Number: WG39061

Welsh Government
Consultation Document

Community Pharmacy Drug Reimbursement Forms

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Overview	The Welsh Government is seeking views on proposals for a number of changes to the way it reimburses community pharmacy contractors in Wales for the drugs they dispense against NHS prescriptions.
How to respond	Please use the questionnaire at the back of this document and email or post it to the addresses below
Further information and related documents	**Large print, Braille and alternative language versions of this document are available on request.**
Contact details	For further information:

Address:

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Date of issue: 21 October 2019
Action required: Responses by 20 December 2019

General Data Protection Regulation (GDPR)

The Welsh Government will be data controller for any personal data you provide as part of your response to the consultation. Welsh Ministers have statutory powers they will rely on to process this personal data which will enable them to make informed decisions about how they exercise their public functions. Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about or planning future consultations. Where the Welsh Government undertakes further analysis of consultation responses then this work may be commissioned to be carried out by an accredited third party (e.g. a research organisation or a consultancy company). Any such work will only be undertaken under contract. Welsh Government's standard terms and conditions for such contracts set out strict requirements for the processing and safekeeping of personal data.

In order to show that the consultation was carried out properly, the Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. If you do not want your name or address published, please tell us this in writing when you send your response. We will then redact them before publishing.

You should also be aware of our responsibilities under Freedom of Information legislation

If your details are published as part of the consultation response then these published reports will be retained indefinitely. Any of your data held otherwise by Welsh Government will be kept for no more than three years.

Your rights

Under the data protection legislation, you have the right:

- to be informed of the personal data held about you and to access it
- to require us to rectify inaccuracies in that data
- to (in certain circumstances) object to or restrict processing
- for (in certain circumstances) your data to be 'erased'
- to (in certain circumstances) data portability
- to lodge a complaint with the Information Commissioner's Office (ICO) who is our independent regulator for data protection.

For further details about the information the Welsh Government holds and its use, or if you want to exercise your rights under the GDPR, please see contact details below:
Data Protection Officer:
Welsh Government
Cathays Park
CARDIFF
CF10 3NQ

e-mail:
Data.ProtectionOfficer@gov.wales

The contact details for the Information Commissioner's Office are:
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Tel: 01625 545 745 or
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1. Detail of consultation

What is the subject of this consultation?

1.1 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.

1.2 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".

1.3The Drug Tariff also sets out the "reimbursement" arrangements for products that are dispensed as part of NHS pharmaceutical services**.** 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".

What is the purpose of this consultation?

1.4 The UK Government's Department of Health and Social Care (DHSC) consulted recently on the proposals in this consultation document. Currently whilst CPCF remuneration may differ, reimbursement arrangements for pharmacy contractors in Wales and England are the same. There are good reasons for this; England and Wales utilise the same supply chain; pharmacy contractors often own pharmacies in both countries; and many patients particularly those in the eastern parts of Wales, use pharmacies on both sides of the border. Having common arrangements with England also provides assurance to both the Welsh Government and pharmacy contractors regarding the levels of medicines margin delivered through CPCF.

1.5 In common with the DHSC, the Welsh Government believes the current reimbursement arrangements generally work well. However, improvements can be made to ensure 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.

1.6 This consultation document contains a range of proposals to improve the current reimbursement arrangements and if appropriate, ensure continued alignment between England and Wales.

2. Introduction – Where are we now?

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 a brand name. The shorthand description for such a product is a “generic medicine”.

2.2 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. More than 80% of medicines prescribed in primary care in Wales are prescribed generically.

Generic prescribing

2.3 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.

2.4 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

2.5 Given that more than 75 million prescription items are reimbursed each year under the CPCF in Wales, 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.

2.6 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 margin.

2.7 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.

Medicine margin

2.8 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. The medicines margin survey conducted by the Pharmaceutical Services Negotiating Committee (PSNC) in England, is a rolling annual survey which seeks to measure the total amount of medicines margin made by pharmacy contractors in England. 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. In Wales it has long been the accepted convention to utilise the margin survey in England to deliver the equivalent proportional medicines margin for pharmacies in Wales.

2.9 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 local health boards 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.

2.10 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 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 (i.e. some medicines will have their price increased). 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 health boards overall.

The Drug Tariff

2.11 The Drug Tariff sets out the fees and allowances to be paid to pharmacy contractors for services they provide under CPCF. 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.

Reimbursement of licensed medicines

2.12 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 Wales will be reimbursed for it by the NHS Wales Shared Services Partnership (NWSSP) 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).

2.13 If a medicine is prescribed generically and the medicine is listed in Part VIIIA of the Drug Tariff, a pharmacy contractor 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.

2.14 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 for Health in England 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.

2.15 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 for Health in England, after consultation with the PSNC.

Reimbursement of unlicensed medicines ('specials')

2.16 The most commonly prescribed specials are listed with a reimbursement price in Part VIIIB of the Drug Tariff. Reimbursement prices are based on quarterly information from suppliers obtained under the Health Service Products (Provision and Disclosure of Information) Regulations 2018 and, until 31 July 2019, under the Specials Memorandum of Understanding from some manufacturers. Specials will be included in Part VIIIB of the Drug Tariff when they fulfil the minimum spend and/or volume requirements.

2.17 Any special not listed in Part VIIIB of the Drug Tariff is reimbursed at the invoice price (less any discount or rebate).

Reimbursement of other drugs (neither licensed nor unlicensed medicines)

2.18 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.

2.19 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.

Deduction scale

2.20 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.

2.21 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.

3. Rationale for Change

3.1 The pharmacy contractor reimbursement arrangements described above generally work well but the Welsh Government, like the DHSC, 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, thereby influencing 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 DHSC 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; and
- 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

  The Welsh Government believes it is appropriate to consider how these matters are addressed in Wales, maintaining what works well and without introducing additional administrative burden for the NHS.

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, we also wish to consult on a number of measures designed to change the methodology for setting listed reimbursement prices to make greater use of market data.

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

4.1 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

4.2 Our 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 pharmacy contractor reimbursement reforms over or under delivery of medicine margin and improve cash flow for pharmacy contractors.

Our proposal

- 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 in England).

4.3 Subject to the views expressed on this proposal, if it were to go ahead, we would consult CPW 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 CPW.

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

5.1 If a medicine is prescribed generically and the medicine is listed in Part VIIIA of the Drug Tariff, a pharmacy contractor in Wales 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.

5.2 In some instances, branded versions of generic medicines (so called “branded generics”) are available that are prices below the Category M reimbursement price. If prescribed by brand name, these are reimbursed under non-Part VIII arrangements. Unlike category M reimbursement prices, prices of branded generics are not adjusted to deliver medicine margin and as a consequence they may appear less expensive than the equivalent generic in Category M. This may encourage local health boards to prescribe the branded rather than generic version even though it may be more expensive to the NHS overall.

The problem with current arrangements

5.3 We believe that adding less medicine margin to those generic medicines for which branded equivalents are available and adding more medicine margin to all other Category M medicines, will help address this problem.

Our proposal

- A change to 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.

Further follow-up with Community Pharmacy Wales (CPW)

5.4 Subject to the views expressed on this proposal we will consult CPW 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.

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

6.1 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.

6.2 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 pays more for Category C medicines in general and branded medicines in particular than it needs to, where there is competition

Our proposal

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

Option 1 - 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.

Option 2 - 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, we would then consult on amending the Regulations to include these medicines in quarterly collection arrangements that parallel those under Part Three of the Regulations.

6.3 Subject to the views expressed on this proposal we will consult CPW 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.

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

7.1 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 pays more for those products than is necessary.

Our proposal

To address the problem outlined above we are proposing to include more "drugs" that are not medicines with a reimbursement price in Part VIII.

We are proposing two different options for the reimbursement of these particular drugs:

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

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, we 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 with Community Pharmacy Wales (CPW)

7.2 Subject to the views expressed on this proposal we will consult CPW 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

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

8.1 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 contractors are reimbursed the list price of their supplier, the NHS pays more for those products than is necessary.

8.2 Because of the disparity in reimbursement, the amount paid for essentially the same products varies across and within local health boards.

8.3 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 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).

For multi-source products for prescriptions written generically, we base the non-Part VIIIA 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.

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).

Further follow-up with Community Pharmacy Wales (CPW)

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

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

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

9.2 For non-Part VIIIB specials there is no incentive for pharmacy contractors to source at the cheapest price possible because they are reimbursed the invoice price (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 proposal

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).

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

1. Require pharmacies to obtain three quotes for non-Part VIII specials ('quotes')
2. Set up or procure a central approvals service for non-Part VIII ('central approvals service')

3a Procure the central supply of non-Part VIII specials and then supply on to pharmacies ('central supply'); or

3b Procure a service that sources specials on behalf of the NHS ('central procurement service')

1. Quotes

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

2. Central approvals service

We would require pharmacy contractors to seek approval from the central approvals service for every quote for a non-Part VIIIB 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.

3. Procurement

There are two options for this:

a) central supply of non-Part VIIIB specials

b) a central procurement service for non-Part VIIIB specials

3a Central supply

NHS Wales Procurement Services would procure the central supply of non-Part VIIIB 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.

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.

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

3b Central procurement service

NHS Wales Procurement Services would procure a central procurement service for non-Part VIIIB 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). Local health boards would then pay the company supplying the special directly.

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.

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

Further follow-up with Community Pharmacy Wales (CPW)

9.3 Subject to the views expressed on these proposals we will consult the CPW 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.

9.4 We will also work closely with the CPW on implementing the solution for non-Part VIII specials

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

10.1 If a product is listed as an appliance in Part IX of the Drug Tariff it cannot also be considered a medicine.

10.2 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

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.

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 with Community Pharmacy Wales (CPW)

10.3 Subject to the views expressed on these proposals we will consult CPW on the detailed methodology for the implementation of these proposals.

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

11.1 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, health boards in areas where more branded medicines are prescribed are not paying their fair share of medicine margin.

Our proposal

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 for community pharmacies and it will improve the deduction scale apportionment to health boards

Further follow-up with Community Pharmacy Wales (CPW)

11.2 Subject to the views expressed on these proposals we will consult CPW on both the detail of and operationalising the proposed changes to the deduction scale

Consultation response form

Your name:

Organisation (if applicable):

Email/telephone number:

Your address:

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

Question 1: Do you agree with the proposed reform? **Yes** ☐ **No** ☐
Question 2: Do you have any comments on the proposed reform?

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

Question 3: Do you agree with the proposed reform? **Yes** ☐ **No** ☐
Question 4: Do you have a preference for option 1 or option 2?
Question 5: Do you have any comments on the proposed reform?

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

Question 6: Do you agree with the proposed reform? **Yes** ☐ **No** ☐
Question 7: Do you have a preference for option 1 or option 2?
Question 8: Do you have any comments on the proposed reform?

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

Question 9: Do you agree with the proposed reform? **Yes** ☐ **No** ☐
Question 10: Do you have any comments on the proposed reform?

Changes to the arrangements for reimbursing and procuring unlicensed medicines ('specials')

Question 11: Do you agree that WG should include tablets and capsules with a reimbursement price in the Part VIII of the Drug Tariff?
Question 12: 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 13: 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 14: Do you have any comments on the options and/or do you think there are additional options that should be considered?

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

Question 15: Do you agree with the proposed reform? **Yes** ☐ **No** ☐
Question 16: Do you have any comments on the proposed reform?

Changes to the deduction scale to reflect different levels of discount for branded and generic medicine

Question 17: Do you agree with the proposed reform? **Yes** ☐ **No** ☐
Question 18: Do you have any comments on the proposed reform

Welsh Language

Question 19: We would like to know your views on the effects that the above proposals would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.

What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Question 20: Please also explain how you believe the proposed policy could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Question 21: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Please enter here:

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐