Prescribing for Diabetes in England
An analysis of volume, expenditure and trends
November 2007
Foreword

It can hardly be a surprise that both the numbers and costs of diabetes-related prescriptions have increased to the extent that such items are now the highest single cost in the NHS prescribing budget, with expenditure in excess of £500m per year. With 2000 more people every week being diagnosed with diabetes it follows that the cost of providing them with insulin, oral therapies and other products should also be increasing. With an estimated 500,000 people still undiagnosed the implications for future expenditure are significant.

It is very interesting, however, that not only is the overall volume of items prescribed increasing, but the average cost of each item is increasing as well - the number of prescription items has risen by 55% over the last five years but the costs of those items has increased by 88%. For 2006 alone this disparity is even more striking, with the number of items prescribed increasing by 7.4% whilst cost went up by 13.6%. This is significant in any case, and even more so when put against a backdrop of falls in costs of other high-volume prescribed items such as statins and other cardiovascular drugs.

What is also interesting is the geographical variation in both numbers and costs of prescriptions across England. The number of oral anti-diabetic items per registered diabetes patient varies 2 fold across PCTs, with a 2.5 fold variation in cost. The spend on insulin per registered diabetes patient also varies more than 2 fold across the PCTs. If these variations were matched by corresponding contrasts in prevalence or outcome, then a ready answer to this variation would be provided, but there is little evidence that this is the case.

It is against this background that this report has been produced. It both highlights the current situation and is the start of a dialogue to establish what is happening in terms of prescribing at the frontline. The outcome will, hopefully, be more evidence to support prescribing decisions, accompanied by examples of how organisations have developed effective and efficient prescribing protocols that deliver improved outcomes whilst recognising the need for both patient choice and the use of alternative treatments.

Dr Sue Roberts
National Clinical Director for Diabetes
Executive Summary

This report provides an overview of prescribing for diabetes in England. Data and intelligence are provided on prescribing for diabetes in primary care and secondary care. Throughout the report the authors identify key messages and points for consideration. These are summarised below:

Diabetes Prevalence and the Impact of Obesity: Points to Consider:

• There are an estimated 2.4 million people (~4.75% prevalence) with diabetes in England in 2006.
• It is estimated that 500,000 of these people, or ~1% of the England population, have diabetes that is undiagnosed.
• It is estimated that by 2010, there will be 2.6 million people with diabetes in England (~5.05% prevalence).
• The National Audit Office suggests that 47% of type 2 diabetes can be attributed to obesity.
• Trends indicate that 29.4% of men and 28.6% of women in England may be obese by 2010.
• Even modest weight reductions provide significant health benefits, particularly in cardiovascular disease, and can reduce the risk of developing diabetes.

Prescribing for Diabetes in Primary Care: Points to Consider:

• In 2006 the total number of items prescribed to treat diabetes was 28.4 million; an increase of 7.4% on 2005.
• The associated Net Ingredient Cost (NIC) was £561.4 million; an increase of 13.6% on 2005.
• Diabetes prescribing accounted for 3.8% of all items prescribed and dispensed in England and 7.0% of the total spent on all prescribing in England in 2006.
• There is considerable variation between Primary Care Trusts in the expenditure on drugs and other diabetes related prescribing items used to treat diabetes.

Insulins: Points to Consider:

• In 2006 4.9 million insulin items were prescribed and dispensed with an associated NIC of £238.1 million. These are increases of 6.4% and 11.5% respectively on 2005.
• The use of human insulin analogues is increasing rapidly and replacing the cheaper isophane and soluble insulins.
• Despite an increase in prescribing of the newer, more expensive insulin analogues, it has been suggested that there is currently no strong evidence that they result in improvements in HbA1c compared with older insulins. It has been suggested that the absence of long-term safety data should be an additional consideration when developing local insulin protocols. [MeReC Bulletin, Volume 17, Number 4 (Summary, June 2007)].
Oral Anti-Diabetic Drugs: Points to Consider:

- Oral antidiabetic drugs should be considered for all patients with type 2 diabetes whose blood glucose is inadequately controlled with lifestyle interventions alone.
- Metformin is the only oral therapy shown to reduce deaths and prevent both micro-vascular and macro-vascular complications. Hence it is the first-line treatment.
- The glitazones account for a substantial proportion of the costs of all oral anti-diabetic drugs.
- The glitazones are contra-indicated in patients with cardiac failure or a history of cardiac failure or hepatic impairment.

Diagnostic and Monitoring Agents: Points to Consider:

- Self-monitoring agents are essential for people with type 1 diabetes, though their value to patients with type 2 diabetes is controversial.
- A recent publication suggests that evidence is not convincing of an effect of self monitoring blood glucose in improving glycaemic control compared with usual care in reasonably well controlled non-insulin treated patients with type 2 diabetes.
- NICE is currently consulting on updated guidance on type 2 diabetes and suggests that self-monitoring of plasma-glucose (SMPG) should be offered to newly diagnosed people with type 2 diabetes as an integral part of self-management education. The purpose of SMPG should be discussed and agreed.

Prescribing for Diabetes in Secondary Care: Points to Consider:

- The cost of medicines for diabetes dispensed in hospitals is only about a fortieth of that dispensed in primary care.
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Introduction

This report presents national-level trends in prescribing for diabetes in England. It has been produced as a result of evidence that:

- Diabetes is one of the clinical areas of high expenditure;
- The growth in expenditure on diabetes prescribing is greater than any other major clinical area;
- There are large variations in primary care drug utilisation and spend on prescribing for diabetes across the country.

This report presents information that illustrates the increasing prevalence of diabetes and obesity in England. It looks at information on primary and secondary care prescribing for diabetes from January 2002 to March 2007 and highlights key points for consideration by the diabetes community.

In parallel with the publication of this report, Dr Sue Roberts, National Clinical Director for Diabetes and the Department of Health are keen to encourage an open dialogue to ascertain views on current prescribing patterns. They want to establish whether there are specific actions that can be taken to address the variations in prescribing practice and to ensure that prescribing is both clinically and cost effective.

Appendix 1 of the report signposts URL links and supporting material. It is hoped that this will encourage and facilitate access to prescribing information for your local NHS organisation.

This report is based on a more detailed report produced by The Information Centre for Health and Social Care in March 2007:


The above report is available from www.ic.nhs.uk.
Developing an Open Dialogue on Prescribing for Diabetes

This report will be circulated widely throughout the diabetes community in England during Autumn 2007. It is envisaged that PCT Prescribing Leads will play a part in championing the report and ensuring that it receives a wide circulation to generate as much discussion as possible.

It will be helpful to look at local information in conjunction with this national report. Ways to access this are shown in Appendix 1. Additional analytical support may also be available through your local PCT Prescribing Lead or PCT Informatics Team.

Dr Sue Roberts, National Clinical Director for Diabetes, is keen to encourage feedback and debate on the content of this report. Consequently, we have developed a web page where you can feedback your comments and observations. The web page prompts you to provide responses to the headline questions overleaf. Please make every effort to log on and provide your feedback.

It is also acknowledged that the National Institute for Health and Clinical Excellence (NICE) are currently updating the guidance on type 2 diabetes: the management of type 2 diabetes. Consultation on the draft guidelines with stakeholders will take place in Autumn 2007. Final guidance is expected to be published in March 2008. More information is available at www.nice.org.uk
Developing an Open Dialogue on Prescribing for Diabetes - Headline Questions

Your comments and thoughts are very welcome. Please log on to http://www.yhpho.org.uk/diabetes_survey.aspx to feedback your views on this report. Please feel free to answer all or any of the questions below.

Thank you

1. What are your observations on prescribing data for diabetes?

2. Does your local data appear to reflect the national picture?

3. How do you compare with local or similar organisations?

4. What do you see as the key variations between the PCTs or SHAs?

5. What do you think accounts for these variations?

6. What do you think the variations indicate about the quality of care for people with diabetes?

7. Who are the people most affected by these variations?

8. Do you think these variations matter?

9. If the variations matter, how do you think they can be reduced?

10. What do you see as the key challenges in reducing the variations?

11. Other general comments.

12. What further data and/or analysis would be helpful in the future?
The Increasing Prevalence of Diabetes and its Potential Impact on Prescribing

There were an estimated 2.4 million people (~4.75% prevalence) with diabetes in England in 2006. However, as only 1.9 million people aged 17 years or over (~3.75% prevalence) are registered as having diabetes in general practices there are probably a further 500,000 people, or ~1% of the England population, whose diabetes is undiagnosed. Early diagnosis and treatment leads to improved health outcomes for patients. People with diabetes have reduced life expectancy and an elevated risk of vascular damage leading to a range of co-morbidities including heart disease, stroke, kidney failure, blindness, lower limb amputation and neuropathy.

Figure 1 shows the prevalence of diabetes in those aged 17 years and over, based on registrations in general practice by SHA and England. Data is presented from the Quality and Outcomes Framework (QOF) for 2004/05, 2005/06 and 2006/07. Although a significant proportion of the observed increase in diabetes prevalence is likely to be genuine and due to rising obesity and population ageing, improved case-finding and recording in general practice may be also be contributory factors. It should be noted that as a consequence of a coding rule change applied in April 2006, it is likely that the prevalence of registered diabetes recorded in the 2006/07 QOF is an underestimate of true levels.
The PBS Diabetes Prevalence Model provides estimates of diabetes prevalence up to 2010. This is illustrated by SHA in Figure 2 below. It is estimated that between 2007 and 2010, the number of people with diabetes in England will have increased by 6.7% to 2.6 million. This will increase the pressure on services required to treat and support people with diabetes. The cost of this could be substantial and should be planned for. Diabetes is now a major driver for the rise in the national drugs bill.

The Impact of Rising Obesity

Being obese and having a sedentary lifestyle significantly increase the risk of developing diabetes. The National Audit Office suggests that 47% of type 2 diabetes can be attributed to obesity. Body Mass Index data from the Health Survey for England indicates that the proportion of obese adults has risen dramatically since 1991. A linear extrapolation of this trend as shown in Figure 3 indicates that 29.4% of men and 28.6% of women may be obese by 2010. A Department of Health forecast suggests that obesity in men may even reach 33% by 2010. Figure 4 shows obesity prevalence broken down by SHA for 2002-04.

Forecasts of expected diabetes prevalence, based on rising obesity levels and the ageing population, suggest that the number of persons with diabetes will have increased by 450,000 (~15.7%) in the decade leading up to 2010, 60% of this rise being attributable to increasing obesity levels and 40% to the ageing population.
Figure 3: Obesity prevalence in England (1991-05 estimate and 2010 predicted)

Source: HSE 1991-2005 (un-weighted), 2010 linear forecast

Figure 4: Obesity prevalence by Strategic Health Authority (2002-04)

Diabetes Prevalence and the Impact of Obesity: Points to Consider:

- There are an estimated 2.4 million people (~4.75% prevalence) with diabetes in England in 2006.

- It is estimated that 500,000 of these people, or ~1% of the England population, have diabetes that is undiagnosed.

- It is estimated that by 2010, there will be 2.6 million people with diabetes in England (~5.05% prevalence).

- The National Audit Office suggests that 47% of type 2 diabetes can be attributed to obesity.

- Trends indicate that 29.4% of men and 28.6% of women in England may be obese by 2010.

- Even modest weight reductions provide significant health benefits, particularly in cardiovascular disease, and can reduce the risk of developing diabetes.
Prescribing for Diabetes in Primary Care

The data presented within this section covers prescriptions issued in primary care in England and dispensed in the community in the UK. The figures show information relating to prescription items and Net Ingredient Cost (NIC).

Prescription items are written on prescription forms known as FP10. Each single item, for a different drug or formulation, written on the form is counted as one prescription item.

Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charges income.

Figures 5 and 6 show the relative proportions of items and NIC respectively, prescribed for insulins, oral anti-diabetic drugs and diagnostic monitoring agents by quarter. There has been a steady growth in both cost and items for all three sections over the last five years. The number of prescription items has increased by 55% and the cost by 88% over this five-year period.

Figure 5: Total Items for Drugs used to treat Diabetes BNF 6.1

[Graph showing the total items for drugs used to treat diabetes from 2002 to 2007, with a steady increase in items and cost over the years.]
Figure 7 shows the association between the number of persons registered with diabetes and the total prescribing cost (for 2005) for diabetes by former Primary Care Trust. Although these two variables are highly correlated, it is clear that some PCTs spent more on diabetes drugs despite having similar numbers of persons registered with diabetes. The absolute discrepancy tends to be greater among PCTs with higher numbers of diabetes registrations.

A range of PCT level comparator data has been made available on both the YHPHO and The Information Centre website at:

www.yhpho.org.uk/prescribingfordiabetes.aspx
or
www.ic.nhs.uk

It is envisaged that this resource will continue to be updated as new material becomes available.
Figure 8 shows the two-fold range (£182.25 to £364.58) in the total annual NIC per person registered with diabetes by former PCT in 2005.

Figures 7 and 8 use registrations in primary care taken from the 2005/06 Quality and Outcomes Framework (QOF) data. This excludes people with diabetes aged less than 17 years, as these patients are generally cared for by hospital specialists.
Prescribing for Diabetes in Primary Care: Points to Consider:

- In 2006 the total number of items prescribed to treat diabetes was 28.4 million; an increase of 7.4% on 2005.
- The associated Net Ingredient Cost (NIC) was £561.4 million, an increase of 13.6% on 2005.
- Diabetes prescribing accounted for 3.8% of all items prescribed and dispensed in England and 7.0% of the total spent on all prescribing in England in 2006.
- There is considerable variation between Primary Care Trusts in the expenditure on drugs and other diabetes related prescribing items used to treat diabetes.

Prescribing for Obesity

Three drugs, sibutramine, orlistat and rimonabant, are currently licensed for use as an adjunct to diet and other lifestyle advice in the management of obesity. The licenses state when these drugs can be used, the monitoring required and when they should be withdrawn, as long-term use is not recommended. Sibutramine and orlistat have been reviewed by NICE. Rimonabant became available on the UK market in 2006. There has been an increase in the prescribing of these drugs over the last three years as shown in Figure 9 below. This may reflect the rise in obesity, the availability of appropriately trained staff and increasing awareness of the availability of therapeutic interventions.

Figure 9: Number of Items of Orlistat, Sibutramine and Rimonabant prescribed in GP practices in England and dispensed in the community

Source: ePACT
**Insulins**

Insulin is categorised by the BNF into two groups: (a) short-acting and rapid-acting insulins and (b) intermediate and long-acting insulins. The use of human insulin analogues produced synthetically by recombinant DNA technology is increasing rapidly and replacing the cheaper isophane and soluble insulins.

Figure 10 shows the cost for 28 days treatment for a range of insulins. These data are provided by the Prescription Pricing Division, NHS Business Services Authority.

**Figure 10: Insulins cost for 28 days treatment (based on DDD = 40iu)**

<table>
<thead>
<tr>
<th>Insulin Type</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soluble insulin (Actrapid) 10ml vial</td>
<td>£8.38</td>
</tr>
<tr>
<td>Soluble insulin (Humulin S) 5 x 3ml cartridge</td>
<td>£21.00</td>
</tr>
<tr>
<td>Soluble insulin (Insuman Rapid) 5 x 3ml cartridge</td>
<td>£17.49</td>
</tr>
<tr>
<td>Insulin Aspart 10ml vial</td>
<td>£19.34</td>
</tr>
<tr>
<td>Insulin Aspart 5 x 3ml cartridge</td>
<td>£21.97</td>
</tr>
<tr>
<td>Insulin Aspart 5 x 3ml prefilled device</td>
<td>£23.89</td>
</tr>
<tr>
<td>Insulin Lispro 10ml vial</td>
<td>£19.35</td>
</tr>
<tr>
<td>Insulin Lispro 5 x 3ml cartridge</td>
<td>£22.00</td>
</tr>
<tr>
<td>Biphasic isophane insulin (Mixtard 30) 10ml vial</td>
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<td>Biphasic insulin Lispro 5 x 3ml prefilled device</td>
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<td>Biphasic insulin Aspart 5 x 3ml cartridge</td>
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<td>Insulin Glargine 10ml vial</td>
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</tr>
<tr>
<td>Insulin Detemir 5 x 3ml prefilled devices</td>
<td>£29.12</td>
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Prices based on Chemist and Druggist September 2007. Dose based on WHO DDDs where possible, otherwise BNF stated dose. The WHO DDD is a unit of measurement based on the assumed average maintenance dose in adults. It may not necessarily reflect the actual dose used.
Short-Acting and Rapid-Acting Insulins

In 2006, 1.3 million short-acting insulin items were prescribed with a NIC of £63.6 million. These are increases of 10.8% in items and 14.1% in NIC on 2005.

Figure 11 shows the number of items prescribed for selected short-acting insulins. The use of Insulin Aspart has increased significantly to replace soluble insulin as the most frequently prescribed formulation, whilst use of Insulin Lispro has risen more slowly over the same time period.

Continuous subcutaneous insulin infusion (insulin pump) is an appropriate route of administration for a small number of patients who are able to use it safely and effectively, and are supported by a specialist. There is no evidence that human analogue insulin provides any benefit over soluble insulins in pumps.

Inhaled insulin became available in the summer of 2006. It must be initiated in a specialist centre. It is not recommended for long-term use, as it does not remove the need for basal insulin and there are concerns about long-term safety in relation to respiratory function.

Intermediate and Long-Acting Insulin

Intermediate and long-acting insulins can be further divided into two sections: (a) Biphasic and (b) Non-Biphasic insulins.

Biphasic Insulin

These are ready-mixed combinations of a short-acting and longer-acting Insulin. Figure 12 and Figure 13 show costs and items respectively for Bisphasic Insulin Lispro, Biphasic Isophane Insulin and Biphasic Insulin Aspart.
In 2006, 1.9m biphasic insulin items were prescribed with an NIC of £89.2m. This was an increase of 0.5% on the previous year in terms of items, and an increase of 4.4% in terms of NIC. Again, the formulation containing Insulin Aspart has increased significantly in use.

**Non-Biphasic Intermediate and Long-Acting Insulin**

This British National Formulary (BNF) section covers all Non-Biphasic Intermediate and Long-Acting Insulin, but figures 14 and 15 show shows Insulin Determir, Insulin Glargine and Isophane Insulin only as these drugs represent the majority of the prescribing.
In 2006, 1.7m non biphasic intermediate and long-acting insulin items were prescribed with a NIC of £85.3m. These are increases of 10.7% in items and 17.9% in NIC on 2005. These are much greater increases than seen with the

Figure 14 illustrates the significant shifts in product choice over the last five years. Insulin Glargine has replaced Isophane Insulin as the most commonly prescribed long-acting insulin. This shift has produced the substantial increase in cost, as insulin glargine and insulin determir are more expensive than isophane insulin as shown in Figure 15 below.

Figure 14: Number of items prescribed and dispensed for selected Non Biphasic Intermediate and Long Acting Insulins

![Graph showing the number of items prescribed and dispensed for selected Non Biphasic Intermediate and Long Acting Insulins.]

Source: ePACT

Figure 15: Net Ingredient Cost spent on items prescribed and dispensed for selected Non-Biphasic Intermediate and Long-Acting Insulins

![Graph showing the net ingredient cost spent on items prescribed and dispensed for selected Non-Biphasic Intermediate and Long-Acting Insulins.]

Source: ePACT
**Insulins: Points to Consider:**

- In 2006, 4.9 million insulin items were prescribed and dispensed with an associated NIC of £238.1 million. These are increases of 6.4% and 11.5% respectively compared to 2005.

- The use of human insulin analogues is increasing rapidly and replacing the cheaper isophane and soluble insulins.

- Despite an increase in the prescribing of the newer, more expensive insulin analogues, it has been suggested that there is currently no strong evidence that they result in improvements in HbA1c compared with older insulins. It has been suggested that the absence of long-term safety data should be an additional consideration when developing local insulin protocols. [MeReC Bulletin, Volume 17, Number 4 (Summary, June 2007)].

**Oral Anti-Diabetic Drugs**

In 2006, 17.2 million oral anti-diabetic drug items were prescribed with an associated NIC of £177.6 million. These are increases of 10.1% and 29% respectively on 2005 values. The numbers of items and associated NIC are shown in Figure 16 and Figure 17 respectively. Metformin (a biguanide) is the most commonly prescribed oral drug, and is relatively low-cost. The use of sulphonylureas has increased slightly.

Other antidiabetic drugs include acarbose, nateglinide, pioglitazone, repaglinide and rosiglitazone. The glitazones account for most of the prescribing in this group, and for most of the overall cost for all anti-diabetic drugs.
Figure 18 shows the comparable costs for 28 days treatment with anti-diabetic drugs and is reproduced with permission of the Prescription Pricing Division of the NHS Business Services Authority.
In 2006, there were 2.1 million prescription items for glitazones, with an associated NIC of £94.2 million. These are increases of 33.5% in items and 35.1% in NIC on 2005. Figure 19 shows that Rosiglitazone remains the most commonly prescribed glitazone. The use of a combination of Rosiglitazone with Metformin has increased steadily and now exceeds that of Pioglitazone.
There have been recent concerns about the cardiovascular risk associated with the use of rosiglitazone. It is acknowledged that this may have an impact on future prescribing patterns.

**Oral Anti-Diabetic Drugs: Points to Consider:**

- Oral antidiabetic drugs should be considered for all patients with type 2 diabetes whose blood glucose is inadequately controlled with lifestyle interventions alone.

- Metformin is the only oral therapy shown to reduce deaths and prevent both micro-vascular and macro-vascular complications. Hence it is the first-line treatment.

- The glitazones account for a substantial proportion of the costs of all oral anti-diabetic drug costs.

- The glitazones are contra-indicated in patients with cardiac failure, a history of cardiac failure or hepatic impairment.

**Diagnostic Monitoring Agents**

The volume and cost of prescriptions for blood glucose monitoring has risen steadily over the last five years. In November 2006 central price reductions were introduced, which reduced the cost growth slightly - see Figure 20.
Diagnostic and Monitoring Agents: Points to Consider:

- Self-monitoring agents are essential for people with type 1 diabetes, though their value to patients with type 2 diabetes is controversial.

- Recent research by Farmer et al published in the British Medical Journal (BMJ 2007;335:132-6) suggests that evidence is not convincing of an effect of self monitoring blood glucose, with or without instruction in incorporating findings into self care, in improving glycaemic control compared with usual care in reasonably well controlled non-insulin treated patients with type 2 diabetes.

- NICE is currently consulting on updated guidance on type 2 diabetes and suggests that self-monitoring of plasma-glucose (SMPG) should be offered to newly diagnosed people with type 2 diabetes as an integral part of self-management education. The purpose of SMPG should be discussed and agreed.
Prescribing for Diabetes in Secondary Care

Data on drugs used in hospitals are supplied on a commercial contract by IMS Health. The costs stated here are calculated from the volumes of drugs issued from pharmacy departments but based on costs in primary care. This may not reflect the true costs paid by the hospitals as these are not controlled centrally and are commercially confidential. The cost of some drugs in hospitals are lower than in primary care, due to discounts, particularly for high profile therapeutic areas, such as diabetes, where there is competition for market share between pharmaceutical companies. Figure 21 shows the total NIC spent on drugs used to treat diabetes in hospital from January 2002 to March 2007.

The cost of medicines for diabetes dispensed in hospitals is far less than that in primary care. It is about 2.5% of the total cost of prescribing for diabetes in primary care. People with diabetes receive most of their support in primary care, though general practice prescribers may be advised and influenced by specialists in secondary care. The expenditure on insulins is much greater than for oral anti-diabetic drugs.
Figure 22 shows the total spend in hospitals on Short-Acting and Intermediate and Long-Acting Insulin. This is a similar pattern to that seen in primary care, where expenditure on short-acting insulins is also substantially lower than that on intermediate and long-acting insulins.

**Prescribing for Diabetes in Secondary Care: Points to Consider:**

- The cost of medicines for diabetes dispensed in hospitals is only about a fortieth of that in primary care.
Future Developments

All areas of prescribing are subject to change with the launch of new medicines or changes in the licences or availability of currently available medicines.

Novo Nordisk have announced that a number of insulins will be withdrawn from the UK market by December 2007. It will be necessary to transfer and train patients to use an alternative insulin and possibly a different device.

There are a range of new medicines for diabetes under development. New oral treatments will reach the market by the end of this year though others are likely to take longer.

The New Medicines Scheme at the National Prescribing Centre (NPC) is a well-established programme for providing advance information to the NHS to support the managed introduction of key new medicines. Monographs summarising the available evidence and information are produced approximately 12 months before the launch of selected key products. This may be followed by a post-launch update monograph. These publications are available on their website, via an NHSnet connection. www.npc.nhs.uk/

Recent notifications include:
- On the Horizon - Post Launch update - Sitagliptin May 2007
- On the Horizon newsletter - Exenatide May 2007
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Appendix 1

Find more local information about diabetes prevalence and your local prescribing for diabetes here:

A range of PCT-level comparator data has been made available on both the YHPHO and The Information Centre for Health and Social Care website which is available at:

www.yhpho.org.uk/prescribingfordiabetes.aspx or www.ic.nhs.uk

It is envisaged that this resource will continue to be updated as new material becomes available.

Additional analytical support to undertake local analysis of the prescribing data may also be available through your local PCT Prescribing Lead or PCT Informatics Team.

The PBS Diabetes Prevalence Model is a spreadsheet model that generates expected total numbers of persons with type 1 and type 2 diabetes mellitus (diagnosed plus undiagnosed combined) in 2001. More information and access to PCT-level data are available here:

This information will be provided at new PCT-level from November 2007.

Data from the Quality and Outcomes Framework (QoF) is available through The Information Centre for Health and Social Care at:

www.ic.nhs.uk

The (QoF) records achievement by general practices for a range of care, including diabetes. The information describes practices’ achievement against a number of clinical indicators. The website contains an on-line database, spreadsheets and reports. Note that detailed diabetes-specific datasets may be provided on request to The Information Centre for Health and Social Care.

Secondary care prescribing information is collected by IMS Health from most hospitals in England. The data held by the Information Centre for Health and Social Care under a commercial contract with IMS Health.

www.ic.nhs.uk
Primary care prescribing data can be obtained from the Prescribing Analysis and Cost Tool (PACT) system, which covers prescriptions from primary care and dispensed in the community. This data are collected by the Prescription Pricing Division of the NHS Business Services Authority (BSA).

The Prescription Pricing Division of the BSA also provides a national prescribing toolkit. This tool can be used to compare prescribing rates at PCT and practice level for a range of over 50 different comparators.

The links to the ePACT site which includes the Toolkit are given below. Pop-ups need to be allowed on this site and it must be an NHS net enabled system. A login screen will appear asking for a user name and password - your PCT Prescribing Lead should be your first point of contact to access this data.

www.ppa.org.uk/ppa/info_sys/info_sys_ePACTnet_CT.htm

MeReC publications are produced by the National Prescribing Centre. They provide concise, evidence-based information about medicines and prescribing-related issues, which can inform prescribing practice, update professional knowledge and help support healthcare planning.

www.npc.co.uk/merec_index.htm

Recent publications include:
MeReC Bulletin - June 2007; The role of newer insulins in diabetes
MeReC Extra - August 2007: CV risks of rosiglitazone
The Prescriptions Pricing Division (PPD) regularly produces PCT prescribing reports entitled “Prescribing Guidance and Discussion Points” which examine specific areas of prescribing. A recent PCT prescribing report was published on drugs used in type 2 diabetes and shows PCT prescribing against Strategic Health Authority and national comparators.

As part of the report, various discussions points were identified which are given below for consideration:

1. Does your PCT have a strategy for prevention of type 2 diabetes? Does this include identifying those at high risk? Does your PCT provide the sort of intensive multifactorial interventions shown to prevent type 2 diabetes?

2. Has your PCT implemented NICE guidance on obesity? Is there a local weight management service? Is there a local referral scheme to support increased activity and exercise?

3. Does your PCT have a strategy to close the local ‘prevalence gap’: the difference between the estimated total prevalence of type 2 diabetes and the number of diagnosed cases?

4. Does your PCT provide structured education programmes for people with type 2 diabetes?

5. Does your PCT offer a medicines management service tailored to the needs of people with type 2 diabetes?

6. Does local guidance on prescribing for type 2 diabetes and local practice coincide with NICE guidance on ‘glitazones’ and insulin analogues?

7. Does local guidance include advice on the role of self-monitoring of blood glucose in the management of type 2 diabetes? Is this consistent with the content of local patient education courses and supporting materials?

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