PM Healthcare
PROGRESS THROUGH PARTNERSHIP

Q&A panel questions

Weight-loss drugs - How can the NHS manage the use of these medicines?

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What is the plan for those who start these medicines and then stop?

The medicines are safe to stop, even abruptly. The risks of stopping are around the patients regaining weight/reversing the benefits achieved whilst on the medication. There are a small number of studies trying to understand what happens when people stop these medications. The initial results so far show that weight is regained. Not at the rate it was lost, it is regained more slowly than it is lost, but is regained. From memory I felt the trials I read were decent sample sizes but a limitation was that we only have data for about 6 months post cessation. We need more studies/need to continue these on for longer. Problem is, they are new medications so we are really watching this play out in real time.

Interestingly, from being at English conferences this year, it seems that South of the Border the plan looks quite different. I was told by a number of sources that, in England, patients were getting two years on the medication. I was baffled by this as I feel it is less safe to rush the weight loss (increased risk of gallstones, detrimental impact on bone health etc). But also, we are afraid these may be required long term, so taking people off the medication may not be cost effective anyway?!

This is a massive opportunity for both pharmacy and the prevention program. How do we convince finance colleagues of the long term savings?

I would frame this less as "convincing finance" and more as making a joint stewardship decision in a finite system. We should also welcome the scrutiny and challenge of finance colleagues, to demonstrate value.

We are all working with the same constraints: a fixed budget, workforce gaps, and a long list of existing commitments. Any significant expansion of GLP-1 use for weight management has to be judged alongside other Scottish priorities, not in isolation.

For me the honest conversation looks like this:

- First, be clear what we are buying
- These medicines can deliver substantial weight loss for many people and likely important gains in cardiometabolic risk, especially in higher risk cohorts. How can we compare this to what is already "bought"?
- Second, be clear what it costs over time

- In an obesogenic environment this is not a short intervention for most people. It is a potential long-term treatment plus monitoring. That needs to be acknowledged up front in our hunger to rush ahead.
- Third, be transparent about opportunity cost
- New spend in this space will sit alongside pressures in mental health, primary care, social care, cancer, prevention and other medicines. We should assume there is displacement, even if we cannot trace it line by line.

So instead of promising "long-term savings," I would propose conditions under which investment is responsible and gives confidence:

- Defined eligibility and ineffectiveness exit criteria.
- Prioritising cohorts with the highest underlying risk, where health gain is greatest.
- A light-footprint delivery model that preserves system capacity whilst retaining benefits and outcomes.
- A time-limited delivery model testing approach based on measured outcomes, equity impact (who gets access) and system effects.

If we can show that, under those conditions, these pathways deliver better health and equity than alternative uses of the same money and workforce, then finance colleagues are more likely to see this as a shared investment decision, and we will feel collective confidence in pursuing this.

Are we distinguishing between the side effects of GLP-1s obtained through illicit sources versus those supplied by regulated manufacturers?

Yes, the Yellow Card Scheme is robust enough for information regarding this, however education for healthcare professionals is required.

Does prescribing of GLP-1s via community pharmacy provide the perfect driver to reassess community pharmacy remuneration completely to future proof care?

I would say no. Purely on the basis that I feel the government (who control remuneration) have been quite clear on their position on weight loss medicines. Let's remember they have chosen not to fund them!

In the bigger picture, I think Community Pharmacy is in a real time of change and it feels like we don't really know what it is we do anymore?! This is quite a personal answer/observation by the way. I have noticed that we are pulling in many different directions. If you look at the bare bones of the books of a pharmacy, we continue to make our money from the margin. Unless a pharmacy has really, really, significantly diversified, the bottom line figure in the business model is most closely linked to volume of drugs dispensed. This therefore remains our core function I believe?

I think a lot of older generation pharmacy owners will probably steadfastly continue with that model and who am I to disagree, particularly when I look at my accounts!

However, this model maybe doesn't suit the newer generation of pharmacists and probably definitely not the ones who will qualify as IPs. I feel they want more clinical input/patient facing roles/want away from the checking bench. But it's hard for smaller volume shops to offer this since the volume is not there to justify an ACT because they can't be involved in dispensing, so they become an inflexible member of the team! One consultation room is all many have space for too.

There is significant diversification going on now into private services. The problem here (for the NHS) is that it has set the bar for remuneration. It has created competition for the NHS so to speak when they try to commission services. This is good for a business owner, for sure. But it is a risk for the NHS (my NHS hat is on a little now!) because I fear they can't compete financially in my opinion.

Above all else, I do believe we need to really think about what we are now and what we want to be. Do I think weight loss drugs will change commissioning/remuneration as a whole? No, I don't. But it might have been the catalyst for pharmacies to really the change the game from a business perspective.

Is Homecare an appropriate supply route for these medicines?

Yes, given the convenience. However, we need to consider practicality, and stability as well as dose changes.

Could pharmacy use clinically verified AI to triage queries for weight loss medicines?

There is a role for AI here, but it needs to be understood as support, not a replacement for clinical decision-making. There is also an assumption that the triaging is a critical solve in the win for access here, it may not be as big a problem or the biggest problem where the solution could have an impact.

In Scotland, we need to invest more in exploring what we mean by “clinically verified” AI. In reality, verification is about the whole system: the tool, the data it uses, the governance around it, and how clinicians use its outputs, as well as understand how the outputs were arrived at.

Used well, AI or automation could help pharmacy in many ways for example (there are more):

- Front-door triage to collect structured information from people asking about these medicines, highlight obvious exclusion factors (for example pregnancy, certain conditions, interacting drugs), and prepare a summary for a clinician to review.
- Safety netting through prompts to pharmacists about guideline criteria (don’t actually need AI to do this), red-flags and potential interactions at the point of review.

- Operational efficiency in how we handle reminders, basic education, and follow-up questionnaires so that pharmacists can focus their time on higher-value conversations and our systems are built in a way that supports safe delivery, and doesn't overly rely on humans.

To do this safely, any AI use would need:

- A good problem statement for this space as well as others, that is validated against practice currently and practice with problem solved.
- Space and support (expertise, governance, evaluation) for prospective testing on cases, with monitoring of performance over time and communication in trial like conditions.
- Clear boundaries: the AI can gather and structure information, with a named clinician remaining responsible for decisions. This also requires engagement with regulatory bodies on what AI means for professional accountability in certain use cases, learning from other spaces like radiologists and their current tests.
- A clinical governance framework and transparency with patients that they are interacting with an automated tool, and how the decision about them has been made using the tool and public assurance and engagement.

So the short answer is yes, AI could support triage and follow-up weight pathways, but it should sit inside a human-led decision pathway with clear accountability, and it should reduce low-value work, not add a new barrier to access (how it makes decisions and if those decisions are different for certain people). At the simplest level, a clear algorithm may be enough rather than AI – which is easier to deliver and more understandable/flexible.

There has been a shortage of GLP-1RAs in the past(diabetes). If there is a shortage of these medicines is there a structured approach if patients cannot receive them?

There are well established routes to enable medicines to be used in the most essential circumstances for shortages of these medicines, which have been enacted in the last couple of years.

What would the immediate cost vs long term benefit look like in creating a non-patented publicly owned GLP-1 be?

It is a useful question because it surfaces how we think about value, markets and public investment, even if a publicly owned GLP-1 is not a near-term option. I don't have the specific expertise to address this in detail, but some thoughts below.

At a high level:

- Developing a public, non-patented GLP-1 would mean large up-front public investment in discovery, trials, regulation and manufacturing, with significant uncertainty. That would come from the same overall public funding envelope as other health and social priorities.

- If successful, it could in theory allow lower unit prices and broader access, because you are not building in a commercial return to shareholders in the same way.
- This would be dependent on talent from the current competitive employment sector with higher revenues being attracted to work in a model that potentially attracts less personal reward overall from salary and other benefits.
- To be sustainable, there would need to be market access to non-NHS providers and beyond UK – the incentive for revenue generation as a distraction from the questions intimation, and the disruption it could create between manufacturers and the NHS in terms of relationships, isn't well understood or developed to comment precisely on actual effect, but it may disincentivise investment and create reluctance for investment in NHS priority areas (untested).
- Patents do expire, and any plan needs to be considerate of those timeframes.
- The current pressures on industry are driving real innovation in manufacturing given how complex it is to manufacture complex drugs like GLP-1s, this is a risk for a public sector competitor to potentially be priced out through technological advance.

For the NHS here and now, the more immediate issue is the interaction between the current market and our economic assessment:

- These products sit in a global market where there is strong demand and high willingness to pay, outside the NHS. That shapes manufacturers strategy around list prices and positioning.
- We then rely on health technology assessment and local (Scottish) economic analysis to decide if use at a given price and volume is a good use of finite public funds (which is determined by policy). We have robust processes in place for the at "a given price" on an individual basis, and less experience of supporting the "at a given volume" parts of this.
- Where there is a large non-NHS market, pricing and marketing strategies may be influenced as much by that external demand as by what a tax-funded system can sustain.

From an NHS perspective, the priority is to make sure that, within that reality, we are only using these medicines on terms that deliver the health and equity outcomes we are accountable for. That means:

- Being clear about what cost per outcome we are seeking (PROMs, QALYs etc.).
- Building in fair (system, constraints) approaches and prioritisation so delivery is targeted in those constraints.
- Continuing to develop real-world effectiveness and safety data as a condition of ongoing reimbursement for new health technologies (medicines and others) and exploring pricing strategies related to this and supported by broader VPAG work.

- Being prepared to adjust or limit use if the real-world value does not match what was assumed, both a risk for manufacturers and for delivery bodies.

I would treat the "public GLP-1" idea as a prompt to think about how we shape value from innovation, rather than a practical proposal for the short term. The question for systems like the NHS is whether the current combination of market behaviour and our own assessment processes is delivering the best possible health gain from the money and workforce we have and are likely to have. We should consider these themes within the VPAG work undertaken as well, which I'm sure is in view of those commissioning those focuses through the improvement on HTA processes.

I'm grateful for the work the SMC and how they collaborate with NICE and HTA bodies generally to work on our behalf on this, and will look forward to the outputs of that work they are involved in via the VPAG HTA development.

Chair:

Ben Hannan, Director of Planning and Transformation, NHS Fife

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