Mr Lewis Macdonald
Convener
Health and Sport Committee
T3.40
The Scottish Parliament
Edinburgh
EH99 1SP

20th February 2020

Dear Lewis,

Re: Health and Sport Committee – Supply and Demand for Medicines

Thank you for the opportunity to further input into the inquiry on Medicines Supply and Demand. There were two questions asked in this correspondence which I am happy to answer.

The first was to cover *'further detail on the proportion of time members spend sourcing medicines at the best price and whether this has to be done by a pharmacist, or whether a technician or other member of staff could undertake this role.'* The attached European level reports highlight the issue specifically around shortages and the issues in terms of time. The good news from this is that patients do generally receive their medication the vast majority of the time, but this highlights the lengths pharmacy teams go to, to ensure the supply happens. The word attachment also highlights how manufacturers (and AstraZeneca only happen to be the example here) have changed their supply routes in the last 14 years. This requires pharmacy teams to have multiple accounts and supply routes for medicines that traditionally used to come from one single wholesaler. This can take more time (unfortunately I cannot find any direct studies on this) but it does highlight the complexity of the supply chain now compared to over a decade ago, this undoubtedly takes more time (some of it mitigated by IT systems) for pharmacy teams. Good pharmacy teams work together to address this workload. Technicians and other pharmacy team members can generally deal with this although as the team leader the pharmacist should have oversight around the supply chain, training for pharmacy team members on how to source medicines and may have to step in at times to ensure supply or source alternatives for patients.

In terms of Value Based Pricing (VBP) this was mooted around ten years ago and has yet to come to fruition in terms of medicines. This, in itself, indicates the challenge in rolling this out. There are four principles that essentially should be considered with regards to VBP and indeed were considered in a UK consultation as part of 2010 NHS England reforms which were then proposed.

- A basic pricing threshold, which reflects therapeutic benefits provided by the medicine, over and against any other therapeutic strategy (including social prescribing).
- A weighting to reflect the "burden of illness" and any unmet need in a particular disease area.
- A weighting to reflect a measure of innovation greater than existing medicines in the therapeutic area (especially "step change" approaches to treatment, as opposed to incremental benefits).

- A weighting to reflect societal benefits of a medicine — for example, improved quality of life, reduced carer input etc.

On considering these determinants of medicine value, however, it is easy to see a number of difficulties in establishing a system of VBP. For example, it is hard to place a price on the less tangible aspects of a medicine's value, as the fourth weighting above requires, and this might require complex algorithms that might be bureaucratic to implement. It is hard to place a fair value on a drug for a very rare disease when there are few population research data. For this reason, it could be argued that rare/orphan drugs should be exempt from any VBP scheme. It also seems unfair that the system values "step changes" in therapy more highly than incremental improvements, which may provide equally valid — and valuable — patient benefits. The difficulties have to date meant this system has not been applied. The principle of VBP is one that can be supported, however applying the principles can be more challenging. SMC are applying similar broad principles and the Montgomery review again was set up to tackle elements of this. I am aware the committee asked questions on the progress of the review's recommendations around orphan pathways, cancer outcomes work and SMC processes.

I would certainly highlight again the potential for community pharmacy to be utilised to capture outcomes as often the final point for supply and conversation with the public receiving medicines. Currently this is not formally captured unless there are significant issues e.g. Yellow Card Reporting for side effects. Systems can be developed to make this seamless and part of patient conversations.

If you require any further information please do not hesitate to get in touch.

Yours sincerely,

Matt Barclay MrPharmS
Director of Operations

Community Pharmacy Scotland, 42 Queen Street, Edinburgh, EH2 3NH
Tel: 0131 467 7766
enquiries@cps.scot | www.cps.scot