

Annexe D

Financial flows relevant to medicines

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ANNEXE D

THE FINANCIAL FLOWS RELEVANT TO MEDICINES

Introduction

- 1.1. This Annexe examines the different types of prescription medicines available in primary care, specifically from pharmacies and dispensing doctors. The distinction between different types of medicines is examined and their payment mechanisms are explained.

Different types of medicines

- 1.2. In the UK, medicines are licensed for human use by the Medicines and Healthcare Regulatory Agency (MHRA) or by the European Agency for the Evaluation of Medicinal Products (EMA). These licensed medicines are split into three broad categories dependent on the level of restrictions over where and how they can be purchased. This report is only concerned with the first category - prescription only medicines (POMs) which are further subdivided into brand and generic medicines. In the interests of clarity, the other two categories - pharmacy-only (P) and General Sales List (GSL) medicines (also known as over-the-counter (OTC) medicines) are briefly explained and distinguished from POMs.

Prescription only medicines

- 1.3. POMs are those medicines where a prescription from either a General Practitioner (GP) or a dentist is needed for a patient to have the medicine supplied or dispensed. These medicines are specified in The Prescription-Only Medicines (Human Use) Order 1997. Prescriptions under the NHS are taken to any pharmacy which has a contract with its local Primary Care Organisation, where the registered pharmacist supervises provision of the relevant medicine and any necessary description and guidance relating to the medicine for the patient.¹
- 1.4. Pharmacies supply prescription medicines to patients at the NHS flat-rate prescription charge.² This fee is not paid on most prescriptions as the patients are exempt; exemptions include the young, elderly and unemployed. In England, for example, only 12.4 per cent of prescriptions dispensed attracted the charge in 2005. The number of prescriptions dispensed in the UK has risen steadily over the past 20 years, and is estimated at 828.7 million in 2005 with the cost rising

¹ In certain rural areas, the prescribing GP may also dispense the medicine.

² This is currently £6.85 in England, Scotland and Northern Ireland, while in Wales the fee was phased out after April 2007.

more than fivefold.³ Revenues from POMs received in retail pharmacies in the UK in 2005 were £9.6 billion.⁴

- 1.5. Table D.1 below gives total expenditure on prescription medicines in primary care in the UK in 2005, which totalled approximately £9.3 billion (£8.3 billion taking into account the clawback).⁵ Of this £9.3 billion, £6.8 billion was spent on branded medicines and £2.5 billion on generics.

Table D.1: Expenditure on prescription medicines in primary care in the UK, 2005

£ millions	England	Wales	Scotland	N Ireland	Total
Generics	1,979	132	330	51	2,492
Brands	5,522	402	554	286	6,764
Total	7,501	534	884	337	9,256
Total (minus clawback)*	6,800	500	800	300	8,300

*Estimates quoted to nearest £100 million.

Source: Prescriptions statistics⁶ and OFT calculations. The figures may differ slightly from those quoted elsewhere. Totals may not equal sum of constituents due to rounding errors.

- 1.6. There are three types of POMs which are described below.
- 1.7. **Branded medicines:** These are medicines where the manufacturing company has typically researched and developed a medicine and sells this to the NHS with a particular brand name attached. This brand name often differs substantially from the generic (or chemical) name of the medicine.⁷
- 1.8. In order to allow branded medicine manufacturers to recover the cost of research and development, patent protection is afforded to new medicines. The diagram and box below describe the life cycle of a medicine, from the research and development stage through trials and licensing, production and use and the entry of generic competition:

³ Keynote Retail Chemists & Drugstores Market Report 2006.

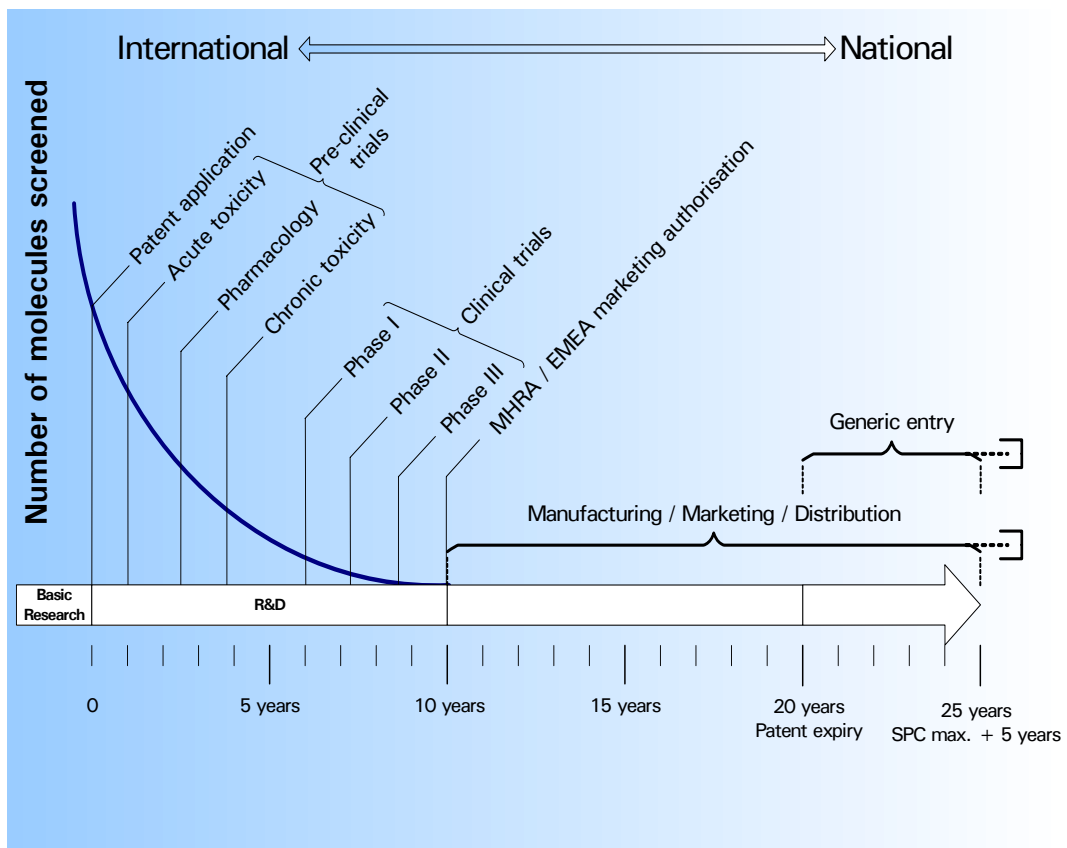
⁴ UK Retail Pharmacy Market 2006, Verdict Research Ltd. Data from ONS and Verdict research Ltd.

⁵ The clawback is a deduction applied to pharmacies' reimbursement by the Department of Health. It is discussed in more detail in Annexe 1a

⁶ Prescription cost analysis (PCA) data provided by the Prescription Pricing Authority (England), Health Solutions Wales, the Information Services Division Scotland and the Central Services Agency (Northern Ireland).

⁷ For example, Zocor® is the brand name of a medicine with the generic name of simvastatin.

Figure D.1: Lifecycle of a medicine



Box D.1: Stages in the lifecycle of a medicine

1. Basic research is conducted on particular areas, some of this research is conducted by private companies and some is undertaken within public sector institutions such as universities.
2. Pharmaceutical companies can acquire patent protection once basic research has led to the identification of promising New Molecular Entities (NMEs).
3. Pre-clinical trials precede any testing on humans and involve rigorous testing of selected NMEs in laboratories and animals. Less than one per cent of compounds successfully make the transition from pre-clinical to clinical trials.
4. Clinical trials are carried out in humans. Three stages of trials are carried out before medicines can receive marketing authorisation. An estimated 21.5 per cent of medicines successfully pass through clinical trials. The different stages are:
 - Phase I trials in 20-100 healthy adults to test the medicine's safety.
 - Phase II trials in 100-300 patient volunteers to determine the safety and efficacy of the medicine.
 - Phase III trials on larger groups of patients (typically 1,000–3,000), to gain further data on safety and efficacy.
5. Marketing authorisation must then be obtained before medicines can be launched onto the market.
6. After medicines reach the market, Phase IV pharmaco-vigilance trials begin. These seek to identify any adverse reactions and continue throughout a medicine's lifetime.
7. Generic manufacturers are able to enter the market and sell generic copies of the medicine after its patent (and any supplementary protection certificate) has expired.

- 1.9. **Generic medicines:** once patent protection for a particular POM has expired, it is possible for other manufacturers to produce copies of the medicine. These are referred to as generic medicines as typically they do not have a brand name and are described by the generic or chemical name of the medicine. Generic medicines are often much cheaper than the equivalent branded medicine as generic manufacturers do not have product research and development costs to recover in the price. When prescribing a particular POM, the doctor will stipulate on the prescription either the original brand name or the generic name.
- 1.10. **Branded generic medicines:** For some medicines where there are modified release profiles, which typically release a chemical more slowly into the patient, the MHRA usually requires that such medicines, including generics, be marketed under a separate brand name. Some generic producers also choose to apply a brand name to other generic medicines to distinguish between alternative presentations (tablet, capsule strength etc.) of the medicine to the originator product for marketing purposes. These are referred to as branded generic medicines.

Over the counter (OTC) medicines

- 1.11. Patients do not require a prescription in order to purchase an OTC medicine and pay the market rate for the medicine without state subsidy. Following the cessation of resale price maintenance in May 2001, OTC medicine prices are not regulated and are set by the retailer. Revenues received in retail pharmacies relating to OTC medicines and other medical products (not prescription medicines) in the UK in 2005 were £2.8 billion, while the total revenue to retail pharmacies was £12.4 billion.⁸ OTC medicines fall into the following two categories.⁹
- 1.12. **Pharmacy only medicines:** These are often referred to as P category medicines, and are those which can only be sold under the supervision of a pharmacist but which do not require a prescription. This supervision can be necessary due to the nature of the active ingredient, the strength of the medicine or size of the pack. These medicines are those with a small chance of adverse reactions and a good safety record. Some prescription only medicines are transferred to become P category medicines where it is possible to demonstrate a good safety record for use as a prescription medicine.
- 1.13. **General Sales List medicines (GSL):** Are those medicines that do not need to be sold in a pharmacy, but do need to be sold in a secured lockable shop. Examples of GSL medicines are smaller pack versions of P medicines such as painkillers aspirin or paracetamol and other basic medicines. They are typically sold in pharmacies, supermarkets, petrol stations and convenience stores. GSL medicines are specified in The Medicines (Products other than Veterinary Drugs) (General Sales List) Order 1984.
- 1.14. Since OTC medicines do not fall within the remit of this study they are not discussed further.

Payment for dispensing NHS prescription medicines

- 1.15. The revenue pharmacists receive from the prescription charge is remitted to central government.
- 1.16. Pharmacists receive reimbursement for the cost of the prescription medicines they dispense, as well as receiving remuneration for NHS pharmacy services they provide, including dispensing fees and a professional allowance. Of these two forms of payment, reimbursement is the more significant.
- 1.17. Reimbursement for prescription medicines is made under two different schemes based on the following conditions:

⁸ UK Retail Pharmacy Market 2006, Verdict Research Ltd. Data from ONS and Verdict research Ltd.

⁹ Dispensing doctors do not sell OTC medicines.

- When pharmacies are obliged to dispense a particular branded medicine (either because a GP prescribed that particular brand by name or has prescribed a generic or chemical name but no generic is available) they are reimbursed at the manufacturer's list price for that medicine. This list price is indirectly controlled by the Pharmaceutical Price Regulation Scheme (PPRS).¹⁰
- When pharmacies are permitted to dispense a generic medicine (because a GP has prescribed a medicine using its generic or chemical name) and where such generic alternatives to the original branded medicine are available, they are reimbursed at prices set by the Drug Tariff.

1.18. **The PPRS:** currently, the PPRS scheme has two main components which are applied to branded and branded generic medicines:

- **Profit controls:** These set both a maximum and minimum level of profit for manufacturers of medicines supplied to the NHS. Below the minimum point, prices of medicines supplied to the NHS may be raised. Above the maximum level of profit, prices should be lowered.
- **Price controls:** These allow manufacturers to set the initial list price of a new medicine sold to the NHS, but which then constrain subsequent price increases. The price controls also comprise price cuts which are agreed during the periodic re-negotiation of the PPRS scheme.¹¹

1.19. Reimbursements to pharmacists where they dispense a branded medicine (and where no generics are available) are made at the PPRS list price.

1.20. **The Drug Tariff:** this provides information about payments to NHS dispensing contractors, both reimbursements for medicines and fee-based remuneration. Part VIII of the Drug Tariff provides prices of medicines not contained within the PPRS, and this price information is split into a number of different categories:

- Category M contains many generic medicines, particularly those prescribed in the highest volumes. Category M prices are based on volume-weighted average prices charged by generic manufacturers (or if these are not available, from wholesalers).¹² Category M was established in April 2005, with prices determined on a quarterly basis since then.

¹⁰ Despite its name, the PPRS is closer to a demand-side control than a more traditional form of regulation. In practice, the PPRS list price is that paid by the NHS to pharmacies for medicines dispensed under the NHS. The prices of off-patent brands set through this process also impose a ceiling on the prices at which generic drugs prescribed in the NHS will be reimbursed. Total spend on generics in the NHS is about £3.25 billion.

¹¹ For example, the negotiation for the 2005 PPRS agreed a seven per cent price cut across all drugs supplied to the NHS. Manufacturers were given freedom over how to achieve this reduction from their portfolios of medicines; this flexibility is often referred to as modulation.

¹² The terms of category M require the ex-manufacturer price of a new generic medicine not to exceed the list price of the equivalent original brand in the same presentation at the time of its patent expiry.

- Category A was the predecessor of category M and still applies to some medicines. These prices are calculated using an average of quotes supplied by up to five manufacturers and wholesalers of generic medicines.
- Category B applies to medicines where usage has declined over time and that are often available from just a single supplier.
- Category C medicines are priced on the basis of the PPRS list price charged for a particular brand or by a particular manufacturer. This price is paid for a generic prescription even if a different supplier's product is dispensed.
- Category E is used for rare preparations that are specially (extemporaneously) made up from time to time.

Supplies of medicines to pharmacists

- 1.21. While the price pharmacists are paid for dispensing NHS prescription medicines are determined by the PPRS list prices and the prices in the Drug Tariff, the prices paid by pharmacists for their medicine supplies are determined by market forces.
- 1.22. Under the traditional wholesale model, manufacturers have sold their branded prescription medicines to wholesalers at a discount from the list price. Part of this discount is absorbed by wholesalers to cover their distribution and supply costs, while the remaining discount is passed on to pharmacies. In many cases, pharmacies receive a discount from wholesalers based on the total level of purchases (including more than just prescription medicines) from a wholesaler in a specified period.
- 1.23. Generic medicines are typically supplied to pharmacists at prices below those specified in the Drug Tariff, particularly those prices specified in category M of the Drug Tariff. This is because Category M reimbursement prices are adjusted to achieve the retained buying profit in the Pharmacy Contract (see paragraph 1.26 below). This means that margins on some category M medicines can be very high; in some cases a mark-up of over 100 per cent is applied to the manufacturer cost to achieve the reimbursement price.
- 1.24. The reimbursement method used for both branded and generic medicines gives pharmacists clear financial incentives to procure such medicines efficiently and at low cost. Pharmacies that are able to procure medicines for lower than average prices benefit through an increased margin. This promotes efficiency and competition in the supply chain to the benefit of efficient suppliers and pharmacies. In addition, the DH also gains by the process of clawback (described in paragraph 1.33 below) where it recaptures some of the dispensing margin earned by pharmacies.

How prescription medicine costs are controlled by the Department of Health

- 1.25. The DH has a number of methods by which it can control the amount of money spent on prescription medicines through the amount it pays to pharmacists in reimbursements and remuneration.

The Pharmacy Contract and Category M prices

- 1.26. The current Pharmacy contract was negotiated in 2003 between the DH and the Pharmaceutical Services Negotiating Committee (PSNC) which represents community pharmacies in the UK. Implementation began in April 2005. While some details are different in each of the four countries in the UK, the contract itself can be regarded as a UK-wide arrangement.
- 1.27. The contract guarantees a level of income to NHS pharmacies in aggregate in each of the four countries in the UK. For example, in England, pharmacies collectively should earn £1.9 billion in revenue from NHS business during 2006/07 in addition to whatever they are able to earn from OTC products.
- 1.28. For example, in England, the contract assumes that pharmacists will earn in aggregate around £500 million (known as the retained pharmacy margin) of the £1.9 billion total (for 2006/07) as a dispensing margin. In Scotland, the equivalent figure is £50 million as a dispensing margin. These margins represent the difference between the reimbursement price to pharmacies and the price paid by pharmacies to purchase medicines. The main mechanism for achieving such margins is through altering the generic reimbursement rate, which the DH achieves by altering category M reimbursement prices. While Category M prices are adjusted quarterly based on transactions in the market, prices are adjusted on an annual basis to ensure that the levels of income required in the Pharmacy contract are maintained in practice. The DH Drug Tariff Category M pricing for generics is also used in Wales, Scotland and Northern Ireland.

Clawback of pharmacy profit

- 1.29. Altering the reimbursement prices of generic drugs is not the only way that the DH can control the profits of pharmacies. The clawback is another tool available to the DH, the Scottish Executive and the Department of Health, Social Services and Public Safety, Northern Ireland (DHNI) to control pharmacy profits.
- 1.30. Clawback is the process by which the relevant authority can recoup some of the profits earned by pharmacists from their dispensing margins. This is to allow the public authorities to benefit from some of the savings pharmacies are making on purchasing drugs at low prices, including parallel imports and generic drugs. The table below shows how the clawback operates in the four countries in the UK:

Table D.1 Clawback rates in the UK

Country	Clawback on branded drugs ¹	Clawback on generic drugs ²
England and Wales	Between 5.63 and 11.5 per cent of a pharmacy's total monthly reimbursement depending on size of claim less exempt items. According to the PSNC, nationally the deduction is about 10 per cent of value at list prices. Average clawback (including zero discount products) is 9.2 per cent.	
Scotland	9.12 per cent	13.25 per cent
Northern Ireland	0 – 8.5 per cent	13.25 per cent

(1) Dispensed to prescriptions for the brand or an on-patent chemical.

(2) Or branded medicines dispensed to prescriptions when generics are available.

Note: slightly different clawback applies to dispensing doctors.

- 1.31. **Applicability of clawback:** Clawback is applied to a wide range of drugs, including brands, branded generics, generics and parallel imports. There are however some drugs which do not tend to be sold by manufacturers at less than the reimbursement price, including a number of medicines for rare conditions, a number of products with complex or controlled administration and some highly perishable preparations including temperature sensitive or cold-chain medicines.
- 1.32. Before September 2006, many such drugs would have been included in a zero-discount list of drugs to which clawback did not apply. Since 2006, the only drugs to which clawback does not apply are those that meet the following three conditions: the manufacturer and the two main wholesalers (AAH and UniChem) do not offer pharmacies a discount from the list price; the item is dispensed fewer than 500,000 times in a year; and the average net ingredient cost per item is more than £50.
- 1.33. **How clawback is determined - the margin or discount inquiry:** The DH, in consultation with the PSNC, measures the margins obtained by a small sample of pharmacies on a rolling monthly basis. This margin inquiry covers branded (including parallel imports) and generic medicines and is examined by auditing all the invoices of the sample pharmacies for the relevant period. The audited margin is then aggregated to cover the whole pharmacy market in England (for the DH inquiry).
- 1.34. The DH typically uses samples of around 40 pharmacies and is now looking to extend the length of the margin inquiries to four months, and further to cover most months of the year in the future. This is desired as it is necessary to see data from several months to detect trends in the margins earned.

- 1.35. Such inquiries focus on the margins earned by independent pharmacies, as the prices of medicines purchased by vertically integrated pharmacies may represent an internal transfer price within the integrated company, rather than being an appropriate measure of the profits earned by pharmacies. Similar inquiries undertaken in Scotland have attempted to take into account the margins of vertically integrated chains of pharmacies. The DHNI does not undertake its own margin inquiries but relies on information from those inquiries undertaken in Scotland.
- 1.36. The margin inquiries are retrospective, so for the DH, it is not possible to predict changes before they happen, instead there would be a natural time-lag before changes would be detected from the margin inquiries.
- 1.37. The information from these inquiries is used (in addition to that submitted to the DH as part of the category M arrangements) to ensure that pharmacies receive the dispensing margin agreed in the Pharmacy Contract. Adjustments can be made in the short run by changing the aggregate margin on category M medicines, or in the longer run by changing the level of clawback which is applied to pharmacies.

Price cuts in PPRS negotiations

- 1.38. As part of its negotiation of the PPRS with the ABPI, the DH agrees price cuts with the ABPI at the time of scheme renegotiations. As part of the negotiations for the 99 - 04 scheme, DH was able to agree a one-off price cut of 4.5 per cent.¹³ For the current PPRS, which began in January 2005, a one-off price cut of 7 per cent was negotiated.
- 1.39. As firms have freedom in setting prices of new medicines entering the PPRS, it is clear that the effect of the price cut on the cost of medicines has a diminishing effect over time, as new medicines enter the market during the course of the PPRS agreement.
- 1.40. The PPRS agreement gives firms flexibility in how they achieve the seven per cent cut in prices. Where firms have a number of different medicines, they can adjust the prices as they see fit, as long as the net result is a seven per cent cut overall. This process of adjustment is known as price modulation.
- 1.41. The PPRS price cuts represent a long-run method by which the DH seeks to constrain the amount it pays for medicines. Given the life of PPRS agreements is typically around five years, there is little scope for PPRS price cuts to react quickly to changes in the market.

¹³ Companies were permitted to lower some prices more than others provided that the overall effect was that of a 4.5 per cent price cut.

PPRS profit controls and discounts from manufacturers' list prices

- 1.42. The PPRS profit controls set the maximum and minimum acceptable profit levels for companies within the PPRS. The upper and lower limits are based on a target rate of return, which is the larger of 21 per cent return on capital employed and six per cent return on sales to the NHS.¹⁴
- 1.43. The maximum profitability is 140 per cent of the relevant target rate, while the minimum profitability is 40 per cent of the relevant target rate.
- 1.44. The DH assesses the profitability of companies in the PPRS each year.¹⁵ Under the terms of the scheme, suppliers with sales to the NHS of at least £25 million provide a financial return to the DH every year. This return states their overall NHS sales and allocates their costs and capital across NHS and non-NHS business.¹⁶ If the overall return on capital on NHS sales exceeds an upper limit (29.4 per cent in the current scheme) they are required to repay the excess to DH. If their rate of return falls below a lower limit (8.4 per cent in the current scheme), they are entitled to apply for a price increase.
- 1.45. The rules governing this assessment are complex, however, there are several key points:
- the sales considered are domestic sales only and do not include parallel imports
 - revenues and capital are allocated between the NHS and other customers of companies
 - there are maximum cost allowances for the levels of research and development (R&D), marketing and information costs
 - the levels of cost and capital may be increased from 'injection' of R&D from elsewhere in the company,
 - DH is entitled to satisfy itself that costs are properly incurred and are reasonable in the light of accepted commercial practice. Companies that disagree in this regard may appeal to an arbitration panel.
- 1.46. The cost allowances for certain cost types are an important feature of the profit control, with profit assessments being based on the allowances rather than the

¹⁴ Companies are assessed under the return on sales measure where their ratio of sales to total capital employed exceeds 3.5.

¹⁵ Only companies with branded sales in excess of £25m p.a. are required to submit regular financial returns to the DH. Companies with branded sales below £25m p.a. are in effect outside the maximum profit control, but would need to submit financial returns to DH if they were to apply for a price increase.

¹⁶ DH, PPRS Seventh Report to Parliament, December 2003. The R&D costs that are taken into account are current costs, not the costs incurred in the development of the drugs that are currently being sold.

actual costs incurred. It should be noted that the 12.5 per cent distribution convention is not one of the categories of cost allowance in the profit control.

- 1.47. The PPRS profit controls are one way in which the DH can control the prices at which branded medicines are supplied to the NHS. If a manufacturer's list prices are set at an unduly high level, or if manufacturers sell medicines to wholesalers at a price very close to the list price, they may earn high levels of profit that would be higher than the maximum level permitted by the PPRS profit controls.
- 1.48. In this way, the PPRS profit controls could prevent excessive price rises by manufacturers. However, in recent years, changes to the profit control element of the PPRS have reduced its significance, with wider margins of tolerance operating and a greater emphasis placed on the importance of price cuts. Consequently, the current profit controls have exerted little if any constraint on the behaviour of companies in the PPRS. Both repayments of excessive profits and price increases from insufficient profits were negligible over the 1999 to 2004 PPRS.
- 1.49. Another method which has acted to control the prices at which manufacturers sell their medicines has been the 12.5 per cent convention (this is described in more detail in Annexe C). Adherence to this convention appears to have limited the possibilities for manufacturers to increase the price of medicines sold to wholesalers.
- 1.50. Under DTP, there is no equivalent convention that applies to manufacturers' sales to pharmacies (see Chapter 3 for an analysis of the possible impact on pharmacy discounts).

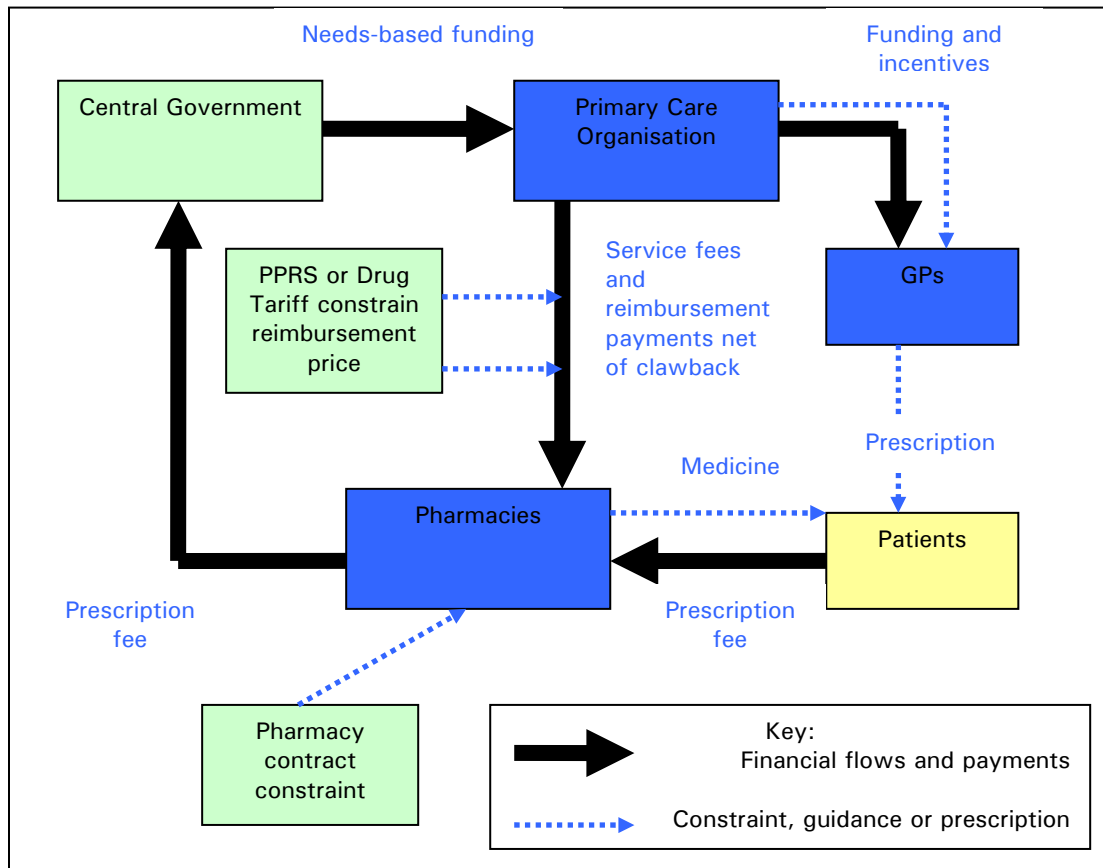
Tracing a prescription medicine through the system

- 1.51. There are two sides to the provision of prescription medicines that are represented below. These are:
- The demand side, i.e. how prescription medicines dispensed in pharmacies are reimbursed.
 - The supply side, i.e. how pharmacies obtain the prescription medicines they need to dispense.
- 1.52. **Demand-side financial flows:** Payments to pharmacies and Dispensing Doctors are provided by Primary Care Organisations (PCOs). The exact names of these bodies vary around the UK, although the concept of a PCO is recognisable throughout the UK. PCOs fund GPs through the General Medical Services

contract which was introduced in 2003.¹⁷ This acts as a constraint on the prescribing behaviour of GPs as it provides rewards for meeting clinical, organisational and patient-experience standards.

- 1.53. PCOs also provide direct funding for pharmacies. This includes reimbursements for the cost of prescription medicines (including a dispensing margin) and payments for services provided. Pharmacies are constrained by the Pharmacy contract, see paragraph 1.26 for details.
- 1.54. Patients visit GPs to obtain prescriptions and take these to a pharmacist to be dispensed. The pharmacist charges the patient the dispensing fee if relevant and dispenses the medicine. The patient fee is transmitted directly to the Government, and the pharmacist is reimbursed for the cost of the medicine dispensed and the service provided to the patient. The financial flows relating to this process can be seen in the following diagram.

Figure D.2 Financial flows relevant to public sector payment for prescription medicines



Source: OFT

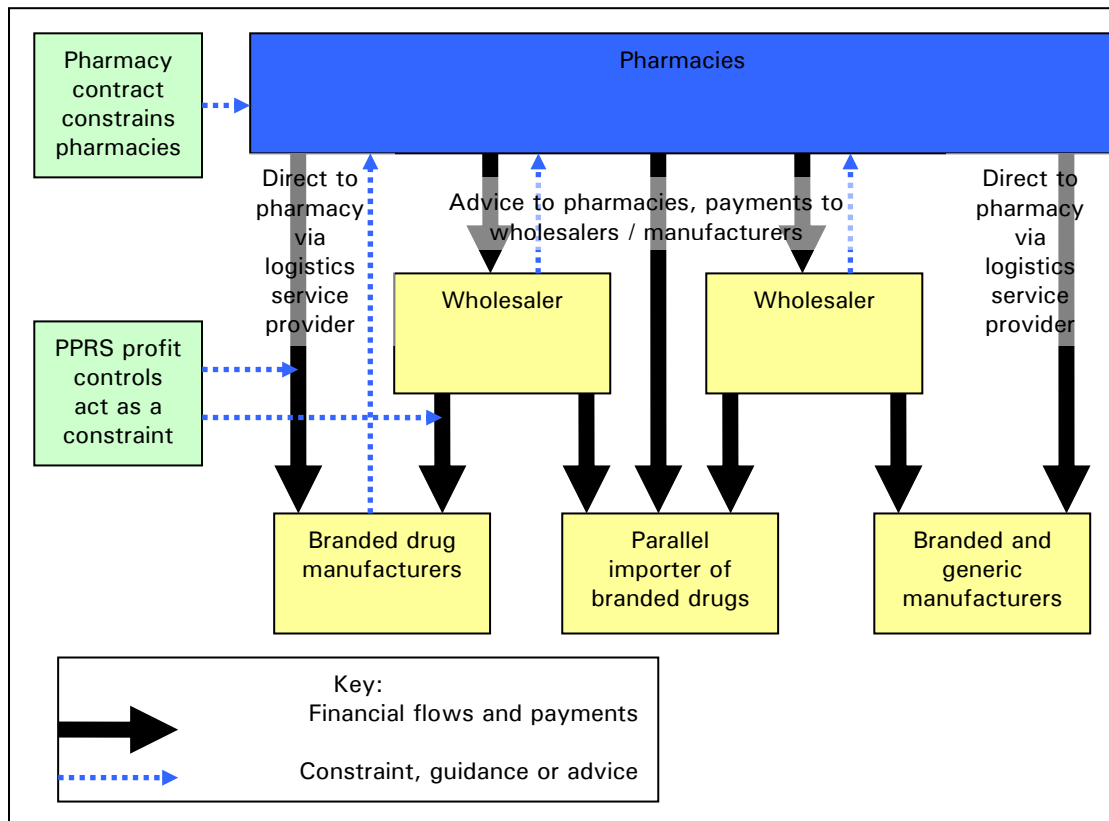
- 1.55. **Supply-side financial flows:** Pharmacists obtain prescription medicines from a number of sources, as follows:

¹⁷ The General Medical Services contract is not the only way the NHS can contract with GPs. There is also a Personal Medical Services contract agreed locally between PCOs and GP practices. In practice, there are few differences between the two contracts.

- wholesale companies, which comprise:
 - full-liners which hold the full range of prescription medicines available on the NHS
 - short-liners which hold a smaller range of prescriptions medicines and concentrate on a number of business areas, such as, fast-moving products, parallel imports, generic medicines etc,
- direct-to-pharmacy supply, where manufacturers use logistics service providers to deliver their products to the pharmacist. Logistics service providers are paid by manufacturers to collect, store and ship medicines on their behalf. The ownership of the medicines remains with the manufacturer rather than ownership transferring to a wholesaler. Pharmacists pay manufacturers directly for the medicines they purchase rather than negotiating payment with wholesalers.

1.56. One (albeit limited) constraint on the pricing for branded manufacturers comes from the PPRS profit controls. Further constraints arise from parallel imported medicines for branded medicine manufacturers, and through competition in manufacturing and distribution for generic medicines. These supply-side financial flows can be seen in the following diagram.

Figure D1.3 Financial flows relevant to the supply of prescription medicines



Source: OFT