3 Audit Scotland, Prescribing in general practice in Scotland, pp6-7 https://www.audit-scotland.gov.uk/docs/health/2013/nr_130124_gp_prescribing.pdf

4 NHS Scotland, Prescribing & Medicines: Dispenser Payments and Prescription Cost Analysis, (July 2019) pp8-14 https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2019-07-23/2019-07-23-Dispenser-Payments-and-Prescription-Cost-Analysis-Report.pdf

8 Introducing new drugs can have an impact on the use of existing drugs that may be more cost effective. Given the limited resources of the health service, NHS Scotland must consider the cost as well as the clinical effectiveness of all the medicines it uses.

Question 1 Does the system ensure patients receive the most clinically and cost-effective treatments and, if not, how can this be improved?

Evidence Base

9 In order to ensure that patients receive the most clinically and cost-effective treatments, it is vital that drugs are prescribed on the strongest possible evidence base. Certain high-cost drugs may be prescribed in response to a number of conditions or symptoms, including some outside of a medication's primary purpose. For example, pregabalin, a drug designed primarily for the treatment of epilepsy, is also often prescribed for both anxiety and chronic pain. Pregabalin had the single highest gross ingredient cost (the price of medicines and appliances dispensed and reimbursed at list price) of any drug prescribed by the NHS in Scotland in 2017/18 at £36.38 million[5] (although this cost decreased by over 71% to £10.41 million in 2018/19).[6] It is of particular importance with such high-cost drugs that the evidence base for their use across the conditions they are prescribed to treat is robust. Too often there is an evidence gap between the development of a drug and the purpose for which it may routinely be used.

10 The effectiveness of the highest-cost drugs, which in turn cost the health service the greatest amount, must be proven and justifiable. It is notable that in some cases, actual medications may be cheaper, often due to lapse of patents, however, the machines or devices needed to administer or control these medications remain proprietary and expensive. For example, combination inhaler devices are almost always in the top ten most expensive items, even although the drugs they contain are cheap.[7]

11 Conversely, some medications which might be cheaper by unit, also suffer from a lack of robust evidence on their effectiveness. The criteria for prescribing medications must prioritise effectiveness and evidence, not simply cost.

12 The RSE notes that many of the devices used in hospitals suffer from the same lack of evidence base as some medicines and must be held to the same standard.

Cost Effectiveness

13 It is often stressed, both by Government and research bodies, that an integrated system of primary and social care should be the predominant source of care in the future. Insofar as this approach promotes healthy lifestyle choices, it reduces the need for medical intervention and so reduces the demand for medicines. Despite this perspective, in recent years there has been a notable focus on building new hospitals and increasing specialist funding. At the same time, primary care services have received only a very modest increase in funding as a proportion of total NHS spending (from 6.2% of the total budget in 2017/18 to 6.5% in 2019/20).[8] Altering this balance in funding has the opportunity to decrease the demand for medicines.

14 We note the success of the national focus on reducing antibiotic use led by the Scottish Antimicrobial Prescribing Group with continued falls in community prescribing since 2012. This success has come after a sustained effort, and a wider campaign should be considered beyond the narrow infection agenda and be diversified into the wider context of prescribing.

15 A significant proportion of drugs prescribed to patients are never used. These medicines are either discarded or eventually pass their expiration date. While, theoretically, unused drugs could be returned to the NHS unopened for redistribution, this raises questions over patient safety and may not prove acceptable to the public.

5 NHS Scotland, Prescribing & Medicines: Dispenser Payments and Prescription Cost Analysis, (July 2018) p7 https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2018-07-24/2018-07-24-Dispenser-Payments-and-Prescription-Cost-Analysis-Report.pdf

6 NHS Scotland, Prescribing & Medicines: Dispenser Payments and Prescription Cost Analysis, (July 2019) p32 https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2019-07-23/2019-07-23-Dispenser-Payments-and-Prescription-Cost-Analysis-Report.pdf

7 NHS Scotland, Prescribing & Medicines: Dispenser Payments and Prescription Cost Analysis, (July 2019) p17 https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2019-07-23/2019-07-23-Dispenser-Payments-and-Prescription-Cost-Analysis-Report.pdf

8 Scottish Government, Scottish Budget: 2019-20, p64 https://www.gov.scot/publications/scottish-budget-2019-20/pages/7/

16 Expired medication, however, can be fairly easily sent for testing to ascertain whether it is still effective and, if so, given official documentation to extend its life if appropriate. Doing this would be relatively inexpensive and would only require a small amount of the expired drug batch.

17 One way in which the current system looks to limit the number of drugs prescribed to patients which then go unused is through limiting the duration of chronic medicines prescription, typically to two months. However, although this reduces wastage if prescriptions are changed, this has to be balanced against the amount of patient, doctor and pharmacist time and resource used to reissue the many prescriptions which have not changed.

18 Patient inconvenience must also be taken into consideration. For example, while the ability to renew prescriptions on-line could improve efficiency and prove helpful for some patients, such a system is inaccessible to many older people who either do not use the internet or have failing cognitive function.

19 Research into drug wastage which does occur could provide a stronger evidence base for deciding the most appropriate supply length period to find the correct balance, with it being extended beyond two months if appropriate.

Polypharmacy

20 Polypharmacy (when patients are prescribed multiple medications taken concurrently) is increasingly a major issue for the National Health Service. While it is an issue that most commonly affects the frail elderly, the interconnecting relationship between physical and mental health means it has significant implications for those with long-term and enduring mental health issues, and is increasingly impacting upon many of the healthy ageing population. Polypharmacy can have various implications for medical practice which may undermine the clinical and cost-effectiveness of treatments, for example misdiagnosed iatrogenic (where illness is caused by the current treatment) symptoms resulting in new medications being prescribed, or combinations of medication undermining therapeutic benefit.[9]

21 The RSE recognises that it is an area in which NHS Scotland is highly active in seeking to identify best practice. Since 2012, NHS Scotland has published guidelines to assist clinicians, with the most recent Polypharmacy Guidance published in 2018.[10] This guidance highlights recommendations made by the EU-funded SIMPATHY project[11] to ensure medication safety.

22 As well as guidance, NHS Scotland and Scottish Government have invested in a number of informatics tools to support polypharmacy review, notably the Scottish Therapeutics Utility which supports the monitoring and review of repeat prescribing systems at practice level for potentially inappropriate prescribing, and which has a polypharmacy review tool currently being piloted and evaluated in NHS Tayside. The new GP contract driven expansion of the primary health team to include more pharmacists has the potential to transform medicines management in primary care, but it will be crucial to work to ensure that the potential of new informatics tools and changing primary care teams is realised.

Social Prescribing

23 One way to ensure patients get the most effective treatment is for clinicians to carefully consider under which circumstances the prescription of medication can be replaced with a "social prescription". This is likely to be of particular value in cases of chronic issues such as anxiety or pain where medicines may not be the best or only way to improve symptoms. While remedies such as increased social interaction and physical activity can prove highly effective, they also require structure and adherence from the patient.

24 Patients often have an expectation that they will always be prescribed painkillers to deal with pain. In some instances, however, providing access to gyms or fitness centres to strengthen muscles could be prescribed instead. This would require trained staff at these facilities to take patients through the best programme of physical treatment for them. Similarly, access for patients to physiotherapy within a very short timescale is needed.

9 The Kings Fund, Polypharmacy and medicines optimisation, px h ttps://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/polypharmacy-and-medicines-optimisation-kingsfund-nov13.pdf

10 Scottish Government, Polypharmacy Guidance, Realistic Prescribing, 3rd Edition, p6, https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/04/Polypharmacy-Guidance-2018.pdf

11 http://www.simpathy.eu/

25 Many patients who require prescriptions from GPs also suffer from psychological problems and are given medications to try to reduce anxiety and distress. While addressing this through social prescribing is a concept beyond the medical model of health, it is something that should be considered. Moving towards this system is likely to be a long process of change and one which would need to be accepted and adopted by government. Furthermore, while social prescribing appears an attractive option, it must be held to the same evidential standards as medicines when determining its benefits and reviewing its effectiveness.

Question 2 Does the NHS in Scotland achieve the most value from the money spent on medicines and, if not, how can this be improved?

Overall Spending on Drugs

26 International comparisons suggest that overall drug spending, in the UK as a whole, is lower than most other European Union counties. For example, spending on drugs per head of population in the UK is lower than in 18 EU states, including being more than 40% lower than the highest per capita spender, Germany. The UK also has the fifth lowest pharmaceutical spending as proportion of health spending (11.9% compared to 41.2% in the highest-spending EU country, Bulgaria) and the seventh lowest spending as a proportion of GDP (1.1% compared to 3.3% in the highest EU spender, again, Bulgaria).[12]

27 The Audit Scotland report highlighted in the call for evidence found that the UK as a whole fared similarly well in European comparisons in 2008, ascribing this to success of the UK-wide Pharmaceutical Price Regulation Scheme (replaced by the Voluntary Scheme for Branded Medicines Pricing and Access in January 2019) being able to negotiate lower drug prices than EU countries with insurance-based healthcare systems, and prescribing initiatives leading to a higher percentage of generic drug prescribing. [13]

Cultural Drivers and Expectation

28 In addition to the medical justification for prescribing, it is important to acknowledge the social drivers that exist. Many patients enter a general practice with the expectation that they will be prescribed drugs to deal with their medical complaint and this expectation can drive an appointment. Doctors are dealing with people, not simply medical conditions, and the pressure on them is often incredibly high to acquiesce when a patient wants what they see as a tangible remedy.

29 For this to change there needs to be a culture change across Scotland around what we, as patients, expect from appointments and primary care services. The example of antibiotic prescription is, potentially, a useful model to follow. The UK Five Year AMR (antimicrobial resistance) strategy aimed to slow the development and spread of AMR, with Scotland having a complementary multi-agency plan. Between 2012 and 2017 there was a reduction in primary care (where the vast majority of antibiotics are prescribed) antibiotic prescriptions in Scotland of 13.1%. Indeed, antibiotic prescribing in primary care in Scotland has fallen continually since 2012, and the rate of antibiotic use in 2017 was the lowest on record.[14]

Adherence

30 Poor adherence to certain treatment regimes by patients is common, with adherence particularly poor for chronic conditions without symptoms, for example hypertension. Figures suggest that as few as 50% of patients with high blood pressure continue to take their prescribed treatment after 12 months. This represents a very significant cost to the NHS, both in relation to wasted medicines if the prescription is unused, and in hospital care if the patient fails to take preventative treatment and has a stroke or heart attack as a result.

12 OECD data https://data.oecd.org/healthres/pharmaceutical-spending.htm

13 Audit Scotland, Prescribing in general practice in Scotland, p7 https://www.audit-scotland.gov.uk/docs/health/2013/nr_130124_gp_prescribing.pdf

14 NHS Scotland, Scottish One Health Antimicrobial Use and Antimicrobial Resistance in 2017, Appendix, https://www.hps.scot.nhs.uk/web-resources-container/scottish-one-health-antimicrobial-use-and-antimicrobial-resistance-in-2017/

31 In infectious diseases, poor adherence can result in the emergence of drug-resistant microorganisms. It is vital that clinicians are given the time to explain to patients the importance of the prescribed medicine to their personal health, discuss side effects, ask about potential difficulties in taking the medication, and explore reasons for poor adherence with patients where this is identified as an issue. Side effects can include a number of unpleasant symptoms which present legitimate reasons why patients may be hesitant to continue certain medications and clinicians need to be able to create a climate where patients can be honest and look at potential alternatives. Linking acts of daily living to the taking of medication and the use of dosette boxes have been traditional solutions to the problem of patients simply forgetting to take medication, although the emergence of new technology may offer help and prompts to patients to take treatments and improve adherence in this regard.

De-prescribing

32 Across the healthcare professions, there is not a strong culture of "de-prescribing"; whereby as part of the assessment of a patient and the development of a suitable treatment, the time the patient will be on medication and the effects of them ceasing this treatment are carefully considered. Outside the infection-antibiotic prescribing space there is very little research on the duration of drug effects, which means that patients who are prescribed a medication are often continued for life with uncertain benefit.

33 As such, a new culture must be developed whereby the expectation of a patient is, firstly that a range of options will be considered to address their issues, not necessarily prescriptions of drugs, and secondly, that if medication is prescribed that this is a course of drugs to be followed, which will end after a finite period of time after being reviewed.

34 Changing the culture in medicine to accommodate this starts with the training of the next generation of doctors. Young doctors are taught to expertly diagnose illness and prescribe medication to treat but are not taught how to stop drugs. This needs to change. Very few stopping trials take place and the lack of evidence for when to stop chronic medicines was highlighted as a key research gap to fill by the NICE guideline on multimorbidity.[15]

35 The emergence of individualised medicine may assist with more accurate prescribing with limited duration regimens. Even with such systems in place, doctors will need the time and resources to talk with patients about their treatment and what they can and should expect. Some patients will wish to simply have a doctor hear their symptoms and prescribe, while others will benefit from a discussion with their physician about how and why a course of treatment is being recommended and its potential impacts and side effects.

Question 3 In what ways can the system be made more efficient?

Structure

36 The RSE considers that while, in general, the current system works well, there is room for improvement. The structure of local drug and therapeutics committees (DTCs) in primary and secondary care, linked into Area DTCs (also feeding membership for the Scottish Medicines Consortium and UK-wide prescribing initiatives), is a longstanding and valuable resource. These organisations generate local formularies, but also do much more, including providing local education and ownership for prescribing decisions, improving prescribing quality and recognising local priorities and differences in case mix (groupings of patients according to their diagnoses and the interventions carried out).

37 Any move towards a centralised therapeutic committee for the whole of Scotland risks undermining the educational role of local DTCs and local ownership of decision making. Instead, the function of local formularies could be strengthened, to avoid unwarranted variation in the use of medicines by individual clinicians, whether in primary or secondary care, that are not consistent with Formulary advice or national guidelines.

15 Migration Advisory Committee, Full review of the Shortage Occupation List, p335
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806331/28_05_2019_Full_Review_SOL_Final_Report_1159.pdf

38 There remain, however, important limitations to best prescribing practice caused by lack of joined up systems between different parts of secondary care, and between secondary care and primary care. This is a major issue in Scotland that may be addressed by NHS Education Scotland's Digital Service (NDS). Misunderstandings about what medicines a patient is taking can have serious consequences for patient safety, although the availability of electronic prescription support systems across the NHS can play an important role in helping to eliminate such errors.

Use of Data

39 In order for NHS Scotland to be as efficient as possible, it must take a data-driven approach to ensuring that patients are being given the most appropriate drugs to suit their diagnosis. A recent investigation by the Times newspaper looked at which GP surgeries across Scotland spent the most money on pregabalin, with various practices in the same or neighbouring local authority areas identified as showing the highest levels.[16] Analysis which identifies pockets of high prescription levels of specific drugs and finding whether these drugs are being dispensed through primary or secondary care could prove valuable in improving efficiency.

40 Analysis, however, must look at a range of data, not simply at the health board level as there also are important variations by drug, by practice and by locality. While some regional variations are important, and need to be addressed, others will prove inconsequential. Some boards may simply prefer the use of certain drugs and, where there is no medical disadvantage to the patient or financial disadvantage to the health service, there remains merit in boards prescribing medications with which they are familiar and comfortable.

41 Scotland is a leader in collecting and integrating healthcare data. Substantial opportunities exist to utilise this data to make the system more efficient and allow health professionals, practices and boards to compare their prescribing practices. The problem that currently exists concerns the inability of health professionals to access this data. The quality of feedback requires improvement to allow clinicians and health boards to access actionable data to analyse and improve performance. Of equal importance will be ensuring that clinicians receive adequate training to best utilise this data. There are welcome recent developments in this area, including the creation of interactive visualisations of the National Therapeutic Indicators,[17] but there is a need to both carefully open up existing data to professional and public scrutiny while ensuring patient confidentiality, and to support stakeholders including GP Clusters to interpret the data and to use it to drive improvement.

42 While an abundance of data exists on primary care, secondary care prescribing data is much more elusive. This must be addressed to allow the full picture of prescribing to be understood, especially as secondary care decisions drive much primary care prescribing and as many of the highest-cost drugs are prescribed in secondary care. A data-driven approach, allowing access to data for both primary and secondary care, would not only improve and aid research, but could also be used to improve management and thus the system as a whole.

16 The Times, GP practice spent up to £70,000 on drug that is "probably not working" https://www.thetimes.co.uk/article/gp-practices-spend-up-to-70-000-on-pregabalin-drug-that-is-probably-not-working-3lwzcfvfn

17 ISD Scotland, National Therapeutic Indicators https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2019-07-16/visualisation.asp

Prescription Charges and Over the Counter Medicines

43 Prescription charges in Scotland were phased out from 2008 before being entirely abolished three years later. The Audit Scotland report (published in 2013) noted the potential risk that abolition of prescription charges could lead to an increase in the prescribing of medication beyond that which was predicted (though it is notable that before abolition 90% of prescriptions were for people already exempt from charges). The report found, due to a number of reasons, including the relative recentness of the change, that it was difficult to reach a conclusion on whether abolition had an impact on prescribing.[18] A more recent piece of research, published in the BMJ in 2018, examining the impact of the abolition on prescribed medicines, was similarly unable to draw firm conclusions about the impact of the policy change.[19]

44 While the licensing of drugs remains a reserved issue for Westminster, it may be the case that making certain drugs available over-the-counter to patients could result in savings for the health service in Scotland and initiatives promoting this could benefit from statements of support from Scottish Government.

45 Moving some medicines from prescription-only medicine status (POM) to either pharmacy medicine (P) or general sales list status (GSL) would have different implications. Pharmacy medicines must be issued with pharmacist supervision and kept behind the counter, whereas GSL can be made available more freely, allowing the purchaser to pick up medicines directly from a shelf or in front of the counter. The list to which certain prescription medicines would be recategorised would affect how effective such a decision may be in terms of improving convenience and accessibility. Pharmacy medicines and those on the general sales list can still be prescribed to patients by doctors to ensure that those with long-term medical conditions or on low incomes would not be disadvantaged.

Utilising Multi-disciplinary Teams

46 One of the key aspects of an effectively running and efficient system is the cohesiveness of a team of professionals working to their respective strengths. Doctors are trained to deal with uncertainty and make judgements about individual patients, while pharmacists have expertise on the technical aspects of prescribing and nurses increasingly take responsibility for long-term follow-up of people with chronic disease. The strength of this team is important. While it may seem *prima facie* that a cost saving measure would be to ask pharmacists or nurses to perform the tasks of doctors as they are on lower salaries, additional training costs and increased time considerations to complete these tasks do not best utilise their skills for the benefit of patients. The principle that might be espoused is – the right professional at the right time working closely together in an integrated multi-disciplinary team (MDT). The new GP contract investment in expanding the primary care MDT has considerable potential to improve care, but will require sustained work over several years to support implementation if it is to be successful.

Question 4 How can the medicines budget be controlled while maintaining clinical and cost effectiveness?

NHS Resourcing and Time

47 NHS Scotland is unquestionably under immense strain both from an ageing population and decrease in the number of GPs. In the 12 months up to 31 August 2017 583 GP vacancies occurred in Scotland, with 240 remaining unfilled past this date. Furthermore, almost half (48%) of practices reported having vacant GP sessions in that 12-month period.[20] This situation impacts on prescribing with existing doctors being responsible for greater and greater numbers of prescriptions. Although the rise in prescription numbers has positive drivers – there is a wide range of effective drugs available and patients are living longer because they increasingly survive life-threatening events – this means doctors must spend less time seeing patients and more time signing prescriptions.

18 Audit Scotland, Prescribing in general practice in Scotland, p18 https://www.audit-scotland.gov.uk/docs/health/2013/nr_130124_gp_prescribing.pdf

19 A. Williams, W. Henley & J Frank, Impact of abolishing prescription fees in Scotland on hospital admissions and prescribed medicines: an interrupted time series evaluation, BMJ Open (November 2018) https://ore.exeter.ac.uk/repository/bitstream/handle/10871/34867/Abolition%20of%20prescption%20fees%20BMJ%20Open%2018-10-19.pdf?sequence=3&isAllowed=y

20 The Times, GP practice spent up to £70,000 on drug that is "probably not working" https://www.thetimes.co.uk/article/gp-practices-spend-up-to-70-000-on-pregabalin-drug-that-is-probably-not-working-3lwzcfvfn

48 Doctors are under such time pressure to see, diagnose and recommend treatment to a patient that offering a prescription can become the quickest and easiest way to terminate an appointment and move on to the next one. While expanding the primary care MDT may help, merely removing the simpler tasks from doctors could, in fact, worsen the situation by leaving them to treat exclusively the most complex cases, yet still be required to do so within a short ten-minute period. A recent report from the Royal College of General Practitioners Scotland found that 37% of GPs surveyed in Scotland felt overwhelmed by workload with the standard 10-minute appointment time highlighted as a contributing factor to 86% of respondents expressing that they felt stressed about the level of uncertainty and risk in their workload.[21] Clinician-patient time must be increased as part of a wider reorganisation of the team providing care.

21 RCGP Scotland, From the Frontline: The changing landscape of Scottish general practice, pp13-14 https://www.rcgp.org.uk/-/media/Files/RCGP-faculties-and-devolved-nations/Scotland/RCGP-Scotland/2019/RCGP-scotland-frontline-june-2019.ashx?la=en

Additional Information

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Responses are published on the RSE website (https://www.rse.org.uk/)

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