Primary - Secondary Care Interface Management

The Scottish Example

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NHS Scotland

- Virtually monopoly payer and provider
- Universal coverage from general taxation
- Free at point of care
- No co-payment - all medicines provided free
- Secondary care provided by state-run hospitals
- Primary care provided by independent doctors
  - …but contracted to work within system 'rules'
- Long history of 'controlled prescribing'
  - Initially on good clinical grounds
  - Now also includes cost considerations

Managing the Interface - 1

- Early (1990) recognition of the problems
  - Primary care prescribing influenced by secondary care recommendation
  - Differential pricing of medicines in primary and secondary care ('loss leaders' in hospitals)
  - Clinical risks in use of too many medicines
    - …and in switching between medicines
  - Huge range of medicines stocked by pharmacies in community and hospitals

Managing the Interface - 2

- Early introduction of joint working
  - Drug & Therapeutics (D & T) Committees involving primary and secondary care
  - Safe, quality prescribing the initial driver
  - Cost containment soon also a factor
    - …equally in primary and secondary care!
    - Single budget for healthcare (1ary and 2ary)
  - Joint working then established as the norm
    - …and transferred to other areas of activity

Managing the Interface - 3

- Formularies
- Guidelines
- Managed clinical networks
- Health technology assessment

- Impact on pricing/reimbursement

Formularies

- All 14 Health Boards have a Formulary
  - Some individual, others shared
- All are developed jointly between primary and secondary care
- All apply equally in primary and secondary care
  - …no ‘carte blanche’ for specialists
- All prescribing is monitored and Formulary adherence assessed
- Some medicines limited to use on specialist advice (or even specialist prescription)

Non-Formulary Prescribing

- Obviously permitted if it can be justified
  - Individual patient treatment request possible
- Would be questioned if high in primary care
  - Prescriber would be individually targetted
- Might be questioned in 'real time' in hospital
  - Therapeutic substitution in some settings
  - Case-by-case justification before medicine used
  - Routine pharmacist monitoring of non-Formulary medicines, especially high-cost

Guidelines

- Almost all guidelines are jointly written
  - Full declarations of interest
  - Evidence-based rather than opinion-based
  - Interface issues usually specifically addressed
    - eg guidance on referral to secondary care
- Guideline advice informs Formulary content
  - …and *vice versa* - if the guideline recommends a class of medicine, the Formulary will name an individual medicine

Managed Clinical Networks

- Disease-specific networks
  - Cross-specialty (physician/surgeon/pharmacist..)
  - Across the interface - primary + secondary care
- Aim to cover all aspects of management
  - Diagnosis, investigation, monitoring
  - …also medicines use
  - Facilitates managed introduction of new drugs
- Adherence to all aspects of MCN monitored

Health Technology Assessment

- New medicines assessment a challenge
  - Vital to keep Formulary up-to-date
  - Often significant cost implications
    - New medicines a cost pressure in all systems
- Pre-2001 - local assessments
  - 15 assessments in Scotland - wasteful
  - Sometimes different decisions - divisive
  - Variable quality of decisions - open to challenge
- Since 2001 - Scottish Medicines Consortium

Scottish Medicines Consortium

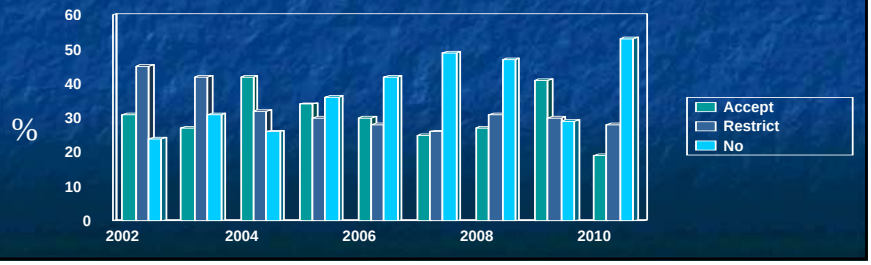
- Consortium of existing (joint) D & TCs
- 30-member committee
  - Doctors, pharmacists, patients, industry
  - Primary and secondary care at the table
- Advises on ALL new medicines
  - Primary, secondary and tertiary care
- Rapid process - 18 weeks
  - “shape practice, not change practice”
- Assesses value - not reference pricing!

SMC - 2002-2010

- 780 submissions considered
  - 2002 – 29
  - 2003 – 62
  - 2004 – 74
  - 2005 – 87
  - 2006 – 130 (111)
  - 2007 – 110 (95)
  - 2008 – 105 (87)
  - 2009 – 81 (73)
  - 2010 – 102

Outcome of Assessments

- Accepted for Use – 34%
- Accepted for Restricted Use – 37%
- Not Recommended – 28%
- No real evidence of change over time



SMC Influences

- Advice informs local Formulary decisions
  - SMC says 'no', cannot be in local Formulary
  - SMC says 'yes', can be in local Formulary
- Advice informs Guideline content
  - Guideline cannot recommend non-approved medicine
- Advice informs MCN protocols
  - Protocol cannot recommend non-approved medicine

Case Study - Clopidogrel

- Expensive compared to aspirin
  - Time-limited therapy appropriate
  - 3/6 month course provided by secondary care
  - Medicine never on primary care prescription
- Savings re-invested in implantable defibs
- Generic clopidogrel launched - different salt
  - SMC facilitated pan-Scotland decision
  - Generic clopidogrel the formulation of choice

Impact on Pricing/Reimbursement

- Medicines pricing reserved to UK
- Local policies affect local pricing/expenditure
  - 85% of prescribing is ‘generic’ (by rINN)
    - 70% of dispensed medicines are generics
  - No ‘loss leaders’ in secondary care
  - No point in ‘influencing’ KOLs in secondary care
  - Value assessment promotes ‘patient access schemes’
    - Often simple discounts (exact amount may be secret!)
- Even a small (non-)country can negotiate better value-for-money

The Scottish Experience

- Built over 20 years of joint working
- Clinical benefits prime, then financial
- Needs culture of openness and transparency
  - …no conflicts of interest - see the big picture!
  - 1ary + 2ary, not 1ary v 2ary!
- Needs careful 'joined-up' thinking
  - Mixed messages unhelpful to everyone
- Now an accepted part of medicines use
  - …by clinicians and patients (and pharma!)

Scottish Medicines Consortium

www.scottishmedicines.org.uk