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COMMON SERVICES AGENCY
RECEIVED
St Andrew's House
Edinburgh EH1 3DG
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ACTION TAKEN
Addressee

National Health Service in Scotland
Management Executive

THE INDICATIVE PRESCRIBING SCHEME 1995/96 PRESCRIBING ALLOCATIONS

Summary

1. This letter draws the attention of Health Boards to prescribing allocations for 1995/96, the retention of a contingency reserve from within the allocations and the consequences to other vital areas of health care of overspending on the drugs bill.

Action

2. Health Boards are asked to note the above and take appropriate action.

Background

3. Health Boards have already received notification of their prescribing allocation for 1995/96.

4. The primary factor in determining the level of allocations, is the overall level of provision decided by the Government for GP prescribed drugs as a result of the Public Expenditure Survey (PES). The prescribing allocation represents an estimate of what each Board might be expected to spend on prescribing drugs in 1995/96 and Health Boards are expected to manage their resources in such a way that their target budget is not exceeded. Spending on drugs above the provision in one year knocks on into future years. Drugs bill growth above the current plans would reduce the proportion of NHS expenditure available for other vital areas of health care.

5. The amount available for expenditure on GPs prescribing of drugs in 1995/96 is £445 million Gross Ingredient Cost (GIC) and individual Health Board allocations are shown in the table at Annex A. The Health Board allocations take as their baseline the forecast GIC outturn for each Board as at December 1994. This approach provides for an approximate real terms increase of 3.2% for all Health Boards on their forecast spend in the current year. The remaining resources (£4.5 million) have then been allocated by taking account of:-

- expected performance by Health Board against 1994/95 budgets;

For action

General Managers,
Health Boards

For information

Chief Executive and
Chief Executives
Designate, NHS Trusts

General Manager,
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- the scope for further efficiency improvements through more cost-effective prescribing by looking at generic prescribing rates.

6. Contingency reserves for fundholders cash-limited drugs budgets have been part of the fundholding scheme from its outset. Last year's guidance on prescribing allocations for 1994/95 (NHS MEL(1994)36) introduced the principle of contingency reserves for non-fundholding practices. These arrangements are being retained in 1995/96 and Health Boards should set contingency reserves at no more than 1% from within their allocations.

7. Health Boards should continue to work with the professions to improve the quality and value for money of prescribing.

8. Boards should now set target budgets for each of its GP practices. In doing so Board objectives should be to:

- ensure equity of access of all patients to available resources;

- bring firm downward pressure on those practices where historical levels of expenditure appear to have no clinical justification

- ensure that practices whose prescribing is considered cost-effective, receive increases on 1994/95 forecast outturn of at least the average available to all practices in the Board area; and

- ensure that all GPs are aware that wasteful prescribing reduces the amount of resources available for other patient care.

Annex B suggests how Boards might implement these key principles in setting prescribing budgets with their GP practices.

AGNES ROBSON
Director of Primary Care

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ANNEX A

1995/96 INDICATIVE PRESCRIBING SCHEME

Health Board	Allocation (£M - GIC)
Argyll & Clyde	40.505
Ayrshire & Arran	35.890
Borders	8.810
Dumfries & Galloway	13.740
Fife	28.735
Forth Valley	25.475
Grampian	37.650
Greater Glasgow	82.430
Highland	16.260
Lanarkshire	53.330
Lothian	59.335
Orkney	1.345
Shetland	1.456
Tayside	37.770
Western Isles	2.295
TOTAL	445.025

ANNEX B

SUGGESTED PROCEDURE FOR HEALTH BOARDS TO USE IN DETERMINING PRESCRIBING BUDGETS AT GP PRACTICE LEVEL

1. The aggregate total of fundholder drug budgets, target budgets for non-fundholding practices and any Board held contingency reserves should be equal to the Board's total allocation, expressed in terms of NIC.

2. Boards should notify practices of their budgets for 1995/96, the basis on which they have been set, and should explain variations from 1994/95 original allocations and forecast outturn. Before confirming budgets, Boards will wish to consider any representations from practices about relevant factors which may need to be taken into account.

3. The prescribing element of fundholders budgets should be expressed as a single cash figure and should be calculated in a way which is consistent with the Guidance on Setting GP Fundholder Allotted Sums 1995/96 contained in NHS MEL (1994)99.

4. The Board needs to adopt a clear method which achieves the key principles set out at paragraph 7 of the Circular. Boards can best do this by looking at the following 3 factors together:

- 1994-95 original allocations and forecast outturn;

- differences in historical levels of drug expenditure between practices;

- the scope for further efficiency improvements in the prescribing behaviour of individual practices

5. In considering these factors, Boards should categorise their practices as follows:

i. above the Board's average prescribing cost;

ii. average for the Board's prescribing cost;

iii. below the Board's average prescribing costs.

6. Medical prescribing advisers should then assess individual practices critically reviewing the prescribing expenditure and, where there is no apparent clinical justification for their spending levels, adjust budgets accordingly.

7. On this basis, the expectation would be that, in aggregate:

i. 'above average' practices would receive increases on forecast outturn below the Board average;

ii. 'average' practices would receive increases on forecast outturn close to he Board average.

iii. 'below average' practices would receive increases on forecast outturn above the Board average.

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8. Not all practices within each category are expected to receive the same increases. Boards should, however, ensure as far as possible that, in aggregate, the pattern prescribed above is achieved. Indeed it would be sensible for Board medical prescribing advisers to check that this is likely to be the case before their budget offers are made to practices.

9. Decisions about final practice budgets need to be informed by a number of other factors, including the following:

- changes in the number and/or distribution of patients in need of high cost drugs;

- changes in practice list sizes;

- other local factors (eg relative levels of local morbidity).

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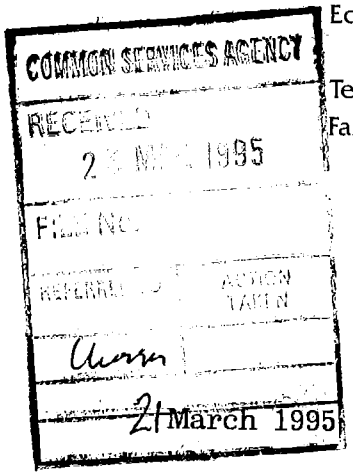

Health Board General Managers

Dear Colleague

THE INDICATIVE PRESCRIBING SCHEME 1995/96
PRESCRIBING ALLOCATIONS
CORRIGENDUM TO NHS: MEL(1995)18

This letter draws the attention of Health Boards to an error in the text of Annex B to the above NHS Circular.

In paragraph 1, Annex B, the final line should be amended to read "GIC" rather than "NIC".

I apologise for any inconvenience this may have caused.

Yours sincerely

Ian Walker

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