

Helping patients to pay for their healthcare

At the NHS Business Services Authority, we are always seeking to improve our services. You may be aware that a Health Select Committee reported to Parliament last summer on all aspects of NHS charging. One of their biggest concerns was about increasing patient access to help with health costs.

Good news about prescription pre-payment certificates!

From 1 July this year, important changes have been made to make prescription prepayment certificates (PPCs) more accessible to patients.

- The 4-month PPC has been replaced by a 3-month PPC costing £26.85
- Patients buying the yearly PPC costing £98.70 will have the option to pay either by a single payment or by 10 monthly Direct Debit instalments.

Changes to the PPC application form

Due to the changes mentioned above, the current version of the PPC application form, FP95, was replaced on 1 July 2007.

If you hold stocks of the FP95 for distribution in your area, please destroy all old stocks from 1 July and replace them with the new version. Supplies of the new version can be ordered as normal from your Primary Care Trust forms supply unit from 1 July.

These certificates can be used for all prescription charges incurred during the period of the certificate, no matter how many. They can lead to real savings for people who need a large number of items.

Positive feedback from stakeholders

David Harker, Chief Executive of the Citizens Advice Bureau said: "The CAB has repeatedly found that many patients who could benefit from a PPC have been unable to do so because they could not afford the large upfront charge. It is really important that news of this helpful new measure now reaches these patients".

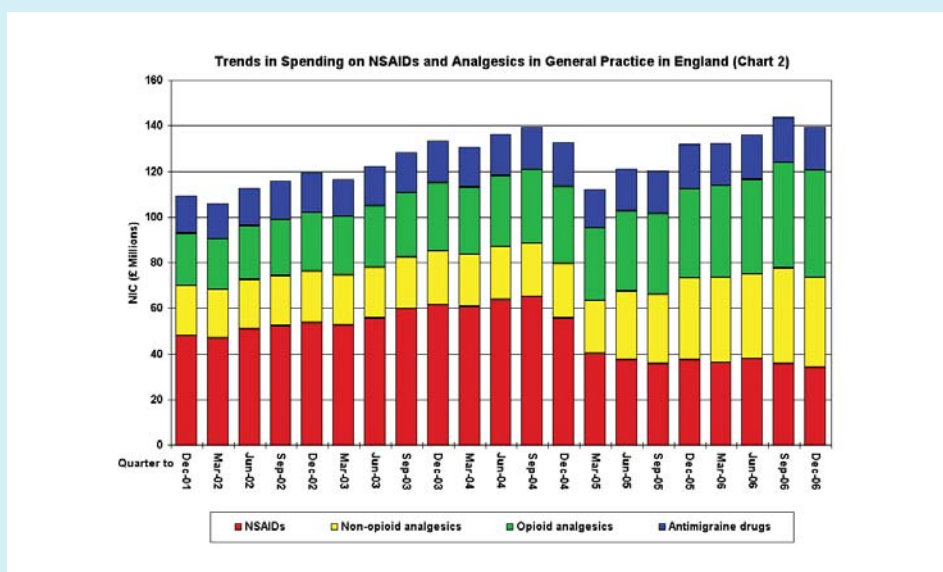
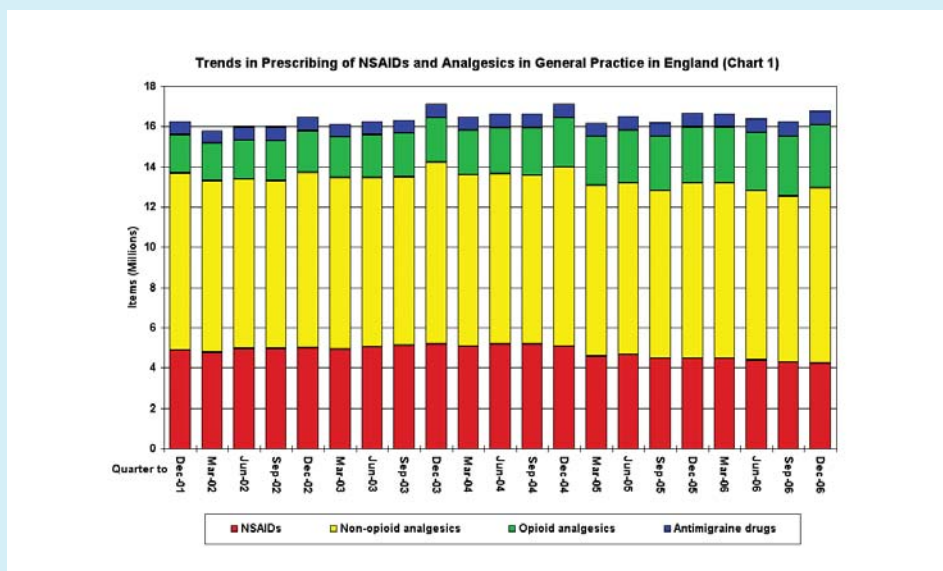
More information about these arrangements will be provided in the October edition of Impact. In the interim information will be published on the PPA Website www.ppa.org.uk as and when it becomes available.

Prescribing Review - Analgesic Drugs

The Prescribing Review report on Analgesic Drugs, available to general practitioners in May 2007, is reproduced here for readers with an interest in patterns and trends of prescribing.

Pain is a universal human experience. It is the third most common reason why people visit their General Practitioner. Chronic pain severe enough to seriously affect quality of life is estimated to affect between 19% and 25% of adults. Chart 1 shows that, despite little change in overall analgesic volumes, prescribing of opioids has increased with a corresponding increase in cost (chart 2). The cost of prescribing non-opioids has also increased whilst expenditure on non-steroidal anti-inflammatory drugs (NSAIDs) has fallen. Management of pain can be challenging and evidence to support most clinical practice is limited. A pragmatic structured approach, with appropriate non-drug treatment addressing the psychological, cultural and social as well as biological factors, is required.

The World Health Organisation's three step analgesic ladder underpins most pain management guidance. It is estimated that up to 88% of patients obtain satisfactory pain relief with this approach. An elaborated version of the analgesic ladder, providing advice on treatment for acute and chronic mild to moderate pain, has been published by the Medicines and Healthcare Products Regulatory Agency/ Committee on Safety of Medicines (MHRA/CSM) and endorsed by the British Pain Society¹. Substituting



or adding drugs in a stepwise manner according to response and tolerability may be less helpful for persisting non-cancer pain than for acute pain and pain related to cancer. Treatment should start at the step of the ladder appropriate to the severity of the pain being experienced and doses should be titrated following regular reassessment of response.

MILD TO MODERATE PAIN

Step 1 - Paracetamol (1g up to four times a day). Paracetamol remains the first choice analgesic for mild-to-

moderate persistent pain. It is well tolerated, effective and inexpensive. People who seek advice on pain control often report that they have already tried paracetamol with little success; they may have used inadequate doses².

Step 2 - Substitute low-dose ibuprofen (e.g. 400mg three times a day). Reliable long-term comparative trials have not been conducted and any short-term efficacy advantages of NSAIDs over paracetamol are likely to be small³. Oral NSAIDs reduce pain in the short term for osteoarthritis (OA) of the knee; however the advantage over placebo is small.

There are no important differences in efficacy between NSAIDs⁴ and choice is based on safety, patient factors and cost. Low dose ibuprofen has the lowest risk of serious upper GI complications.

Step 3 - Add paracetamol 1g four times a day to low-dose ibuprofen. Combining an NSAID with paracetamol may allow lower NSAID doses to be used.

Step 4 - Continue paracetamol and replace ibuprofen with alternative NSAID. The lowest effective dose of NSAID should be prescribed and the need for long-term use should be reviewed periodically. Based on GI safety and cost, diclofenac 25-50mg three times a day would be suitable. Naproxen is associated with a lower risk of thrombotic events and may be preferred where cardiovascular risk is of concern. A weak opioid may be an alternative to an NSAID for people at high risk of NSAID-induced adverse effects.

Step 5 - Full therapeutic dose of a weak opioid (e.g. codeine 30-60mg up to four times a day) in addition to full dose paracetamol and/or NSAID. Weak opioids may be considered earlier (e.g. in OA). Adding high doses (60 mg) of codeine to paracetamol provides additional analgesia, but also increases drowsiness and should be reserved for patients with more severe pain when the response to paracetamol and/or an NSAID has been inadequate⁵.

Fixed combination analgesics have a limited role, but may be convenient. If used, full therapeutic doses should be prescribed. Effervescent combination formulations are expensive, contain very high concentrations of sodium and offer no advantages for patients who are able to swallow tablets. Co-proxamol is implicated in almost one fifth of UK drug related suicides. A MHRA/CSM review of safety and effectiveness concluded that there is no identifiable group in whom the risk:benefit balance may be positive. A gradual withdrawal was announced in January 2005 to allow long-term users an opportunity to move to suitable alternatives. All licenses for co-proxamol will be cancelled at the end of 2007. Prescribers contemplating continuing treating patients with co-proxamol after licenses are cancelled are advised to consult GMC guidance.

A Cochrane review concluded that the potential for adverse effects greatly disadvantages tramadol compared to other treatments for OA⁶. There is no evidence that modified release (m/r) tramadol preparations provide any advantages. They are considerably more expensive than alternatives. Chart 3 shows the variation in prescribing of m/r tramadol between Strategic Health

Authorities. Tramacet[®], a tramadol/paracetamol combination, provides a sub-therapeutic dose of paracetamol and offers patients little advantage in terms of efficacy, adverse effects or convenience compared with current standard analgesics.

Step 6 - Consider a therapeutic trial of a tricyclic antidepressant or an antiepileptic. For the small minority of patients who do not respond at Step 5, a therapeutic trial of a tricyclic antidepressant (e.g. amitriptyline) for neuropathic pain or pain which disturbs sleep, or an antiepileptic (e.g. carbamazepine/gabapentin) for neuropathic pain may be considered. There is no RCT evidence that newer agents such as gabapentin, pregabalin or duloxetine are any more effective or better tolerated than established alternatives. Although evidence for short-term effects on acute neuropathic pain is contradictory, there is evidence that opioids are effective in both cancer-related and non-malignant neuropathic pain when used for longer (weeks to months). A Cochrane review suggested that low to moderate doses of opioids may be as effective as maximum doses of gabapentin⁷.

SEVERE PAIN

Morphine is the opioid of first choice for moderate to severe pain for reasons of familiarity, availability and cost. Hydromorphone and oxycodone may be considered as alternatives for the small proportion of patients who develop intolerable adverse effects with oral morphine. Switching between opioids can complicate pain management and is not recommended for non-specialists without expert advice. There is little good evidence to support the practice of switching opioids to reduce adverse effects⁸. Alternatives include: reducing the dose of opioid (and possibly adding non-opioid or adjuvant analgesics); managing adverse effects symptomatically; and switching the route of administration.

Fentanyl patches may be an alternative to sub-cutaneous infusion for patients with stable opioid requirements who are unable to tolerate oral medications⁹. They lack flexibility for managing patients with fluctuating pain or for titrating in uncontrolled pain; analgesic effects are not obtained for 12-24 hours. A role for transdermal buprenorphine in the management of chronic pain has not yet been established.

MIGRAINE

The evidence base for many acute anti-migraine drugs is poor. Many patients with migraine respond to simple analgesics. Aspirin, paracetamol or ibuprofen are effective first-line treatments for acute migraine, especially when given early in an attack¹⁰. Addition of an anti-emetic may reduce nausea and vomiting and increase analgesic absorption; evidence for combining aspirin and metoclopramide is better. Opioid containing analgesics should be avoided. Oral triptans may be suitable when migraine attacks are unresponsive to adequate doses of analgesic and anti-emetic. Current evidence suggests that there are no major differences in efficacy between the available oral triptans¹¹. Intranasal or subcutaneous preparations are expensive and inconvenient and should be reserved for patients who have not responded to oral therapy or where vomiting is a problem.

Prophylaxis with a beta-blocker (first line) or an alternative (e.g. amitriptyline) should be considered when either: acute treatments are contraindicated or ineffective; acute treatment is required more than twice a week; disability lasting 3 days or more occurs more than twice a month, or; attacks are severe or prolonged¹².

PRESCRIBING DATA

(Reporting quarter = October-December 2006, Index quarter = October-December 2001)

Non-opioid analgesic (98% paracetamol and paracetamol combinations) are prescribed more often than other drugs for pain. Prescription volumes have shown little change over the last 5 years (8.7 million prescription items, 69% of all analgesics), whereas costs have increased by 80% to £39.4 million (37% of all spending on analgesics). Paracetamol and paracetamol with codeine account for 82% of non-opioid items and 85% of costs. Prescriptions and expenditure have both risen, to 3.9 million (up 33%) costing £12.4 million and 3.2 million (up 42%) costing £21 million, respectively. Due to the impending withdrawal of co-proxamol, there has been an 88% decrease to 270,000 items, costing just under £1 million. There has been little change in the volume of prescribing of paracetamol with dihydrocodeine, but expenditure has increased by 73%.

Overall, NSAID items have declined by 13% to 4.2 million, costing £34.2 million. Diclofenac prescriptions are most common, 1.9 million items (45%) at £15 million (44%), with ibuprofen next, 1.1 million items (25%) at £3.4 million (10%). Prescribing of ibuprofen has decreased by

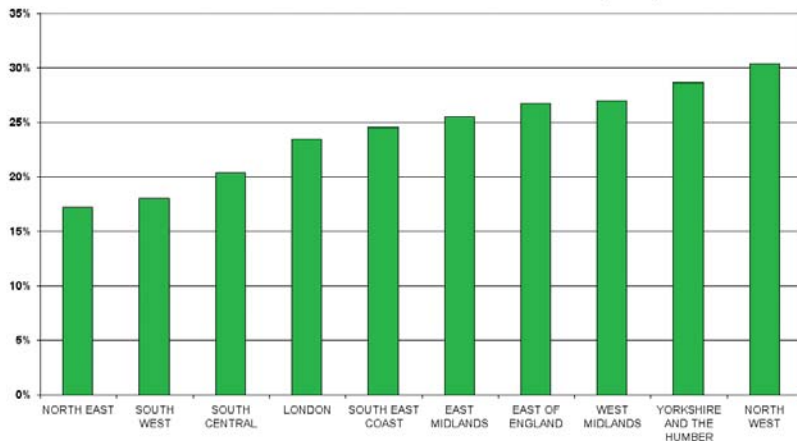
20% over the last 5 years, with diclofenac prescribing increasing by 7%. 15% of all NSAID prescriptions (625,000 items, a 30% decrease) were for Cox-II selective inhibitors (meloxicam, celecoxib, etoricoxib, etodolac, lumiracoxib, rofecoxib and valdecoxib). Spend on Cox II selective inhibitors has fallen by 43% to £11 million.

There has been a 62% increase in opioid analgesic items with a two-fold increase in expenditure (3.1 million items, £46.8 million). Opioids account for 25% of all analgesic prescribing and 45% of costs for the reporting quarter. The most commonly prescribed opioid analgesic is Tramadol (38% items, 26% cost) with 1.2 million items at a cost of £12 million. Oxycodone, buprenorphine and fentanyl

prescribing have increased markedly; 98% of fentanyl prescribing and 93% of spending being attributed to the patches. Diamorphine prescribing declined 29%, probably due to recent shortages. There was a 57% increase in morphine items to 381,000 (12% of all opioids).

Over the last 5 years gabapentin prescriptions have increased three-fold to 331,000 items per quarter. Costs have increased much less (2.5% to £6.7 million), due to availability of generic gabapentin. Pregabalin became available from July 2004 and prescribing reached 139,000 items, £11.2 million for the reporting quarter. Prescriptions for triptans have increased by 22% to 400,000, whilst costs have grown by 12% to £16 million.

Strategic Health Authority Distribution of Prescription Items for Modified Release Tramadol as a % of all Tramadol Items for Quarter to December 2006 (Chart 3)



Summary

Managing pain requires a pragmatic structured approach, which includes appropriate non-drug treatment and which addresses psychological, cultural and social as well as biological factors.

Newer drugs have not been shown to have any consistent advantages over established alternatives (e.g. paracetamol, ibuprofen, amitriptyline and morphine).

Transdermal analgesics offer few advantages and should only be used in patients who have specific problems with oral therapy.

Prophylaxis and non-drug management are important for migraine.

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Business Services Authority

The NHS Business Services Authority needs your help to improve its services

A company called KGS Ltd may call you over the next few weeks asking if you'd like to take part in a short telephone survey. The NHS Business Services Authority (NHSBSA) has appointed KGS Ltd, based in East Yorkshire, to carry out research for us to find out what sort of service our customers get from our Prescription Pricing Division (PPD).

KGS Ltd have already held a focus group with pharmacists, GP practice managers and PCTs based in the North-East and are using this information as the basis for the telephone survey. They will be contacting around 300 customers across England.

The research will cover areas such as how payments are made, information provision and customer service. It will not be looking at areas controlled by the Department of Health such as policy.

If you are invited to take part in this exercise, please take the time to make a difference to the service you receive.

A sticky problem

We wrote to pharmacists, the head offices of pharmacy chains, and Primary Care Trusts (PCTs) nationally in May to ask for your help. Letters were sent out to them in May reminding them not to attach sticky labels onto prescriptions or anything else that might obscure prescribing data. It also asked them not to submit invoices with their batches and told them that we don't return any invoices we're sent.

Attachments of any kind on prescription forms can cause delays in items being processed, sticky labels can cover up data and sticky residues can cause forms to stick together, so items may not get correctly reimbursed. These sorts of problems affect both the current system and the CIP scanning equipment.

The letters also gave out our Prescription Processing Help Desk (0845 610 1171) for customers to ring if they have any questions about the letters.

Change to reimbursement for Amlodipine Besilate

Following the launch of generic products for amlodipine besilate, the Department of Health has announced that the concession which allows dispensing contractors to be paid based on the list price for Istin when a prescription reads, 'amlodipine besilate' and the contractor has supplied and endorsed 'Istin,' will no longer apply to prescriptions dispensed from the 1st July 2007.



Contact details for the PPD

For general enquires relating to the PPD, contact the Head Office:

Bridge House, 152 Pilgrim Street, Newcastle upon Tyne, NE1 6SN

0191 232 5371

For all queries relating to the NHS Low Income Scheme, contact Patient Services:

0845 850 1166

For general queries, prior to applying for Prescription Pre-payment, Medical and Maternity Exemption Certificates:

0845 850 0030

For specific queries, after applying for/receiving Prescription Pre-payment, Medical and Maternity Certificates:

0845 601 8076

For queries about NHS Tax Credit Exemption Certificate:

0845 609 9299

For enquiries relating to Pharmacy Processing, Prescription Searches, Personal Administration, Dispensing Doctors and Contractor Payment Information contact the new Prescription Pricing Help Desk on:

0845 610 1171

This number should be used with immediate effect and replaces any existing numbers you currently use.

For enquiries relating to applications for the European Health Insurance Card (EHIC):

0845 605 0707

0191 203 5555 (from outside UK)

Ehicenquiries@ppa.nhs.uk

Enquiries on all PPA Electronic Systems (EPACT, ePACT.net and Prescribing Toolkit) and on the availability and content of reports produced by the PPA:

0191 203 5050

help@ppa.nhs.uk

www.ppa.nhs.uk

www.nhsbsa.nhs.uk

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