Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Prescription Charges

10 March 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Pól Callaghan
Mr Alex Easton
Mr Tommy Gallagher
Mr Paul Girvan
Mr John McCallister

Witnesses:
Ms Emer Morelli) Department of Health, Social Services and Public Safety
Dr Norman Morrow)

The Chairperson (Mr Wells):

I welcome Ms Emer Morelli and Dr Norman Morrow from the Department of Health, Social Services and Public Safety, who are here to brief us on prescription charges. I am sorry that we have brought you in a little bit earlier than you had anticipated, but you are the fount of all knowledge on the issue, and I know that you are ready to get going. As usual, please take 10 minutes to set the scene, after which we will have questions from members. You will hardly be surprised if we have a quick saunter into Castlederg in the middle of the discussion; I am sure that you were expecting that.

Dr Norman Morrow (Department of Health, Social Services and Public Safety):
I suppose that I was. Thank you for the opportunity to address the Committee. Rather than merely repeat the contents of the briefing that the Minister sent to the Committee, I thought that it may be helpful, in aiding our discussion, to talk a little bit about the context and application of the policy and its impact.

It is in the ethos of the NHS that services are based on need, not on the ability to pay. Therefore, it was deemed that our charging system, as was, was unjust, and that the exemptions list, which had been created over many years, was rather outdated. There was also concern that individuals were deciding to have their medications dispensed on the basis of affordability. Of course, that is not a helpful situation inasmuch as not taking the necessary medications introduces new morbidity into the system, among other things. The charges were generally viewed as a tax on the sick.

On the other side of the context of policy, is the question of efficiency. Members may recall that the Appleby report of 2004-05 identified some £55 million of savings in the drugs bill. That heralded the introduction of the pharmaceutical clinical effectiveness programme, which was designed to deliver efficiencies. It was not predicated on a solely economic model, but rather, the paradigm was that, by investing in quality and safety, we could demonstrate health improvements and deliver efficiencies. That has been the paradigm that we have operated since that time. Over the period, we have demonstrated some £94 million of efficiencies in the medicines budget.

Members will also be aware that in the 2008-2011 comprehensive spending review (CSR) period the service was required to deliver some £40 million of medicines efficiencies, and that, in 2010-11, a further £41 million was added to be gained in a single year. That was quite a challenge. It is in the wider policy context, and this efficiency context, that the free prescriptions policy was introduced, amid a wide range of initiatives in our pharmaceutical clinical effectiveness programme, which was designed to improve medicines management across the health and social care sector. That continues today and will, I anticipate, have to continue beyond this point.

In relation to application, the Minister heralded the policy change in 2007, and he announced in September 2008 that there would be the abolition of prescription charges from 1 April 2010.

That was endorsed by the Executive, and that instigated the work to introduce the change, including the necessary legislative changes. In January 2009, prescription charges were reduced to £3, and charges for pre-payment certificates were also reduced. As the Committee knows, the final stage of the process was fulfilled with complete abolition of charging in April 2010.

The aspect that is probably the most important and will be of interest to the Committee is the impact that the abolition of prescription charging has had. It might be helpful if I try to outline how things sat before and to indicate what happened after, so that the Committee can make the comparison.

Before charges were abolished, some 50% of people receiving prescriptions were entitled to free prescriptions, and around 89% of all items were dispensed free of charge. Of the 11% that were paid for, some 6% was by pre-payment certificate and the other 5% was by people paying the full charge. Those charges generated something in the order of £13 million net in 2008-09. From 2004 to 2010, the growth in prescription volumes averaged approximately 5·6% each year, and it was about 33% over that six-year period. Up to 2004, prescription costs were increasing at a rate of some 9% to 12% each year, but, since we introduced our programme in 2005, that has roughly halved to about 6%. Therefore, you can see through the comparison of those figures that the growth in prescription cost closely tracked and was related to the growth in prescription volume.

That was the before story; I now turn to the after story. The income dropped initially to £6 million when the charge was reduced to £3. It has, of course, dropped to zero since April 2010 when prescription charges were abolished. We have made savings of some £850,000 through the alleviation of administrative costs that were associated with the charging policy.

At the same time, the number of prescription items dispensed has continued to grow at a pace that is roughly comparable with historical rates. However, I want to make one correction to paragraph 8 of the briefing note to the Committee. In that paragraph, we give the Committee some figures that compare the rates of change from April to November 2009 with April to November 2010. The percentage figure for the increase in the number of items dispensed should read 7·1% rather than 6%, and the costs should show an increase of 6·6% rather than 6%. I apologise for that error, but I am pleased to be able to correct it at this point.

Across the bands of prescription ingredient costs, growth in item-level activity is evident only for the less expensive medications, particularly those costing up to about £5. That implies the influence of generic prescribing policy; indeed, some 45% of all items cost £3 or less. Recent evidence also suggests that there is no change in demand for prescriptions across age bands, apart from a slight increase in working males from 17% to 18%. However, it is doubtful how statistically valid that is in that particular case.

Having outlined the before and after situation, I now want to paint in some of the background picture. Our generic prescribing rate has increased from 43% in 2005-06 to 62% in December 2010. Our target for this year up to March is 64%, so we are tracking that target. At the same time, we have continued, throughout the whole period, to apply a range of actions to improve medicines management across the service; significantly, work to develop clinical guidelines, to apply them to both prescribing and procurement practice, and to elaborate them further within a formulary. We hope that, within the next two weeks, the Health and Social Care Board will put out for consultation work around the introduction of a formulary in Northern Ireland.

Members will have seen that, just before Christmas, we launched a public education campaign designed to reduce the waste of medicines, which built on work carried out in England at the University of York and in London. Northern Ireland was the first to act on that information, and the other countries have followed suit with public education. It is a good opportunity not only to highlight the issue of waste but to seed the message that, with freedom, comes responsibility, both by prescribers and by members of the public, allied to the use of medicines, and that continues.

To date, we have had quite a successful programme to improve medicines management in health and social care. However, there is more to do, and we are not in any way complacent about that fact.

Data is not available at a much more micro-level to be able to assess the discrete impact of free prescriptions and the numbers written and dispensed, because that activity is somewhat confounded by all the other activity going on. However, in the past year or less, there appears to be a slight increase in the prescription volumes against the background level of something in the order of 1% to 1·5%. It is not possible to say with absolute certainty that that is uniquely due to the effects of the policy change. As I indicated, other changes have gone on. Indeed, the statistical advice that we have received is that we need data covering at least 18 months to be able

to offer statistical validity, and we will continue to monitor that data.

Nevertheless, for the years up to 2009-2010 for which we have full-year figures, costs have been contained within the allocated budgets, and, at the same time, we have had greater productivity relative to the dispensing of medications, as well as being able to introduce free prescriptions. That is the situation as we judge it at the moment. I am happy to answer any questions.

The Chairperson:

Thank you, Norman. For the record, I state that Dr Norman Morrow is the Chief Pharmaceutical Officer from the Department and Ms Emer Morelli is from the Department's primary care directorate. I am not going to ask the obvious question, Emer, about your surname. However, I hope to visit you over the summer to get some free samples.

Initially, I thought that we would go through some technical questions and then come to Castlederg, but I am afraid that I cannot resist the temptation. Brendan O'Hare from the Castlederg surgery made a dramatic announcement. His quite astonishing figures have revealed savings of £311,000 in five weeks — enough to fund every heart bypass surgery request in his surgery for a year. If that is what a surgery can do in somewhere such as Castlederg, which is slightly off the beaten track — Thomas Buchanan will beat me up when he hears that, but it is not south Belfast or north Down — what savings could be obtained throughout the country if every GP surgery adopted that policy?

Dr N Morrow:

First, I want to say that I welcome that, because it supports a lot of the work that we have been doing to improve the way in which medicines are prescribed and managed in the service. It is also true to say that, over past weeks, the Health and Social Care Board has put significant resources into work in the western area through the primary care partnership programme, and prescribing has been one of the focus areas for that work. So, it has been a supported programme.

The other thing that I would like to say is that we need to achieve higher levels of generic prescribing compared to some of our counterparts. My view is that that is the policy and we should be expecting our GP prescribers to do exactly that. It has taken us considerable time even to get from 43% to 62%, but we have done that over the past number of years, and it is incumbent

on the service for prescribers to follow that pathway. I add one caveat: not every medicine can be prescribed generically. In some cases, it would not be appropriate. Nonetheless, it is an important policy, and we believe that there is continuing benefit to be derived from it.

The Chairperson:

I always like to ask a question to which I already know the answer. The BBC research department has shown that, if everybody went down the Castlederg route, there would be £60 million worth of savings in five weeks.

Dr N Morrow:

This morning, I contacted the regional Health and Social Care Board to ask it to confirm those figures and to give details about how they were developed. As yet, it does not have that information available. So, I have tried to get a little more detail, without success.

The Chairperson:

You and I attended a dinner the other night at which we met many of those people. My understanding is that discretion is still with the GP as to whether he prescribes generic or branded medicines. Is it still his decision?

Dr N Morrow:

Yes.

The Chairperson:

The fact that, as my mother would say, there is not a ha'p'orth of difference between the two products is neither here nor there; it is the difference between buying a branded product and what a certain supermarket used to call a yellow-pack product. Given the present financial situation, if it does not affect front line patient care one iota, why do we not simply tell GPs that, from now on, unless there is no other option, they must prescribe generic products? The savings would be enormous: £60 million spread over the CSR period amounts to £240 million. That would be a huge saving, and it would solve many of the perceived problems that the Minister says exist under the new Budget. Why are we leaving it to GPs' discretion to decide whether to go for the £26-a-bottle medicine or, in old money, the seventeen-and-six bottle? Why is he allowed discretion to prescribe something that can be 20 times dearer than the generic product?

Dr N Morrow:

That has been the position historically. I agree that it is incumbent on prescribers to prescribe according to the policy, and we should expect them to do that. That is their responsibility, and we made that point to the Health and Social Care Board, which is responsible for the monitoring and performance management of prescribing in the service. I told it that I believe that that is the position that we should adopt.

The Chairperson:

Could we not just issue an edict? As the Chief Pharmaceutical Officer, could you not just tell GPs that, as of Monday, they must prescribe generic products unless there is no other option?

Dr N Morrow:

That policy would have to come from the Minister, but I am happy to take that view back.

The Chairperson:

If it were to be done, would the decision affect patient care in any way?

Dr N Morrow:

In my view, they are all licensed products and, therefore, fulfil the quality standards relative to their nature. There are some areas where generic preparations would not be appropriate or suitable, but they tend to be well known and only in a minority of cases. There is no reason why we could not apply the policy much more widely. I should say that, at this moment in time, we are sitting at 62%. The data from England suggests a figure of 68%, so we have a little way to go, but, in my view, we should be pushing to do that.

The Chairperson:

In a budget of £604 million, each percentage point increase represents an enormous amount of money.

Dr N Morrow:

The budget is just over £400 million, and there is about £100 million in secondary care.

The Chairperson:

Even at six percentage points, the increase is £24 million, with no impact whatsoever on the

patient.

Mr Girvan:

Does that include medication that is prescribed through the hospital as well? It is not necessarily only GPs that we are dealing with here. Income from receipts was £13 million, which represented 3% of the £433 million allocated for drugs. That is my calculation of the figures. That is how much money was being spent annually on drugs through prescription. At another Committee meeting, Kieran Deeny alluded to the fact that some generic drugs are nearly as dear now because of what is happening. Drugs companies have inflated their prices. Their drugs were seen to be cheap at one stage, so they filtered in and increased the prices. Is there some tracking mechanism that can be used to ensure that we are getting a reasonable price on a world market base for the drugs?

Dr N Morrow:

We have a drug tariff in the system. It controls the reimbursement prices that are paid to community pharmacists for dispensing medication. That is part of the controls in that situation.

The Chairperson:

For continuity, I am allowing folk in on the implications of the situation in Castlederg. Pól is next, and he will be followed by Michelle and John.

Mr Callaghan:

One obvious question strikes me, and I do not know the answer to it. Is there something odd about Castlederg? By that, I mean in relation to the pharmacy specifically and not generically, if you pardon the pun. Is there something particular about the circumstances there? This has big ramifications for the wider issue. Was there a particular issue that needed to be addressed in that district of Tyrone or in the Western Health and Social Care Trust area that is very different to other parts of the North? Or is it your assessment that what was going on in Castlederg previously was broadly reflective of general practices in dispensing?

Dr N Morrow:

I cannot answer that question specifically. It may have been helpful to have had representation from the health board. It is closer to it. This is a general statement, but it is true to say that there are variations in generic prescribing across the 360 practices. Some well exceed our current

average levels, and others are not at those levels. Dr O'Hare has been a member of our efficiency group. He has been trying to take forward work to identify opportunities where, in that area, the levels of generic prescribing can be increased. I do not have any specific data. The question is more appropriate to the health board.

Mr Callaghan:

Will you tell us more about the drug tariff? When we talk to people who are involved in primary care to get a bit of a handle on some of the issues, it is drawn to our attention that even the word "prescription" is potentially misleading. We talk about prescription charges, because the charge was applied as a result of a prescription. Is the cost to the system not as a result of the decision at the point of dispensing, rather than the point of prescribing? If so, what steps are being taken to deal with that? As I have declared before, my wife is a chemist — I am not saying that what I am going to say came from her. Is it possible for a GP to prescribe a generic drug and the pharmacist to dispense a branded drug for that prescription? From a public policy perspective, that would be a fairly serious matter, given all of the issues that are under consideration. Is there anything to stop that happening at the minute? What guidance is in place on that?

Mr Easton:

The answer is "yes", it is possible, because it has happened to me.

Dr N Morrow:

The answer is "yes". If the prescription is written generically, it is up to the pharmacist to choose the preparation that he or she wishes to give. That could be a non-branded preparation or a branded preparation. However, the other side of that is that, when a GP prescribes a branded product, the pharmacist is required to dispense that branded product. So, on the one hand, the pharmacist has some freedom and, on the other, he or she does not.

Mrs O'Neill:

You said that some GPs prescribe generic drugs and some do not. Why do some GPs not prescribe generic drugs? What is the reason for that reluctance? Do they believe that the drugs are of lesser quality? Why would a GP not prescribe generic drugs?

Dr N Morrow:

There is a responsibility in the way that we treat public money to follow the policy. At the same

time, some GPs would say that there is a degree of patient pressure to follow the branded route, and there is a perception among the public that some branded medicines are better than the non-branded ones. We can all go into the supermarket and see yellow-pack cornflakes, but how many of us buy those and how many buy Kellogg's Corn Flakes? So, public behaviour is a factor, and having branded medicines is an issue for some patients. We have had various representations from some of the patient-interest groups on our generic policy, because they favour branded drugs.

Ms Emer Morelli (Department of Health, Social Services and Public Safety):

Anecdotal evidence shows that older people are more comfortable with a tablet that they recognise and are loath to be moved to a new tablet that they do not recognise or that looks similar to other tablets that they take.

The Chairperson:

That is costing an extra £311,000 every five weeks in one surgery.

Dr N Morrow:

I would like to bottom-out those figures, if I may.

The Chairperson:

Maybe that surgery started from a high level and has come down, I do not know, but it is an astonishing figure that I never thought was possible. It begs the question of how much money was wasted in that surgery and many others over the past four or five years.

Mrs O'Neill:

Legally, there cannot be a difference between a generic drug and a branded drug. Is that correct?

Dr N Morrow:

Not from a licensing point of view. The drugs may be a different colour or shape and they may have markings on them, but the effect will be the same, because they are licensed products.

The Chairperson:

So, you could be paying 10 times more for a label. That is basically what you are paying for. The other day, I had a headache in this Building and bought a certain pain reliever, the name of

which starts with "A". I paid £3·60 for 10. At home, I have a box of the same tablets, which cost me £2 for something like 200 tablets from Tesco. That is the problem, and yet GPs are reserving the right to go for the big yellow packet rather than for the Tesco-type cheap alternative.

Mr Easton:

They are cheaper in ASDA by the way.

Dr N Morrow:

I am like you, Chairperson: if I need medicines, I buy generic ones if they are available, because I have no difficulty with their efficacy. We also have to recognise that, while we have a policy, we also have a pharmaceutical industry that is very keen to see its branded products used. It would be wrong for any of us to think that there is just one issue here, but the general principle is there. That is the policy that we should follow.

Mrs O'Neill:

Just for clarification: is it part of a GP's contract that he or she has the right to prescribe branded drugs, or could the Minister simply set a policy that all GPs must, by and large, prescribe generically?

Dr N Morrow:

I am not an expert on the details of the GP contract. I do not think that it requires them to follow that absolutely, but I think that it requires them to have regard to the public purse in relation to cost-effective prescribing. I think that the General Medical Council's ethics and standards require them to do likewise. My view is that there is a moral, ethical responsibility on all professions to utilise public money appropriately.

The Chairperson:

Norman, you could simply say, "From 1 April, we will not pay the bill. If you wish to allocate a branded product to a patient, that is fine, but it will come from the internal resources of your surgery. The Health and Social Care Board will not pick up that tab." If you did that, you would find that the generics would rise rapidly.

Dr N Morrow:

We need to remember the sequence of events. The GP or the prescriber will prescribe. That

prescription will come to the pharmacist, and he or she is bound to dispense the medication according to the prescription. In fact, we are not reimbursing GPs relative to what they prescribe; we are reimbursing pharmacists for what they dispense.

The Chairperson:

For how long would the pharmacy continue to accept scripts from a GP, if it had to pick up the tab for it? It would simply send the boy back and tell him to get the generic prescription, because it will not want to pay for the branded medicine.

Dr N Morrow:

I think that the pharmacists would probably say that it is wrong to penalise them by proxy.

Mrs O'Neill:

I think that your point, Chairperson, is that where there is a will there is a way.

The Chairperson:

It seems that it is £60 million for nothing, in a terribly difficult financial situation. It is £240 million over the CSR. That would go a long way to meet the problems that are perceived to be facing the Health Department over the next four years. It is an even softer hit than the consultants' bonuses.

Mr McCallister:

Norman, I have heard you and Emer say before that people view generics as somehow inferior. Emer, you made a point about older people, in particular, changing tablets. It can be confusing for them if they get a different generic drug every time that they get a batch of tablets. However, the principle of driving up the usage of generics is an obvious area in which the Health Department can drive efficiencies. Roughly £400 million is spent in community pharmacies, and something in the region of £100 million is spent in hospitals. Do all hospitals use generic drugs?

Dr N Morrow:

Yes, where the generic product is available. They have policies on that.

Mr McCallister:

So, the real problem is in the community. You say that we are currently at 62% generic usage,

and England is at 68%. Where will the cut-off point be? Will it be at 68%, 78% or 88%? Where are we driving to? I take the Chairperson's point that we might need to get very draconian on the issue: to tell them what the policy is and to get on with it.

The Chairperson:

What is the upper limit? What is the maximum that you could go to on generics?

Mr McCallister:

I am not expecting an absolute answer.

Dr N Morrow:

My view is that it is probably the low seventies.

Ms Morelli:

Not every product has a generic equivalent.

Mr McCallister:

I accept that, especially with new developments coming along.

Dr N Morrow:

It is a dynamic situation in which products constantly run out of patent, and, when they are going out of patent, other things are being introduced. The industry is also keen to try to think of ways in which it can prolong the life of its products. We term that the greening of a pharmaceutical product. Some modification can be done to it to allow it to stay within the system, thereby maintaining the brand situation. We are trying to think about ways in which those kinds of things can be best managed.

Mr McCallister:

As a rough guide, we are probably 10% off what a target might be.

Dr N Morrow:

Possibly.

Mr McCallister:

England is not even there yet. There are huge savings to be made, if we rose to that level.

Dr N Morrow:

I will put it in context for the Committee. Before 2005 — this may come as a shock — our generic rate was rising at about 1% a year.

The Chairperson:

One percentage point a year?

Dr N Morrow:

Yes. Over the period of the programme for which we have had responsibility, the rate has moved from 43% to 62%. That is something like four percentage points a year. One might ask why it has taken so long, and I fully accept that. The fact is that we have done it using a kind of voluntary persuasive system. I think that what you are saying, Chairman, is that we should make it a coercive system.

The Chairperson:

We are good friends, and I want us to remain so. One letter from you three years ago, co-signed by John Compton, saying that you are the boss and that you will not sanction any further prescriptions of branded drugs where there is a generic alternative, would have saved an absolute fortune.

Dr N Morrow:

If only I were the boss.

The Chairperson:

You are the Chief Pharmaceutical Officer. You are the boss. You could have said to GPs that, from 1 April 2007, branded products would not be sanctioned. The savings would have been absolutely enormous; we are talking about hundreds of millions of pounds. However, you have gone about it very gently and urged them. You say that there is a moral imperative and that you try your best. Those folk are being paid by the taxpayer; they are under the control of the Department; and it will not affect patient care one iota. Why are we not doing it immediately, if not sooner?

Dr N Morrow:

With respect, Chairman, it was not in my gift to have that as a mandatory policy. At the same time, I believe that that is the position that we should be in; we should require that we follow the policy assiduously.

Mr Callaghan:

The Hansard report will show the different figures that have been given. It is difficult to keep track of figures when they start flying around the table, but I am nearly sure that you said that it was £300 million plus £100 million between community and secondary and then, when John suggested that it was £400 million plus £100 million, you agreed with that.

Dr N Morrow:

£400 million plus £100 million is correct.

Mr Callaghan:

Maybe it was my misapprehension. As long as I know what it is when I leave here, I am happy enough. Thank you for that clarification.

If it is the case that a pharmacist has the discretion to dispense a branded formula when a GP or other practitioner prescribes the generic formula, is there any monitoring of that by the board or the Department? Is the pharmacy obliged to report that to the board, given that the board is picking up the tab? If so, can you quantify that? If not, can you give us an estimation of what the cost of that is? Furthermore, is that issue one of the things that was addressed in Castlederg? Was the power to dispense a branded concoction when a generic one was prescribed removed from the pharmacy in Castlederg? You may not know the answer to that, but it may be one of the issues that contributed to the drastic reduction.

Dr N Morrow:

If a prescriber prescribes a generic product, even though the pharmacist dispenses a branded product, it will be paid as a generic product. That deals with that situation.

The Chairperson:

I apologise, Alex; I did not see you looking to get in.

Mr Easton:

I have a question about a different issue.

The Chairperson:

I will let you in first in the next round of questions to make up for —

Mr Easton:

Can I make a point quickly?

The Chairperson:

Yes.

Mr Easton:

Some of the public, particularly the older generation, have a fear about the use of generics. I dealt with the case of a lady whose GP put her on a generic drug — she was on the other type beforehand — and she refused point blank to accept it. It got that ridiculous that I ended up writing to the Minister and stuff, but we got her sorted out. Similarly, my mother would not touch a generic drug if you tried to pay her. A certain amount of education is needed to increase the use of generic medicines and to get the older generation to accept their use. There is a fear factor that those medicines are substandard, but that is not the case.

Dr N Morrow:

I take your point, and I agree that there is a need for education. I have two points that I want to make. If patients' medications are changed from branded products to generics, it is important that pharmacists explain that the tablet may be a different colour, but that it is "the same only different" — if I can put it in those terms. The other factor that is perhaps more concerning for patients is that, because there is such a range of generics in the market prepared by different companies or manufacturers, a patient may have a white generic dispensed one month and a yellow one the next. I am keen to achieve consistency in generic medicines and to ensure that, for example, your mother can get the same generic month after month, so that she is confident in that medicine. However, that may be difficult to arrange because of the way that we procure our medicines through community pharmacies. That is an important issue of safety and confidence.

The Chairperson:

I have one last question on generics. Other European countries must have faced the same problem. Also, there must be some countries with mandatory lists that will simply not pay for a branded product if a generic product is available. Do we know what the best practice is elsewhere? What percentage of generic use have other countries achieved?

Dr N Morrow:

I do not know the absolute answer to that. The systems in Europe are different. Some are run through insurance companies that have their own methods of control, some have public bases and some require patients to pay or to pay in part, and if they want a particular product they may have to pay the extra. Therefore, there is a range of factors.

In the wider world of the branded market, the United Kingdom has a pharmaceutical price regulation scheme that aims to ensure that the NHS is able to access medicines at a price that it can afford, while allowing due profitability for the pharmaceutical industry. That scheme is under review, and you may have read some consultation information on value-based pricing. However, that is another story, and maybe I should not go there.

The Chairperson:

Many years ago, I took a tour of a crisp factory that will remain nameless. Some crisps went into branded packets and others into plain packets for a supermarket. For years, I swore that the crisps in the branded packets tasted much better than the ones in the plain packets, but, as it turned out, they were exactly the same. The only difference was that they were considerably cheaper in the supermarket. That is the same problem as the one to which Alex referred. There is a placebo effect, and people feel that, because the medicine is a particular colour or in a packet that they recognise or understand, it will make them better. However, the fact that generics are always prescribed in hospitals indicates to me that the professionals know that it does not make a ha'penny of difference what is on the label and that it is the content of the pill that counts.

We have given the issue of generic medicines a fair crack, and I want to move on. Why on earth was £53,000 spent prescribing suntan lotion between April and July 2009 and £51,000 between April and July 2010? That is almost £200,000 in a year for prescribing suntan lotion. If I can afford to go on holiday to Spain or Portugal and need suntan lotion, I should go into a pharmacy, pick up a tube of suntan lotion and pay for it. In difficult times, why should the

taxpayer pick up that type of bill?

Dr N Morrow:

I am unsure of your figures, Chairman, however —

The Chairperson:

You provided those figures in a table in paragraph 16 of your briefing paper.

Dr N Morrow:

Sorry, I see them now.

The Chairperson:

That means that, in the past five years, £1 million was spent on suntan lotion for people going on holiday.

Dr N Morrow:

Let me try to clarify the situation if I can. It is not, to use your terminology, suntan lotion. As categorised in the British National Formulary (BNF), it tends to be a sun-screening agent that is included because of its therapeutic effects. Our briefing paper includes some examples of patients who may be sensitive to sun because of the use of other medication, et cetera. We assume that those agents are being prescribed for therapeutic reasons, not for the purposes of people taking sunscreen on holiday. As I understand it, the way that those are categorised in the British National Formulary and quantified by our Business Services Organisation (BSO) in relation to prescribing, it is a matter of those agents treating patients who need that particular type of medication. For example, patients on antibiotics or on psychiatric medication can become much more sensitive to sun, and, therefore, such agents may be prescribed.

The Chairperson:

Presumably, one can go into a pharmacy and buy those products off the shelf?

Dr N Morrow:

That is true of a number of them, yes.

The Chairperson:

When a product is available to buy off the shelf and competition means that the "yellow pack" version can be purchased, is it unreasonable to expect people to do what I or anyone else would do, which is simply to go and buy it?

Ms Morelli:

The issue is the frequency of use. Anyone who is undergoing radiotherapy or has a skin condition would have to buy a significant amount of suncream. Why is that different from any other health condition that would be regarded as deserving of free medication?

The Chairperson:

Therefore, it is not a case of someone who is going to Madeira for three weeks walking into a pharmacist and getting extra suncream?

Ms Morelli:

No.

Dr N Morrow:

That is not our understanding of it. A range of medications that is legitimately prescribed can be bought in a pharmacy. In some cases, people can go into a garage and buy general sales list products, whereas others are pharmacy-only products. A range of prescribed products is also available to buy. Not all medicines prescribed are prescription-only medicines.

Mr Callaghan:

On that point, Emer, in 2009, we were told that just over 6,500 items were dispensed. Thanks to the Blackberry, I can work out that that equates to just over £8 per item. From what I can remember, that is similar to the amount that one would pay for suncream. Do you know how many unique users — to use the Internet terminology — that involves? You mentioned repeat usage. Do about 6,000 people get a one-off prescription in a year, or do the same people get multiple prescriptions?

Our confidence in spending depends on whether this is about people going on holidays who might have a legitimate condition or whether they ought to be given a prescription for sunscreen, given that they can afford to go on holidays. One of my friends cannot go out in extreme sun

because he was burned on the face as the result of an explosion. I do not know how he gets his suncream, but that is neither here nor there. I can accept that there may be legitimate purposes. However, we do not really know anything about it. I am not sure whether what you have said — with respect — sheds any light, if you will pardon the pun, on it. Do you have details of how many people are involved?

Dr N Morrow:

Not from this data.

Mr Callaghan:

Presumably, that detail can be found out?

The Chairperson:

If 6,000 people get a prescription once a year, that is the Madeira scenario, but if 600 people get a prescription 10 times a year, they have a medical complaint.

Dr N Morrow:

I fully accept that. I do not think that we have any evidence that it is a case of people going on holiday. We cannot say that at this point. Our understanding is that those products are available for legitimate therapeutic reasons.

The Chairperson:

All sorts of allegations have been made about, for example, Savlon and Germolene, which the ordinary man on the street would expect to have to buy. I wonder how many other items on this list, which most reasonable people would just buy, have been prescribed.

In the old days, certain people would not get prescriptions because they had to pay for them. The problem with free prescriptions is that there may be a temptation for folk to go into a surgery and say that they need a certain product, when, in the normal course of events, they would have bought that product.

Ms Morelli:

That was one of the conditions on the introduction of free prescribing. Through the BSO, we are monitoring the top five most common over-the-counter medications to determine whether there

has been an increase as a result of free prescribing. We have only six months' data at the moment and will probably not have data for the full year until next June.

The Chairperson:

There should be a lower tier of products that are prescribable but should not, reasonably, be prescribed. Otherwise, the system will become cluttered up with people in surgeries trying to get such products. I understand that £26 is the average consultation figure.

I have attended various dinners at which pharmacists told me that folk have been told that they can get certain products on prescription. Therefore, instead of buying those products, they hoof across to their GP's surgery and get a prescription. If that false situation is beginning to develop, we are storing up trouble for ourselves, and it brings the whole system into disrepute. Of course, people at the other extreme, facing life-and-death situations, need expensive drugs.

Also, people have now cottoned on to the fact that some forms of baby food are available on prescription, something that I would never have dreamt of looking for on prescription; at least, my wife would not have.

Is any analysis being done between pharmacists and GP surgeries? I am told that, in some areas, people have twigged on to free products big time and the whole community is in on the act. Therefore, the amount of menial stuff being ordered on prescription in those areas is much higher than in areas that have not got into that routine yet. Is anybody watching to see what is happening on the ground? In certain pharmacies, is anything being bought or is everything on prescription? What is happening? In the present economic situation, this is another area in which savings can be made. When you have 18 months' data, do you think that you may be in a position to answer those questions?

Dr N Morrow:

We want to try to track any patterns. For the benefit of the Committee, there are, fundamentally, three types of medicine. General sales list medicines can be bought in supermarkets, garages, and so on. Secondly, pharmacy-only medicines can be sold in a pharmacy under the supervision of a pharmacist. In a pharmacy, of course, people can also buy general sales list medicines. So the pharmacy has other medicines that are a bit more strictly controlled. Thirdly, prescription-only medicines can be made available only on prescription. In any future analysis, it should be

possible to examine those three categories to determine whether there is any correlation with our policy.

I have carried out research on the impacts that result from some form of intervention. The most important element of such research is how to control the variables so that they do not confound the problem. The point that I was trying to make earlier is that we are in a situation in which a considerable number of things are happening at the same time. It is not possible to pin down and stop those variables so that we can get a true picture of a single factor. Therefore, it is a question of trying to get the data together to analyse it and to see if we can extract that single factor from some of the other background variables.

The Chairperson:

Under the present system, what is to stop my wife, who has fair skin, going into the doctor's surgery and asking the doctor to prescribe her Ambre Solaire because is going on holiday to Madeira and tends to burn in the sun?

Dr N Morrow:

The doctor's professional responsibility.

The Chairperson:

A doctor, who may have known that lady for 30 years socially as well as professionally, may be anxious to get a person out of the consulting room because 20 others are waiting. Therefore, he could give that lady the prescription to get her out of the way. What is to stop that happening?

Dr N Morrow:

Effectively, nothing, apart from the prescriber taking the decision not to prescribe that product, will stop that happening. Earlier, you described a situation in Castlederg and asked what I was doing about it. The same question could be asked of the GP surgeries. Given the policy, what have they been doing about it prior to now? We place a certain amount of responsibility on our healthcare professionals, and we expect the prescribers and the pharmacists to act in a cost-effective and ethical way. That is important to the way in which we provide our services. However, at the same time, we should have ways to try to monitor that so that we know that that kind of discipline is being observed.

Mr Callaghan:

How many items are being prescribed in the community? The briefing paper gives the total number of items dispensed. In that six-month period for which you have data, are you able to evaluate, compared with previous years when there were different regimes, how many items are now being dispensed? That is separate from the issues of inflation in drug prices, patient demand, and so on. Is there an increase in the number of items being dispensed as opposed to how much the items cost us in total? Those figures would help to answer the Chairperson's question.

Dr N Morrow:

Earlier, I corrected a little bit of information in our briefing paper. Comparing the two periods in 2009 and 2010, there is about a 7·1% increase in the volume of items and about a 6·6% increase in the cost.

Ms Morelli:

That is comparable with a 6% increase in the previous year.

Mr Callaghan:

Unless I am mistaken, that is not the figure that I am looking for. You are referring to paragraph 8, which is about the growth attributable to free prescriptions. However, the figures in paragraph 8 are for the total number of items dispensed. At the top of the same page, your paper states that 89% of items were dispensed free of charge before charges were abolished. I am asking about the remaining 11% of items that were paid for. Five years ago, I would have paid for prescriptions, but not now. Has there been a growth in the number of items — leaving aside the cost — being dispensed to that previously exempt group? That is central to the question of what happens when Jim's wife goes to the surgery for a free prescription.

The Chairperson:

That is a crucial question.

Ms Morelli:

Previously, about three million items were prescribed for that group. The difficulty is that that entire group has been subsumed, because all exemptions have been lifted, and no one pays now. The only evidence that we have is a 1% increase in items in the working-age male regime.

Mr Callaghan:

It is not being monitored effectively — that is the answer.

Ms Morelli:

Everyone is exempt.

Mr Callaghan:

My point is that the target group is not being monitored. To use the testing parlance, there is no control group.

Ms Morelli:

No, but the majority of the control group would have been working-age people. Previously, everyone over 60 years of age was exempt, along with all children and young people under 18, those with medical exemptions and those with maternity certificates. The list of exemptions was extensive. Fifty per cent of people in Northern Ireland do not get prescriptions: they are healthy and not in the system. Of the 50% of the people that were in the system, 11% paid in some form: 6% through a prepaid certificate and 5% paid for their prescriptions. Those 5% generated the income available to the system.

The Chairperson:

Of course, people just walk in now. Whether they are working or not is not monitored. When I went to collect a prescription, I was amazed to be asked whether I was entitled to free prescriptions. Clearly, a lot of people had been saying yes when they were not so entitled.

Ms Morelli:

Fraud was a major issue in the last regime.

Mr Callaghan:

Maybe I am confused, but did you just say that 5% of people paid for prescriptions?

Dr N Morrow:

Five per cent of people were paying the full amount. The other 6% paid through exemption certificates, which meant that they could buy a prepaid certificate that allowed them to access as many prescriptions as they needed in a given period.

Mr Callaghan:

That, however, is not what appears in the briefing paper that you provided to us. Page 3, paragraph 6 states:

"50% of people were entitled to free prescriptions and around 89% of items were dispensed free of charge. Of the 11% of items".

You have just been talking about people, but the paper refers to items, which is totally different. As a layperson, I would have thought, generally speaking, that the people entitled to free prescriptions in the old regime were those who were more likely to be demanding on the regime. Generally, you would be talking about older people, those with maternity certificates and children, rather than people like me. Thank God, I cannot remember the last time that I had to get a prescription for myself. We need to be clear about what we are talking about. There are huge differences in quantum between the items and the people. Do you understand why I am a bit concerned about what has just been said?

Ms Morelli:

Yes, because if everyone suddenly accessed prescriptions —

Mr Callaghan:

I am also concerned that, unless I am mistaken, what is being said orally in evidence does not appear to be the same as what was presented in written evidence. I am as confused as everyone else about it, but we need clarity. Maybe I picked it up wrong, but I think that there was a difference in what was said.

Dr N Morrow:

I think that I know what you are getting at. Older people are exempt from prescription charges, and, as a generalisation, older people tend to be on three or four prescription items at any one time. Therefore, even though 50% of the population who access prescriptions are exempt from charges, you would expect to find a much higher number of items not being paid for simply because, potentially, that 50% would consume a greater volume of prescriptions. An exempt older person could be receiving four prescription items. Therefore, you can understand the difference between the 50% and the 89%. The fact is that, over the piece, 89% of prescriptions were exempt from charges.

The Chairperson:

Emer, you said that 50% of the population were entitled to free prescriptions. Is that the same as 50% actually obtaining prescriptions?

Ms Morelli:

No.

The Chairperson:

I can see how the confusion has arisen. Pól is right that there is a bit of a discrepancy between the oral and written evidence. It would be helpful if we could try to tie it down. Basically, we are trying to find out whether there has been a significant rise in the cost of prescriptions as a result of them being free. In other words, by eliminating those who paid, has the graph risen faster than it otherwise would have? For obvious reasons, that is proving very difficult to tie down. Even more worrying is whether that elimination will lead to a rapid increase in future years of people obtaining prescriptions for all sorts of reasons: they are free; they may get more of them; and they may go to GPs to get free on prescription products that every reasonable person, until now, would have bought.

The other point, which has not been picked up by anyone else, is that a 7·1% increase since 1 April 2010 represents a significant hike in the absolute number of prescriptions.

Ms Morelli:

Yes, but that is comparable. We always expect an increase of at least 5% or 6% year on year, whether there are free prescriptions or not, because demand increases.

The Chairperson:

That is a worrying figure even if there had not been free prescriptions. Pól has lived an upright, non-smoking and non-drinking lifestyle. He is a lucky guy.

Mr Callaghan:

Actually, I do drink, unlike you. I have some vices, Chair.

The Chairperson:

He has not been to a GP surgery for years. That was me for 40 years until recently, but ever since

taking on the role of Chairperson of the Health Committee, I am never out of the surgery.

Dr N Morrow:

It can damage your health.

The Chairperson:

It certainly has. I see the system at first hand, and I see hard-pressed GP surgeries. The quickest way for a GP to get someone out of his or her consulting room is to hand out a prescription. The pad is out before the person comes in. That takes the pressure off. The little old lady or the middle-aged politician grabs that piece of paper, goes across the road to the pharmacy and is satisfied. A prescription is often used to get a consultation over quickly. It seems that few people leave a consulting room without a piece of paper in their hands.

Are there any controls? Again, we come back to the situation in Castlederg. In normal circumstances, I could have envisaged the Committee taking a coach up to Castlederg, but that will not happen because of the election. Did Castlederg involve not only a control in generics but GPs making decisions about whether a person needed a script in the first place? It strikes me that there is a worrying trend of hard-pressed GPs using prescriptions as a way of solving a difficult problem, when that might not be the most cost-effective way from the taxpayers' point of view.

Dr N Morrow:

There has been a great deal of social research on prescriptions. The issuing of a prescription legitimises the fact that someone is ill. It is also a potential way of closing a consultation. Everyone is aware of that.

In light of the Committee's request, we wanted to provide the best information that we have available. Given that we are only about 10 months into a complete abolition of prescription charges, we wanted to show you the figures that we have, which is where the 7% and 6·6% figures came in. I tried to set the figures in the context of before and after so that you could see the difference.

Maybe I have not made this point clearly enough, but what I was also trying to say is that it is simply not possible to attribute the 1·5% figure absolutely to the introduction of free prescriptions. There are too many confounding variables. Those of you from scientific research

backgrounds will appreciate that.

The Chairperson:

If my maths are right, a 7·1% increase in the number of prescriptions will lead to a doubling every nine years, because it is a compound increase.

Dr N Morrow:

I will go back to the figures that I gave you earlier. In the six years between 2004 and 2010, the overall increase in the volume of prescriptions was about 33%, which works out at an average increase of about 5·6% a year. That is the broad background. In relation to what we might call background noise, we must also say that there are policies on the increased use of statins to treat cardiovascular disease, and the flu pandemics also generated more prescriptions. I am not trying to justify this. All that I am saying is that the situation is never static.

We need to track the increase in prescriptions and see whether it is possible, through the necessary research, to correlate it absolutely with a free prescription policy. However, the other point is equally true: since the period for which we have full-year data, we have lived within our budget for prescribing. That is not to say that other efficiencies are not included in that. At the same time, we have had greater productivity relative to the number of prescriptions dispensed. I am not justifying the increase in numbers; I am just saying that we have managed that increase within our available resources. Therefore, even though we are seeing shifts and increased demand, we have tried, through everything else that we do, to live within that budget. In effect, we are trying through those processes to put in place the Assembly's and Minister's policy on free prescriptions. It is a case of trying to manage that as something that the Assembly wants to be in place.

The Chairperson:

Are there any final questions?

Mrs O'Neill:

I just want to make a comment. Obviously, I am 100% behind the policy, and we should be proud of it. Sometimes, we miss the fact that we have saved £850,000 in administration, and those efficiencies go back into the Department.

I want to pick up on your point, Norman. I know that you do not have all of the statistics yet and that you need a longer period to carry out proper analysis. The increase is, by and large, in line with that of previous years. Jim raised the point that, perhaps, that is a wider issue that we need to look at. However, the early indications are that there has not been a surge in people running out to get free prescriptions, which is positive.

We are all talking about health and where we can find more money. It is easy for journalists to say that that policy should be abolished and that those who can afford to pay for prescriptions should do so. That point is frequently thrown up. I know that, Jim, you were asked on a certain radio programme why charges were not reintroduced and that policy abolished. That would be very much a backward step. I am pleased that the early indications are that we have actually saved money.

Ms Morelli:

I just want to add that a free prescribing policy has been in place in Wales since 2007. Its evidence shows no significant increase in demand there either. Scotland is moving towards the abolition of prescription charges from 1 April 2011.

The Chairperson:

Are there any final questions on that issue? It will be the last question of the session.

Mr Callaghan:

I have two questions. Is there a monthly breakdown of the figures in paragraph 8 of your briefing paper? I might be wrong because I was not on the Committee at the time, but I wonder whether November 2009 was when the swine flu pandemic kicked in.

The Chairperson:

It started in July 2009.

Dr N Morrow:

It was over a period.

Mr Callaghan:

So the figures would have included the period of the pandemic?

Dr N Morrow:

Yes, although not all of it.

Mr Callaghan:

It would have included a significant period of it, whereas the epidemic that occurred during the most recent winter would not fall into the comparator that you have given for 2010-11. Therefore, that would go against the suggestion that exceptional events, such as a pandemic, have to be factored in. If anything, the 2009 figure should be lower, in the normal run of things, compared with the 2010 figure. Presumably, the pandemic would have cost —

Dr N Morrow:

I would like to make one point about that. We have seen the figures for November — in fact, I think that they are included in the paper. I cannot remember the figures offhand. However, there was quite a hike in prescription numbers in November 2010. The figures are not validated, so I cannot quote them. However, the number seems to have dropped in December. Perhaps, I should have mentioned that, within our efficiency programme, we have tracked prescription volumes year on year. In the past year, the tracking for 2010 followed absolutely that of 2009, except at a higher level because of the 6% to 7% increase. However, in November, it deviated, and the numbers went up. At the same time, my understanding is that that figure will come down in December. However, as I said, that figure has not been validated yet.

Ms Morelli:

We can provide historical data.

Mr Callaghan:

Before I move on to my final question, you are talking about £250 million of public money. A month-by-month narrative might, therefore, be helpful, so that our successors in the next Committee can make informed evaluations of what is going on.

I apologise if I am the only person who does not understand this, but I want to go back to my previous point about who is entitled to free prescriptions and who, as the Chairman clarified, is actually getting free prescriptions among the pool of people who seek drugs for whatever legitimate purposes — I do not mean that they seek them for any nefarious purposes. Is

paragraph 6 saying that 50% of people who receive a prescription are entitled to free prescriptions? Is that what it means? To be honest, I would not be happy leaving here without understanding that, because it is a fairly significant point.

Dr N Morrow:

That is what I understand it to mean. The data is based on reports from our Business Services Organisation relative to the prescriptions that they receive.

The Chairperson:

Norman, could you drop the Committee a note to clarify that? Get the statistical boffins to let us know. It will, probably, be our successors who will deal with it, as the issue of prescriptions and generics will continue to be raised. We just need to know where we stand on it.

Dr N Morrow:

Yes. That is perfectly OK, Chairman. As I say, the prescriptions coming in to our Business Services Organisation for pricing, et cetera, reflect the people who receive them. Therefore, of the people who receive them, historically, that percentage was entitled to free prescriptions.

Mr Callaghan:

I was thrown on that point. It was useful that our attention was drawn to it, however inadvertently. If you did use an abstract figure of 5% of people being entitled to free prescriptions, that would, probably, add up, given what you said about a certain proportion of people having more than one prescription. Therefore, if 11% of items were being charged for — well, you can do the sums yourself.

The Chairperson:

Thank you very much. We hope that we have not endangered our free samples in Portstewart. *[Laughter.]* The meeting, which was supposed to last for one hour, has lasted for one hour and 20 minutes. However, the issue is topical and interesting. Although you may not be back to meet the same 11 people, I have no doubt that you will be back to meet another group in the future. Thank you.