

# Spending on prescribing for diabetes in England: A holistic perspective

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The NHS in England spent over £800 million on 45.1 million items prescribed for diabetes (British National Formulary section 6.1) in the financial year 2013–14 – equivalent to £2.2 million, on average, every single day. Prescribing for diabetes now accounts for close to 10% of the total cost of prescribing in primary care in England (Health and Social Care Information Centre, 2014).

Spend on prescribing for diabetes has been increasing over time, rising by 8.2% in value terms, but this rate is over-shadowed by the rise of 42.3% in volume terms, since 2005–6. This is prescribing that helps to meet the needs of 2.7 million people diagnosed with diabetes in England (NHS England, 2014).

To place the sum of £800 million of primary care prescribing on diabetes in context, the total costs to the NHS across the UK of treating diabetes has been estimated at nearly £10 billion a year (Diabetes UK, 2014). The majority of these costs, around 80%, relate to complications of diabetes that can be devastating for those with the condition and their loved ones but are also expensive for the NHS to manage. The wider costs to society are even higher, being estimated at £13.9 billion across the UK (Hex et al, 2012). Avoiding complications related to diabetes in the first place will often prove to be far better for all concerned, whether from a patient perspective or from a taxpayer one.

Naturally, there is always going to be some concern when we see rising spend in almost any area within the NHS. That's because it is getting increasingly difficult to meet healthcare needs from limited funds. A more holistic perspective when looking at prescribing spend on diabetes needs to consider whether that spend offers value for

money, and, in some cases, whether it can generate cost savings.

In England, NICE carefully scrutinizes both clinical and cost-effectiveness of medicines and provides guidance specifically for the diabetes patient pathway (NICE, 2014). There is evidence that some medicines prescribed for diabetes not only are cost-effective but can deliver cost savings. Examples of this include angiotensin-converting-enzyme (ACE) inhibitor therapy for intensive hypertension control compared with standard hypertension control, or ACE inhibitor or angiotensin receptor blocker (ARB) therapy to prevent end-stage renal disease compared with no ACE inhibitor or ARB treatment (Li et al, 2010).

In addition, spending on branded medicines from 1 January 2014 is subject to an overarching safety net of affordability for the NHS through the 2014 Pharmaceutical Price Regulation Scheme (PPRS; Department of Health and Association of the British Pharmaceutical Industry, 2013). Under these arrangements, the NHS spend on branded medicines in totality cannot exceed an allowable growth rate over the lifetime of the PPRS (to 2018), with companies making payments to the Department of Health if spend exceeds this. The allowable growth rate is 0% for 2014.

Rising spend on prescribing in diabetes is likely to continue, reflecting the rising number of people diagnosed with diabetes each year. NHS England suggests that this is rising by around 5% per year (NHS England, 2014); 3.8 million people are expected to have diabetes in England by 2020 (NICE, 2011). But as Simon Stevens has said, we must think like a patient and act like a taxpayer, and so scrutiny of spending will continue. This scrutiny is right and proper, but it should look at not just the headline spend but the value that this spend generates in the round. ■

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