MEDIX

INTELLIGENT INFORMATION

Market Research Report

Red Listed Products Study

Medix PCT Red Listed Products Report		

Table of Contents

Executive Summary

Fieldwork for this study ran from Wednesday 20 April to Tuesday 3 May 2011. The sample comprised 120 PCT personnel comprising 49 Senior Managers, 71 GP Commissioners and 23 Pharmacists. The methodology used was a quantitative online survey with respondents invited to participate by e-mail.

The sample was screened in two ways: Firstly, for those who are involved in formulary and recommended products lists in the PCT. Secondly, only respondents from PCTs who use the traffic light system or red listed products were able to enter. 73% of those who tried to enter this survey met both criteria and were included as respondents.

A large geographical coverage was achieved by the sample with 87 different PCTs represented by respondents. Among those providing multiple participants were Birmingham East and North, Norfolk and Salford.

For most respondents, the red list would be a sizeable one. 56% answered that their PCT's list would contain 20 products or more, with 12% estimating around 10 and 13% choosing 15. Only 13% gave an answer of fewer than 10.

The most likely group to make the decision as to whether a product should be added to the red list was the Prescribing Committee, with 25% of respondents giving this answer. 23% felt that the Medicines Management would do so and 19% considered Clinical Advisors to have this influence.

Typically a review of products would take place once per quarter according to 31% of respondents. 13% answered that this process is continual or performed for all new products. 13% also answered bi-monthly and monthly respectively.

Respondents were asked for the top 3 clinical areas in which their PCT is attempting to make savings through red-listing products. 38% chose Cardiology as one of their top 3, with Rheumatology (33%), Psychiatric (24%) and Immunology (23%) commonly selected. 13% answered that the decision to red list a product is done on clinical grounds, rather than financial.

For 25% of respondents, the process of red-listing a drug involves a discussion among the Formulary or Medicines Management committee. 24% wrote that all new products are considered for the red list, and 18% that a GP or Consultant request would lead to a product being discussed.

The most common reason for a drug to be placed on the red list would be that the total expenditure on it is too much, according to 42% of respondents. 34% answered that a product would be considered if expenditure relating to it is generally high, and 32% felt an unacceptable rise in price would lead to a review.

Of those in whose PCT a product comes under consideration for red-listing when its cost is high or too high, the specific amount of money that would lead to this was

found to mostly vary depending on the product or clinical area. Some answered that the process begins simply because a more effective alternative is available.

Where an increase in expenditure was cited as a reason for a product coming under review for red-listing, 26% specified that the rise would need to be more than 20% to be significant. 24% gave an answer between 11 and 20%.

A variety of products was named by respondents when asked what they are considering adding to their red list, of which the full list along with reasons for their consideration can be found in the main report. 52% of products suggested were felt to be more suitable for prescribing by specialists, 39% were not believed to be cost effective in the long term and 38% had a cheaper alternative available.

A smaller list was provided for products that respondents would like to return to the green list, with examples named by more than one including Atorvastatin, Duloxetine and Exanatide.

Of respondents who would like to make a product green again, 47% answered that in order to do so the price must be reduced. Other suggestions included better evidence, training for GPs and improved safety.

Asked how far they felt the practice of red-listing drugs in primary care is an effective measure to save money, a mean rating of 6.2 out of 10 (where 10 = very effective) was given. 21% chose 7, and 19% 8. 25% gave an answer of 4 out of 10 or fewer.

For respondents who did not feel that red-listing is an effective way of saving money for PCTs, the most common reason was that they do not use this practice for financial reasons. Some pointed out that such products would still get prescribed in secondary care anyway.

Of those who gave an answer of 7 or greater, 18% felt that red-listing is effective because it leads to more cost effective products being prescribed. 15% answered that prescribing needs to be controlled and only 13% had seen evidence that it works.

The use of red-lists is generally expected to become more prominent over the next 2 years. 30% of respondents felt it will increase significantly over the next 2 years in their PCT, and 37% that it would increase slightly. 51% of those who believed it would increase explained that they need to save money and cut costs. Just 3% felt that red-listing would decrease and 5% were unsure.

The most likely action that a pharmaceutical company would need to take in order to prevent more products becoming red-listed would be to reduce their costs (43%). Other suggestions included that of improving the cost effectiveness (24%), providing evidence of efficacy (23%) and ensuring the safety of drugs (10%).

69% of respondents answered that their PCT also has an amber list of products. Of those, 49% explained that the criteria for a product being moved to the amber list would be that it is subject to a shared care agreement between primary care and the hospital. 19% wrote that a drug would be moved to the amber list if its price is rising or falling.

Numerous other methods of reducing drug expenditure were named by respondents and being utilised by their PCT. 28% wrote that they are encouraging the use of generics or branded generics, and 25% are attempting to switch to more cost effective products generally. Others included reducing waste, enforcing the formulary or a ScriptSwitch system.

50% did not feel there would be any adverse consequences of implementing the planned changes in their PCT. Some possible outcomes included the idea of the doctor – patient relationship suffering, a lack of patient choice, and GPs disliking being given guidance.

The process of red-listing drugs is continual and many are currently listed as being considered. The most common reason for consideration was cost effectiveness.

Conclusions

Red-listing is a practice that is extremely widespread across PCTs in Britain and does not look to be one that will diminish in influence any time soon. Of 164 respondents who attempted to enter the study, 73% answered that their PCT uses a red-list for the purposes of preventing drugs being prescribed in primary care, with a further 14% not sure. Many (69% of respondents who completed) also use amber lists in their organisation, which mainly seem to be concerned with products used in shared care agreements. Prescribing committees and medicines management committees were the most usual vehicles through which drugs were placed on the red list.

With just 3% of respondents expecting their PCT's use of red lists to decrease to any extent at all, the vast majority expect it to rise over the coming 2 years. The need to save money in the NHS was of course a huge concern, and few respondents indicated that they were looking to return any drugs to their green list.

There was a fairly lukewarm reaction when respondents were asked how useful they consider the idea of red-listing to be with regards to making financial savings, with a mean of 6.2 out of 10 given. Several wrote that it had led to more cost effective prescribing, although a large number of other suggestions for saving money on the drugs budget were given

There were large numbers of respondents who stated that clinical reasons for moving products to the red list were paramount. Indeed, several commented that red-listing in their PCT was not done under any financial motivation. Possible clinical explanations for a product being limited to secondary included the need for monitoring and potential safety concerns.

Of respondents who scored red-listing between 4 and 6 out of 10 for its usefulness in saving money, 24% wrote that red-listing is not done for financial reasons, and 18% pointed out that products on the red-list can still be prescribed anyway, just not in primary care. However, reducing the cost of a product was most commonly volunteered as a way of restoring a drug to the green list.

A large variety of alternative methods for saving money on drug expenditure was given, including use of generics, switching to more cost effective drugs, and enforcing the formulary. Although red-listing is done widely and they generally feature a considerable number of different drugs (56% said 20+ in their PCT), it is also often used for genuinely clinical purposes. In some cases it may not be avoidable for a drug to be placed on the list – for example where a more cost effective treatment is available.

However if pharmaceutical companies can ensure that GPs are properly educated, their evidence base remains strong and that their products are suitable for use in primary care they can minimise this possibility of drugs being put on the red list. A reduction of prices of products that have been put onto the red list may also encourage restoration to the green list.

History

Fieldwork dates: 20 April – 3 May 2011
Sample: 120 PCT personnel comprising 49 Senior Managers, 71 GP Commissioners and 23 Pharmacists.

Q1 For Which Primary Care Trust (PCT) do you currently work?
(Verbatim responses)
Aberdeenshire
Barnet
Barnet
Barnsley
Barnsley
Belfast
Birmingham East and North
Birmingham East and North
Birmingham East and North
Berkshire East
Berkshire West
Bournemouth and Poole
Bournemouth and Poole
Brent
Brent and Harrow
Brighton and Hove
Bristol
Buckinghamshire
Bucks
Cambridgeshire
Cambridgeshire
Central Lancs
County Durham
Coventry
Derbyshire County
Devon
Doncaster
Dudley
Ealing
East and Coastal Kent

East Berks
East Sussex Downs and Weald
Gateshead
Hampshire
Hants
Harrow
Hastings and Rother
Havering PCT

[Q1 continued]

Herefordshire
Heywood, Middleton and Rochdale PCT
Isle of Wight
Isle of Wight
Isle of Wight NHS PCT
Islington PCT
Kirklees
Knowsley
Lcpct
Leeds PCT
Leicester County and Rutland
Leicestershire County and Rutland
Lincolnshire
Lincolnshire
Liverpool
Liverpool
Liverpool Community Health NHS Trust
Mid-Essex
Neath Port Talbot
Newham
NHS Borders
NHS Devon
NHS Devon
NHS Haringey
NHS Hertfordshire
NHS Lincolnshire
NHS Luton
NHS Norfolk
NHS Sutton and Merton
NHS Worcestershire

Norfolk
Norfolk
Norfolk
Norfolk
North East Essex
North Lincs
North London
North Somerset
North Tyneside

[Q1 continued]

Northamptonshire Teaching PCT
Northamptonshire Teaching PCT
Nottingham
Nottinghamshire County
Nottinghamshire County Teaching PCT
Notts County
Oxfordshire
Poole and Bournemouth
Redbridge
Rotherham
Salford
Salford
Sheffield
Solihull
Somerset
South Birmingham
South Birmingham
South Birmingham PCT
South Staffordshire
South Tyneside
St Helens
Stockport
Stockport
Suffolk
Surrey
Surrey
Surrey
Sutton and Merton

Sutton and Merton
Tameside & Glossop
Tameside & Glossop
Varies
Waltham Forest
Warrington
Warwickshire
West Essex
West Essex
West Sussex
Western / Northern Ireland

[Q1 continued]

Wiltshire
Wolverhampton
Worcester
York

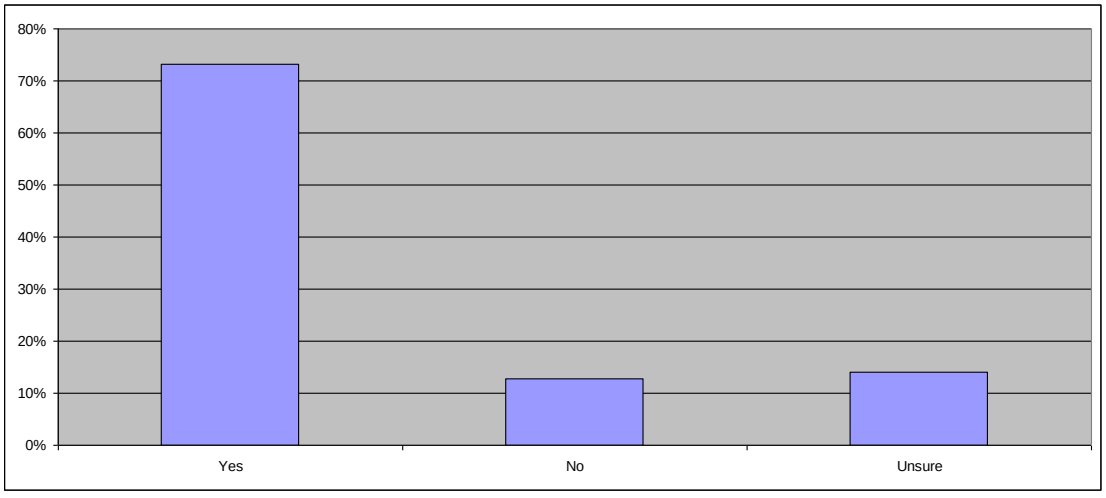
Q2 Are you currently, or are you planning to be, involved in decisions relating to formulary or recommended product lists in your PCT?		
	Total	
	N	%
Yes	120	**100%**
No	0	**0%**
Base	120	

[Respondents who answered 'No' to Q2 were screened out]

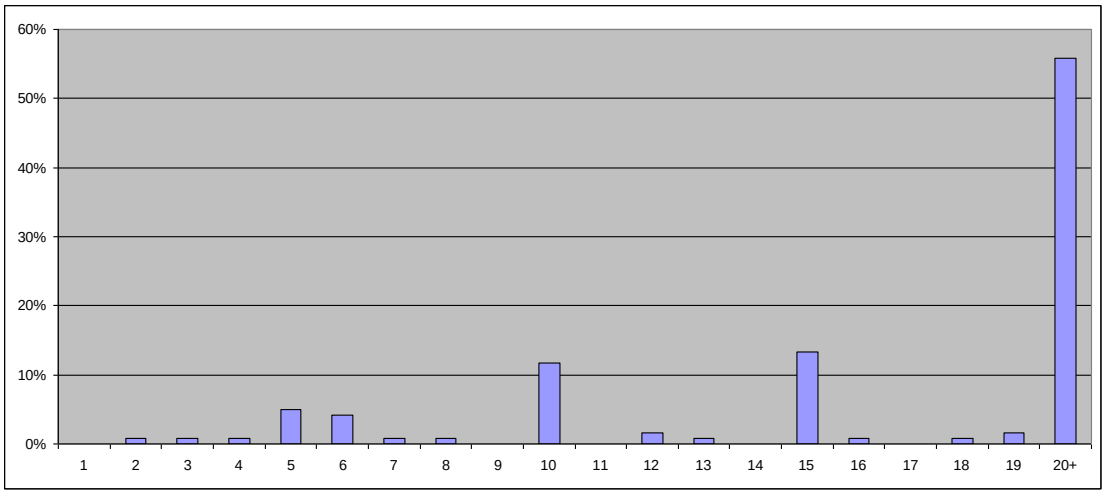
A recent study has found that over half of the English PCTs are adding drugs to their 'Red lists' of products that can only be prescribed by a Consultant in secondary care. (http://www.telegraph.co.uk/health/healthnews/8446782/Patients-are-denied-high-cost-drugs-by-NHS-trusts.html)

Q3 Does your PCT have a red list of products which GPs cannot prescribe, and can only be used by hospital Consultants?		
	Total	
	N	%
Yes	120	**73%**
No	21	**13%**
Unsure	23	**14%**
Base	164	

[Respondents who answered 'No' or 'Unsure' to Q3 were screened out – They have been included in results here but not for other questions]



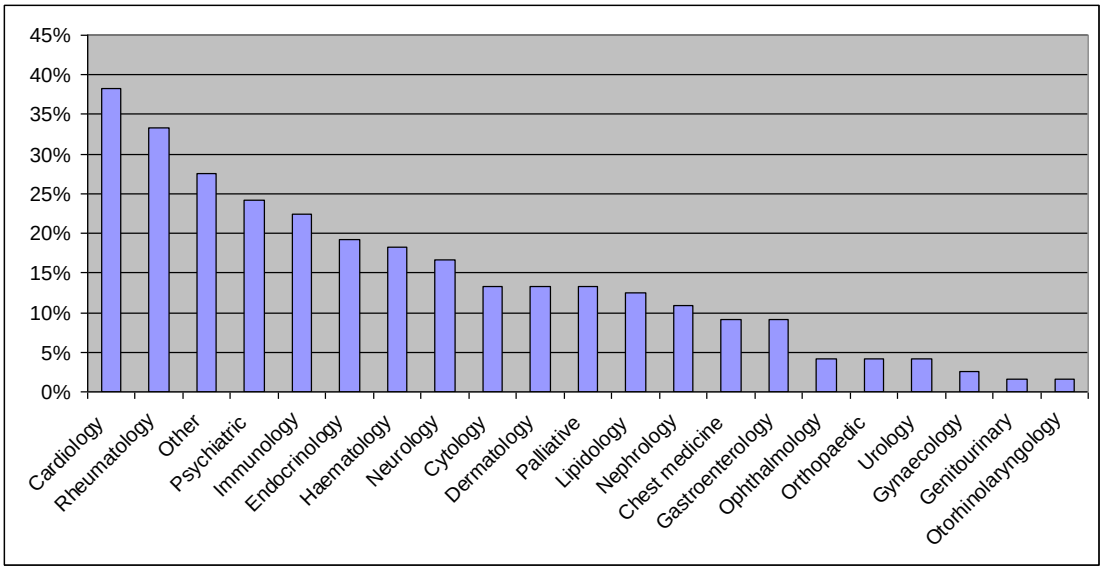
Q4 Approximately how many individual drugs comprise this list?		
	Total	
	N	%
1	0	**0%**
2	1	**1%**
3	1	**1%**
4	1	**1%**
5	6	**5%**
6	5	**4%**
7	1	**1%**
8	1	**1%**
9	0	**0%**
10	14	**12%**
11	0	**0%**
12	2	**2%**
13	1	**1%**
14	0	**0%**
15	16	**13%**
16	1	**1%**
17	0	**0%**
18	1	**1%**
19	2	**2%**
20+	67	**56%**
Base	120	



Q5 Who would typically make the decision to add a product to such a list?		
	Total	
(Summary of coding)	N	%
Prescribing Committee	30	**25%**
Medicines management	27	**23%**
Clinical advisors (e.g. prescribing leads, pharmaceutical advisors)	23	**19%**
Drugs and Therapeutics Committee	17	**14%**
Unsure	10	**8%**
Pharmacist(s) / advisors	9	**8%**
Formulary group / committee	6	**5%**
Medicines strategy committee	5	**4%**
Prescribing and Clinical Effectiveness	3	**3%**
GP consortia	2	**2%**
PCT management	2	**2%**
Therapeutics Advisory Group	2	**2%**
Commissioning group	1	**1%**
SHA	1	**1%**
Base	120	

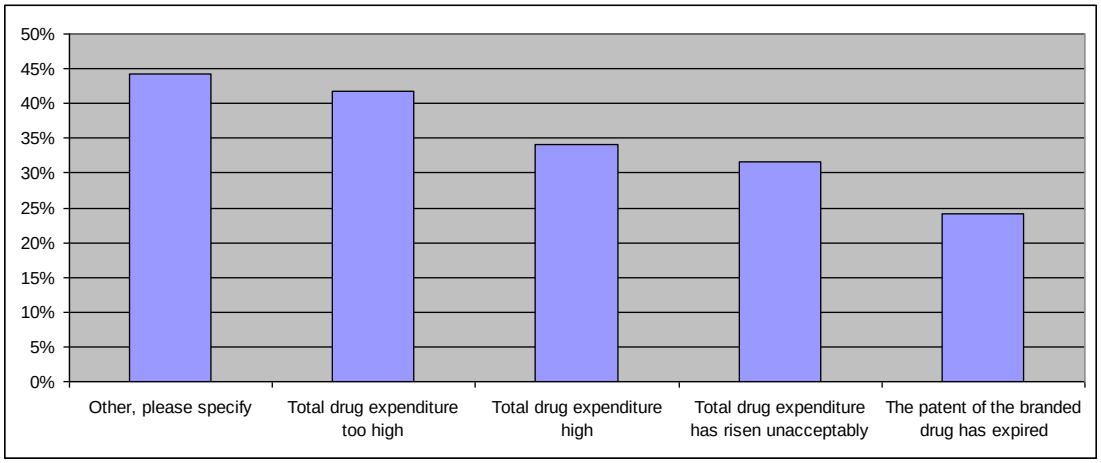
Q6 How often would your PCT review products with the intention of adding them to the red list?		
	Total	
(Summary of coding)	N	%
Quarterly	37	**31%**
Bi-monthly	16	**13%**
Monthly	16	**13%**
Continual / all new products	15	**13%**
6 monthly	14	**12%**
Annually	13	**11%**
Unsure	17	**8%**
Every 3-5 years	1	**1%**
Rarely	1	**1%**
Base	120	

Q7 Please select the top 3 therapy areas in which your PCT is looking to save money by adding products to the red list.		
	Total	
	N	%
Cardiology	46	**38%**
Rheumatology	40	**33%**
Psychiatric	29	**24%**
Immunology	27	**23%**
Endocrinology	23	**19%**
Haematology	22	**18%**
Neurology	20	**17%**
Cytology	16	**13%**
Dermatology	16	**13%**
Palliative	16	**13%**
Decisions made on clinical grounds not cost	16	**13%**
Lipidology	15	**13%**
Nephrology	13	**11%**
Chest medicine	11	**9%**
Gastroenterology	11	**9%**
Oncology	9	**8%**
Ophthalmology	5	**4%**
Orthopaedic	5	**4%**
Urology	5	**4%**
Gynaecology	3	**3%**
Unsure	3	**3%**
Genitourinary	2	**2%**
Otorhinolaryngology	2	**2%**
Any	1	**1%**
Drug addiction therapy	1	**1%**
Hypertension	1	**1%**
Pain	1	**1%**
Weight loss	1	**1%**
Base	120	



Q8 Please describe the process by which products come under consideration for adding to the red list?		
	Total	
(Summary of coding)	N	%
Formulary /medicines management committee considers the product	30	**25%**
New products	29	**24%**
Consultant / GP request	22	**18%**
Cost effectiveness / evidence base	20	**17%**
Drugs that should be prescribed in secondary care / need a lot of monitoring	20	**17%**
NICE guidelines (or absence)	16	**13%**
Cost	13	**11%**
Evidence available (or lack thereof)	13	**11%**
Unsure	10	**8%**
Hospital DTC request	7	**6%**
Drugs that appear "expensive"	6	**5%**
Product coming off patent	4	**3%**
Off licence use	3	**3%**
Base	120	

Q9 What criteria would decide whether a product was put on the red list?		
	Total	
	N	%
Total drug expenditure too high	50	**42%**
Total drug expenditure high	41	**34%**
Total drug expenditure has risen unacceptably	38	**32%**
The patent of the branded drug has expired	29	**24%**
Clinical reasons (efficacy, safety)	23	**19%**
Need for secondary care expertise / specialised	11	**9%**
Cost effectiveness	7	**6%**
Lack of evidence	7	**6%**
Unsuitable for primary care use	6	**5%**
Require monitoring	5	**4%**
Overall budgetary impact	2	**2%**
Unsure	2	**2%**
High volume of secondary care prescriptions	2	**2%**
Cheaper alternative	1	**1%**
Only for use in limited circumstances	1	**1%**
Base	120	



[Q10 was shown to respondents who answered 'Total drug expenditure high' at Q9]

Q10 What level of expenditure is considered high?		
	Total	
(Summary of coding)	N	%
Varies	13	**32%**
Unsure	8	**20%**
£30 - £300 per month	7	**17%**
Clinical effectiveness / cheaper alternative	7	**17%**
£301- £1000 per month	4	**10%**
A rise	3	**7%**
More than £1,000 per month	1	**2%**
Confidential information	1	**2%**
Base	41	

[Respondents who answered 'Total drug expenditure too high' at Q9 were shown Q11]

Q11 What level of expenditure is considered too high?		
	Total	
(Summary of coding)	N	%
Varies	21	**42%**
Unsure	12	**24%**
Clinical effectiveness / cheaper alternative	7	**14%**
£30 - £300 per month	5	**10%**
£301- £1000 per month	3	**6%**
more than £12,000 per year	2	**4%**
Has risen	2	**4%**
Base	50	

[Respondents who answered 'Total drug expenditure has risen unacceptably' at Q9 were shown Q12]

Q12 What level of increase has been considered unacceptable?		
	Total	
(Summary of coding)	N	%
More than 20%	10	**26%**
11-20%	9	**24%**
Varies	9	**24%**
Unsure	5	**13%**
Clinical effectiveness	3	**8%**
1-10%	2	**5%**
Base	38	

Q13 Are you aware of any drugs that your PCT is considering ADDING to its red list?	Q14 For what reason(s) would you add [Product] to the red-list, other than cost?
(Verbatim responses)	
1	
Abacavir	Not cost effective in short term, Should be prescribed by specialists
Agomelatine	Should be prescribed by specialists, Cost is the only factor, No view from NICE yet
Analogue insulins	Not cost effective in long term, Cheaper alternative available
Botulinum toxin	Cost is the only factor
Donepezil	Should be prescribed by specialists, Lifestyle changes preferable to medicine
Dovobet	Should be prescribed by specialists
Dronodarone	Should be prescribed by specialists
Duloxetine	Should be prescribed by specialists
eslicarbamazepine	Not cost effective in short term, Not cost effective in long term, Cheaper alternative available, Should be prescribed by specialists
Esomeprazole	Not cost effective in long term, Cheaper alternative available
Exenatide and insulin as combination	Should be prescribed by specialists, unlicensed
Ezetrol	New clinical evidence, Cheaper alternative available, Generic available, Should be prescribed by specialists
Fosinomycin	Hospital requesting GPs to prescribe when it is not even in the BNF or drug tariff!
Glucosamine	Not clinically effective
Gylcopyrronium	Not cost effective in long term, Cheaper alternative available
Look at drugs of limited clinical effectiveness	Not cost effective in short term, Not cost effective in long term, evidence doesn't suggest significant clinical benefits for patient
No	Should be prescribed by specialists
No	Should be prescribed by specialists
No outstanding applications	Not cost effective in short term, Not cost effective in long term, New clinical evidence Should be prescribed by specialists
None	Cost is not the only reason for putting drugs on red list
Omiluzimab	Should be prescribed by specialists
Onbreze	New clinical evidence, Cheaper alternative available, Should be prescribed by specialists, Cost is the only factor

Oncology use of all IV and oral cytotoxics	Should be prescribed by specialists

[Q13/14 continued]

Requires clinician request	Should be prescribed by specialists
Salbutamol inhalers	Cost is the only factor
See previous answer - everything new!	Not cost effective in short term, Not cost effective in long term, New clinical evidence, Cheaper alternative available, Generic available, Should be prescribed by specialists, Lifestyle changes preferable to medicine, Cost is the only factor
Versatis	Should be prescribed by specialists
We will consider it next month	No reason
Zoladex	Not cost effective in long term, Cheaper alternative available

2	
Aliskiren	Not cost effective in long term, Should be prescribed by specialists
All IV Antibacterials	Should be prescribed by specialists, Have to be given by specialist IV Nurses
Colief	Colief is classified by the NHS as a borderline substance. There must be a diagnosis of lactose intolerance for it to be Rx
Daxas	Should be prescribed by specialists
Fentanyl immediate release	Not cost effective in short term, Not cost effective in long term, Cheaper alternative available
Fesoterodine	Not cost effective in long term, Cheaper alternative available, Should be prescribed by specialists
Glucosamine	Not cost effective in long term, Lifestyle changes preferable to medicine
Ibavridine	Should be prescribed by specialists
Infiximab	Should be prescribed by specialists, Cost is the only factor
Lipitor	Not cost effective in long term, Cheaper alternative available, Cost is the only factor
Naltrexone	Not cost effective in long term, Should be prescribed by specialists, Lifestyle changes preferable to medicine
Orlistat	Not cost effective in long term, Lifestyle changes preferable to medicine
Physeptone	Cost is the only factor
Roflumilast	Not cost effective in short term, Not cost effective in long term

Vimovo	Cheaper alternative available, Generic available

[Q13/14 continued]

3	
Adalimumab	Not cost effective in long term, Cost is the only factor
Cinacalcet	Not cost effective in short term, New clinical evidence
Cipralex	Not cost effective in long term, Cheaper alternative available
Dabigatran	New clinical evidence, Cheaper alternative available, Should be prescribed by specialists, Need to prove more cost effective than warfarin and safer
Dabigatran	Not cost effective in short term, Cheaper alternative available, Should be prescribed by specialists
Fentanyl lonsenges-actiq	Not cost effective in short term, Not cost effective in long term, Cheaper alternative available, Generic available
Ibadronate	Cheaper alternative available, Generic available, No hip fracture outcome
Movelat gel	Not cost effective in long term, Generic available
Roflumilast	New clinical evidence, Cheaper alternative available, Should be prescribed by specialists

4	
Clozipine	Should be prescribed by specialists
Fentanyl nasal spray	Not cost effective in short term, Not cost effective in long term, Cheaper alternative available
indacaterol	Unclear place in therapy
Pramiprexole MR	Not cost effective in long term, Should be prescribed by specialists
Sativex	Should be prescribed by specialists, For MS-specialist only

5	
Adalimumab	New clinical evidence
Epiduo	Cost is the only factor
Liraglutide	Not cost effective in short term

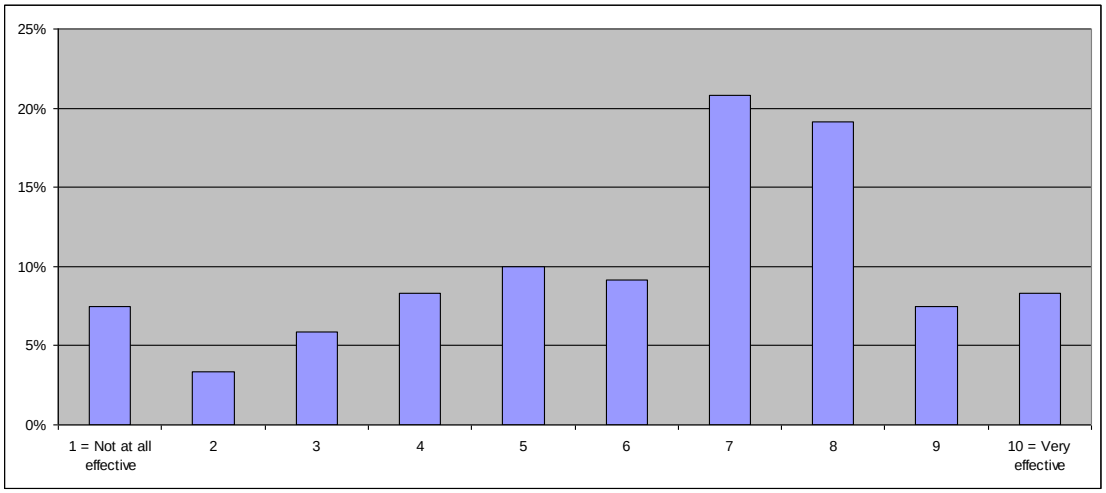
Q14 For what reason(s) would you add [Product] to the red-list, other than cost? (Overall)		
	Total	
	N	%
Should be prescribed by specialists	34	**52%**
Not cost effective in long term	26	**39%**
Cheaper alternative available	25	**38%**
Not cost effective in short term	14	**21%**
Other, please specify	14	**21%**
New clinical evidence	10	**15%**
Cost is the only factor	10	**15%**
Generic available	9	**14%**
Lifestyle changes preferable to medicine	5	**8%**
Base	66	

Q15 Are there any drugs currently on the red list that you would like to return to the green list?
(Verbatim responses)
Atorvastatin
Atorvastatin
Colchicine
Crestor
Drugs for dementia we are starting to move to green
Duloxetine for depression
Duloxetine for depression
Escitalopram
Exanatide
Exanatide
Heminevrin
Humira
Januvia
Liraglutide
Lucentis
Melatonin
Methotrexate
None
Risedronate
Roaccutane
Roflumilast
Targinact
Unsure

[Respondents who named a product at Q15 were shown Q16]

Q16 What would the manufacturers need to do in order to have their product returned to the green list?		
	Total	
(Summary of coding)	N	%
Reduce cost	9	**47%**
Better data / evidence	3	**16%**
Training for GPs	3	**16%**
Nothing	3	**16%**
Better safety	2	**11%**
Patient access scheme	1	**5%**
Lobby Therapeutics Advisory Group	1	**5%**
NICE position statements	1	**5%**
Base	19	

Q17 How effective do you feel that the measure of preventing certain drugs from being prescribed in primary care is in saving money for PCTs?		
	Total	
	N	%
1 = Not at all effective	9	**8%**
2	4	**3%**
3	7	**6%**
4	10	**8%**
5	12	**10%**
6	11	**9%**
7	25	**21%**
8	23	**19%**
9	9	**8%**
10 = Very effective	10	**8%**
Mean	**6.2**	
Base	120	



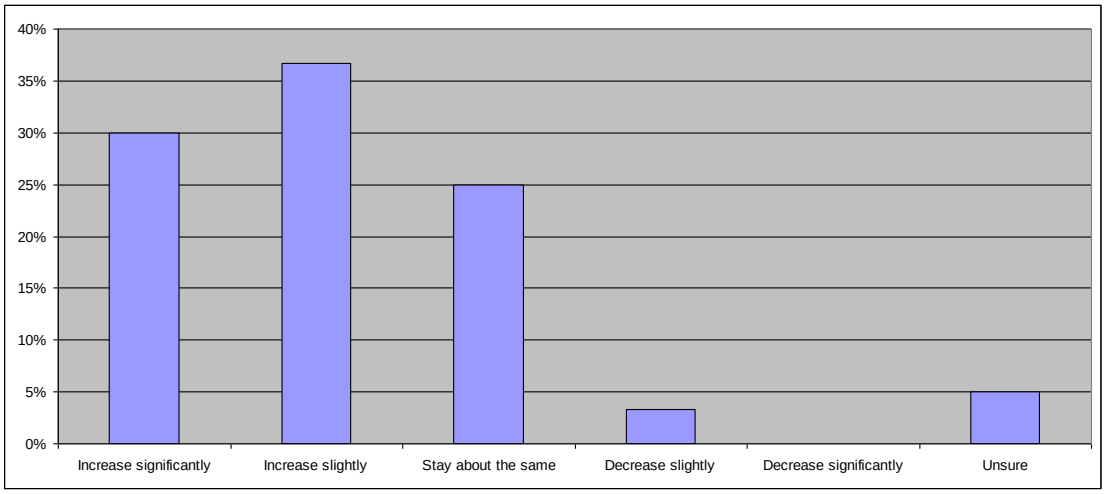
Q18 Why do you say that?		
	Total	
(Summary of coding)	N	%
1-3		
Done for clinical reasons not cost	7	**35%**
Not cost effective in long term	3	**15%**
Secondary care prescriptions paid for by PCT anyway	2	**10%**
Negative effect on patient care	2	**10%**
Small sums compared to overall expenditure	2	**10%**
Secondary care worse than primary	1	**5%**
Incur VAT	1	**5%**
Time consuming	1	**5%**
New drugs expensive	1	**5%**
Not used to full extent possible	1	**5%**
Base	20	

4-6		
Done for clinical reasons not just cost	8	**24%**
Still get prescribed anyway	6	**18%**
Drugs in secondary care still paid for	4	**12%**
Moving budget	3	**9%**
Time consuming	3	**9%**
Cheaper drugs not always as good	2	**6%**
Drugs not blocked but specialised	1	**3%**
Only small measures	1	**3%**
Unsure of long term cost effectiveness	1	**3%**
Difficult and sensitive issue	1	**3%**
Secondary care more aware of costs	1	**3%**
Poor communication from hospitals	1	**3%**
No results yet	1	**3%**
Base	33	

[Q18 continued]

7-10		
More cost effective products used	12	**18%**
Prescribing needs to be controlled	10	**15%**
Evidence that it works	9	**13%**
Adherence to guidelines from GPs	8	**12%**
Gives GPs 'excuse' not to prescribe certain treatments	8	**12%**
Appropriate prescribing is important	8	**12%**
Drugs still paid for in secondary care	2	**3%**
Products cheaper through hospital	2	**3%**
Unsure	2	**3%**
Poor communication from hospital doctors	2	**3%**
Done for clinical reasons not just cost	2	**3%**
As long as it is cost effective	1	**1%**
New drugs brought out often	1	**1%**
Other more significant factors e.g. waste	1	**1%**
Doesn't work for tertiary care initiated drugs	1	**1%**
Base	67	

Q19 How do you feel that the use of red-lists to prevent the prescription of certain products in primary care will change over the next 2 years in your PCT?		
	Total	
	N	%
Increase significantly	36	**30%**
Increase slightly	44	**37%**
Stay about the same	30	**25%**
Decrease slightly	4	**3%**
Decrease significantly	0	**0%**
Unsure	6	**5%**
Base	120	



[Respondents who answered 'Unsure' at Q19 were not shown Q20]

Q20 Why do you feel that the use of red-lists will [Answer from Q19] over the next 2 years?		
	Total	
(Summary of coding)	N	%
Increase significantly		
Need to cut costs / save money	20	**56%**
Drug expenditure looked at	7	**19%**
GP consortia	7	**19%**
New expensive drugs	5	**14%**
The system works	2	**6%**
Inevitable	1	**3%**
Safety concerns	1	**3%**
Certain conditions managed increasingly in secondary care	1	**3%**
Only recently introduced	1	**3%**
Tied to secondary care through shared budgets	1	**3%**
Base	36	

Increase slightly		
Need to cut costs / save money	21	**48%**
New expensive drugs	6	**14%**
GP consortia	5	**11%**
Drug expenditure looked at	3	**7%**
New alternatives available	3	**7%**
Appropriate prescribing is important (safety)	3	**7%**
The system works	2	**5%**
Pharmacist advisors role	2	**5%**
Will be used more	2	**5%**
NICE guidelines	1	**2%**
More work shifts to primary care	1	**2%**
Base	44	

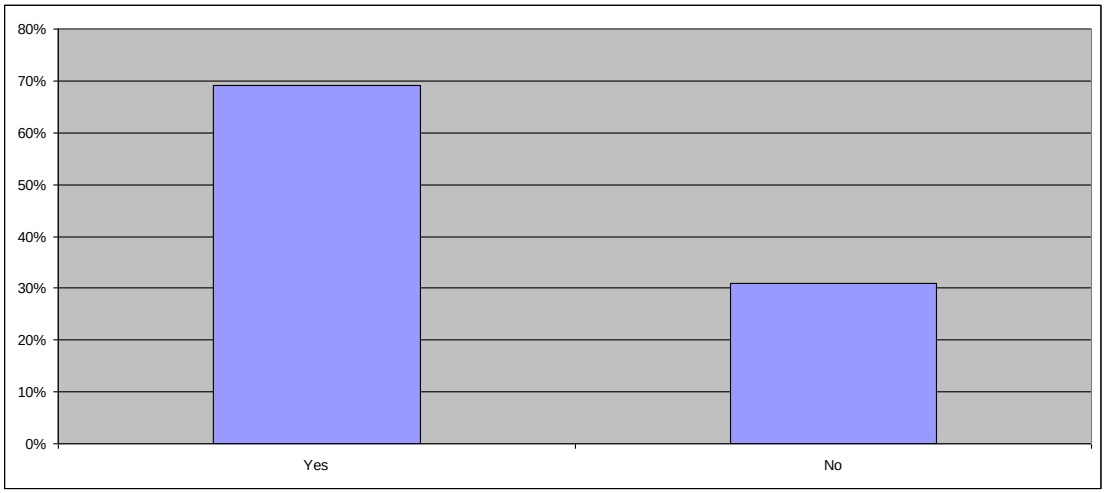
[Q20 continued]

Stay about the same		
No reason to change	10	**33%**
Mainly used for clinical reasons	5	**17%**
GP consortia	3	**10%**
Lists rarely change	3	**10%**
The system works as it is	2	**7%**
PCT structures / personnel changing	1	**3%**
No productivity saving	1	**3%**
Same rate of review	1	**3%**
GPs specialising	1	**3%**
Drugs paid for in secondary care anyway	1	**3%**
Prescribing more closely controlled	1	**3%**
National agreement needed	1	**3%**
Base	30	

Decrease slightly		
Cost of seeing dr in secondary care	3	**75%**
GPs specialising more	1	**25%**
Base	4	

Q21 What measures would a pharmaceutical company need to take to prevent more of its products from being red-listed?		
	Total	
(Summary of coding)	N	%
Reduce costs	52	**43%**
Cost effectiveness	29	**24%**
Good evidence base (efficacy)	28	**23%**
Nothing / unsure	17	**14%**
Safety ensured	12	**10%**
Advice / training for GPs	6	**5%**
Support patient monitoring	5	**4%**
Shared care	4	**3%**
Collaborate with PCTs	4	**3%**
No 'me too' products	3	**3%**
Patient access	3	**3%**
Flexibility with indications	3	**3%**
Availability	3	**3%**
Take care over marketing	2	**2%**
National / local approval	2	**2%**
Invent better drugs	2	**2%**
Demonstrate it can be prescribed in primary care	1	**1%**
Restrict use in secondary care	1	**1%**
Base	120	

Q22 Does your PCT have an amber list of products?		
	Total	
	N	%
Yes	83	**69%**
No	37	**31%**
Base	120	



[Q23 was shown to respondents who answered 'Yes' at Q22]

Q23 What are the criteria for a product to be moved to the amber list?		
	Total	
(Summary of coding)	N	%
Shared care agreement between secondary and primary care	41	**49%**
Cost rising / falling	16	**19%**
Experience / approval being gained	11	**13%**
Unsure	6	**7%**
New evidence	6	**7%**
2nd line	5	**6%**
NICE guidelines	3	**4%**
Can be only be used under certain circumstances	3	**4%**
Safety	3	**4%**
Trial period / under discussion	3	**4%**
Lower monitoring	1	**1%**
Clinical competence of GPs	1	**1%**
Well tolerated products	1	**1%**
Ease of use	1	**1%**
GPwSI can use	1	**1%**
High volume of prescriptions	1	**1%**
Patent	1	**1%**
Same as red drugs	1	**1%**
Base	83	

Q24 What methods of drug expenditure reduction, other than red-listing products, have you identified in order to cut the costs for your PCT?		
	Total	
(Summary of coding)	N	%
Use of generics / branded generics	34	**28%**
Cost effective drugs / switching	30	**25%**
28 day prescribing / reduce waste	23	**19%**
Formulary enforced (e.g. incentives)	23	**19%**
ScriptSwitch	20	**17%**
Reviews of prescribing / products	18	**15%**
Education of prescribers	9	**8%**
Fewer special products used	9	**8%**
QIPP targets	8	**7%**
Limit use of limited value / inappropriate drugs	8	**7%**
Medicines Use Reviews	6	**5%**
Black listing	6	**5%**
Local committees	5	**4%**
None	5	**4%**
Branded prescribing where cheaper	4	**3%**
Best practice	3	**3%**
Encourage OTC treatments	3	**3%**
Evidence based	2	**2%**
Patient access schemes	2	**2%**
Newsletters	1	**1%**
Base	120	

Q25 Do you believe there are likely to be any adverse consequences of implementing these planned changes? If so what are they?		
	Total	
(Summary of coding)	N	%
None	60	**50%**
Doctor - patient relationship suffers / complaints	11	**9%**
Patient choice suffers	9	**8%**
GPs dislike guidance	7	**6%**
Unsure	6	**5%**
Possibility of misunderstanding	5	**4%**
Risk of using less effective treatments	5	**4%**
Lose new / good treatments	5	**4%**
None if protocols / guidance followed	4	**3%**
Workload in primary care	4	**3%**
Pharmacy remuneration structure	3	**3%**
Compliance from patients	3	**3%**
Lack of individualised therapy	2	**2%**
Patient health must be prioritised	1	**1%**
GPs rely on external help	1	**1%**
Postcode lottery	1	**1%**
Increased costs in long term	1	**1%**
Transition to GP commissioning	1	**1%**
Supply chain issues	1	**1%**
Base	120	

Q26 If you have any comments or other questions on the subject or questionnaire, please write them here.
(Verbatim responses)
Although a red list may be seen as a cost saving exercise it also promotes good medicines management for drugs that need specialist initiation and monitoring. It also focuses secondary care clinicians to prescribe within national and local guidelines - a worthy goal.
Category M in the Drug tariff is a joke. The price should ALWAYS be the cheapest commonly available pack. Ventolin Evohalers for about 6 years was CHEAPER than the drug tariff generic equivalent (not the case now). I have a list of about 20 drugs which we will now be branding as Cat M is not fit for purpose.
Drug companies need to provide full evidence of the effectiveness of their products (not just flimsy studies involving a handful of patients)
Just that decisions are made on a clinical basis rather than financial
Massive savings needed!! Drs still able to write more or less what they like, e.g. 3 months supply, branded products when generics are available. We see tremendous waste - 5 dustbins full of returned drugs disposed of each month !!!
Pharmaceutical sales reps just don't understand any of this. They are completely product focused
Red listing as a cost containment tool is in my view doomed to fail - the only justification can be on clinical responsibility grounds. NHS money will be spent wherever the drug is prescribed so the PCT will pay even if only indirectly. It is illogical for patients and poses a risk if the hospital drugs are not included in the patient's GP clinical record.
Red lists are used where the benefits of the drug have been judged unaffordable by the HE. It does not mean that the drug doesn't work just that the money has been used to fund another drug or intervention
The assumption seems to be that the only criteria for red-listing is on the grounds of cost. This is not true. Red-lists are used to limit use of newly launched or clinically inappropriate drugs. Drugs where the safety profile is unclear, They may also be for drugs where there is a more appropriate alternative, and it is preferable that this is used instead. It isn't used as a means of limiting prescribing due to cost. This is a totally incorrect assumption.

[Q26 continued]

The PCTs are always trying to save money by using various devices such as branded generic prescribing for cheaper alternatives or restricting the use of new drugs under the guise of not having a ruling from NICE or being a new drug etc. We the clinicians have to see through those points and put across the patient benefits and ensure that any decisions taken are not based on costs. In our PCT there is a Black list which. The drugs on this list can only be prescribed by a specialist with the special permission of a committee of the Board, and must report their experience with such drugs to the committee to justify continued prescribing. Shared care agreements will also lead to transfer of drugs from the Red list to the Amber List. Our board is taking a chapter by chapter review of the BNF and recommending preferred drugs list.
The questionnaire was all about saving money which is not what red lists are for, they are for ensuring safe and appropriate prescribing and monitoring of complex diagnoses and drugs
The red list is nothing to do with cost
This is a difficult subject in practice and will get worse as consortia come under financial pressure
This stuff has been going on for several years at our PCT - surprised no interest shown earlier

Appendix A - Original Questionnaire

Q1 For Which Primary Care Trust (PCT) do you currently work?

Open-ended

Q2 Are you currently, or do you expect to be, involved in decisions relating to formulary or recommended product lists in your PCT?

Yes
No [Screen out]

A recent study has found that over half of the English PCTs are adding drugs to their 'Red lists' of products that can only be prescribed by a Consultant in secondary care. (http://www.telegraph.co.uk/health/healthnews/8446782/Patients-are-denied-high-cost-drugs-by-NHS-trusts.html)

Q3 Does your PCT have a red list of products which GPs cannot prescribe, and can only be used by hospital Consultants?

Yes
No [screen out?]
Unsure [screen out?]

Q4 Approximately how many individual drugs comprise this list?

[drop down list]
1
2
3
Etc.
20+

Q5 Who would typically make the decision to add a product to such a list?
Please provide job or committee titles where possible

Open-ended

Q6 How often would your PCT review products with the intention of adding them to the red list?

Open-ended

Q7 Please select the top 3 therapy areas in which your PCT is looking to save money by adding products to the red list.

Cardiology
Chest medicine
Cytology
Dermatology
Endocrinology
Gastroenterology
Genitourinary
Gynaecology
Haematology
Immunology
Lipidology
Nephrology
Neurology
Ophthalmology
Orthopaedic
Otorhinolaryngology
Palliative
Psychiatric
Rheumatology
Urology
Other, please specify _____

Q8 Please describe the process by which products come under consideration for adding to the red list?
Open-ended

Q9 What criteria would decide whether a product was put on the red list?
Please select all that apply

Total drug expenditure high [go to Q10]
Total drug expenditure too high [go to Q11]
Total drug expenditure has risen unacceptably [go to Q12]
The patent of the branded drug has expired
Other, please specify_____

Q10 What level of expenditure is considered high?

Open-ended

Q11 What level of expenditure is considered too high?

Open-ended

Q12 What level of increase has been considered unacceptable?

Open-ended

Q13 Are you aware of any drugs that your PCT is considering ADDING to its red list?
Please list as many as applicable

_____

_____

_____

_____

_____

Or: Unsure

[Repeat Q14 for all at Q13]
Q14 For what reason(s) would you add [Answer from Q13] to the red-list, other than cost?

Not cost effective in short term
Not cost effective in long term
New clinical evidence
Cheaper alternative available
Generic available
Should be prescribed by specialists
Lifestyle changes preferable to medicine
Cost is the only factor
Other, please specify _____

Q15 Are there any drugs currently on the red list that you would like to return to the green list?
Please list all that apply

_____

_____

_____

_____

_____

Or: None [Go to Q17]

Q16 What would the manufacturers need to do in order to have their product returned to the green list?

Open-ended

Q17 How effective do you feel that the measure of preventing certain drugs from being prescribed in primary care is in saving money for PCTs?

10 = Very effective | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 = Not at all effective

Q18 Why do you say that?

Open-ended

Q19 How do you feel that the use of red-lists to prevent the prescription of certain products in primary care will change over the next 2 years in your PCT?

Increase significantly
Increase slightly
Stay about the same
Decrease slightly
Decrease significantly
Unsure [go to Q21]

Q20 Why do you feel that the use of red-lists will [Answer from Q17] over the next 2 years?

Open-ended

Q21 What measures would a pharmaceutical company need to take to prevent more of its products from being red-listed?

Open-ended

Q22 Does your PCT have an amber list of products?

Yes
No [go to Q24]

Q23 What are the criteria for a product to be moved to the amber list?

Open-ended

Q24 What methods of drug expenditure reduction, other than red-listing products, have you identified in order to cut the costs for your PCT?

Open-ended

Q25 Do you believe there are likely to be any adverse consequences of implementing these planned changes? If so what are they?

Open-ended

Q26 If you have any comments or other questions on the subject or questionnaire, please write them here.

Open-ended

Medix Contact Details

MedixGlobal
Address: 15 Meadway Court,

Stevenage, SG1 2EF, United Kingdom

Tel: 01763 853303
Fax: 01763 853573
E-Mail: me@medixglobal.com
Website: http://www.medixglobal.com/

Research Director: Mehdi Ehtesham