Thomson, R. S. (1886). *Med. Chir. Trans.*, **69**, 97.
Tirard, N. (1909). *Practitioner*, **1**, 18.
Weinstein, L., *et al.* (1950). *New Engl. J. Med.*, **242**, 1002.
Wesselow, O. L. V. de (1934). *Lancet*, **2**, 579.
White, R. H. R. (1964). *Guys Hosp. Rep.*, **113**, 190.
Wickbom, H. (1928). *Dtsch. Arch. Klin. Med.*, **162**, 239.
Wilson, J. A. (1942). *Minn. Med.*, **25**, 470.
Zischinsky, H. (1936). *Münch. Med. Wschr.*, **83**, 1960.

PERSONAL POINTS OF VIEW

PRESCRIBING COSTS

G. STOUT, M.B., Ch.B., F.R.C.S.
Middlesbrough

SINCE 1955, THE CLERK TO THE Executive Council has sent out to each of his flock of general practitioners a roneoed form on 'Prescribing Costs'. This gives certain statistics for one month's prescribing, for example the total number of prescriptions, their total cost, the average cost per prescription, and for comparison your partners' figures, the average figures for your area and for England. Figures below the average pass without commendation, yet figures above the average merit a visit from the regional medical officer. As I remember from schooldays, there should be as many figures below as above this mythical 'average'.

Analysis of these figures and their changing pattern over seven years is interesting.

TABLE
PRESCRIBING COSTS

Year Mnth	Partnership figures: No. of prescriptions	Partnership figures: Total cost £	Partnership figures: Cost per prescription s. d.	Area: Average cost s. d.	England: Average cost s. d.	No. of prescriptions per person on N.H.S. list: Practice	Area	England
1961 Mar	3,820	1,313	6 10½	8 3	7 10½	.235	.310	.400
1961 Nov	3,634	1,294	7 1	8 8	8 2¼	.223	.297	.372
1963 June	3,207	1,182	7 4	9 2	9 0¾	.196	.264	.335
1964 June	3,856	1,377	7 2	9 2	9 6	.239	.309	.375
1965 May	4,820	1,862	7 9	9 9	10 3	.295	.386	.439
1966 Mar	5,933	2,281	7 8	9 10	10 6	.363	.466	.512
1967 Jan	5,765	2,320	8 1	10 1	10 7	.357	.435	.506

J. ROY. COLL. GEN. PRACTIT., 1968, 15, 160

Our practice is in an industrial town, with little private practice. Five partners share the work, with average lists of 3,200 patients. Over the period concerned by this analysis, from 1959 to 1966, there has been negligible change in the total practice list. There has been recently considerable slum clearance, with patients moving out of the town boundaries, thus the increase of the fifties has stopped in the sixties. In our practice, during March of 1966, each partner was churning out prescriptions at the rate of over 50 each working day, based on a five and a half day working week. The total monthly cost of prescribing varied from £400 to £500 per partner.

Although separate months, year to year, must vary in their workload, it is significant that the total number of prescriptions dispensed in March 1966 was 50 per cent higher than the months in the years 1961 to 1964. The abolition of the two shilling prescription charge in February 1965 must be the main factor responsible for this sudden rise. (Thus the yearly total of National Health Service prescriptions increased from 208 million in 1964, to 249 million in 1965—a 20 per cent increase[1]).

The average cost of each prescription per partner in 1966 was 7s. 8d., the area figure being 9s. 10d. and the average figure for England 10s. 6d. These figures for the average cost per prescription have risen steadily throughout the years of the National Health Service. This increase reflects the introduction of new drugs. It also reflects the rising proportion of prescriptions for proprietary preparations rather than *British National Formulary* standard preparations. In 1955, about 36 per cent of prescriptions were for branded medicines, but by 1965, this figure had reached 72 per cent.[2] It appears likely that the Sainsbury Committee of Enquiry into the relationship of the Pharmaceutical Industry with the National Health Service will recommend that family doctors prescribe *British National Formulary* products whenever possible. The unwieldy chemical names in the Formulary need revision, if such an aim is to be achieved.

"The number of prescriptions per person on N.H.S. prescribing list" sounds a formidable statistic, especially expressed as 0.363 for our practice in 1966, 0.460 for the area, and 0.512 for England. Interpreting these figures for our practice—0.363—one third of our patients received a prescription in the month considered. Thus over a year, our patients would receive an average of four prescriptions. The area figure is higher at 0.460, and the England figure highest at 0.512—which is six prescriptions per patient per year.

Many surgery consultations and home visits are given without a prescription resulting, so these figures are conservative ones on which to base the total patient–doctor contacts during one year.

Comparison with earlier years shows that these figures are also changing. In 1961, the figures were 0.310 for the area, and 0.400 for England; in 1964, 0.309 for the area and 0.375 for England. Thus the 1966 figures reflect the greatly increased work load which general practitioners are encountering.

While the total prescribing figures for our practice are high, the average

figures for this area and for England are higher than ours. This suggests that large practices have fewer patient–doctor contacts than smaller practices. Is this because busy practices have long waits at their surgeries?

In many urban practices, the surgery/home consultation rate is 2/1[3]—possibly slightly higher in some practices. Thus one third of all patient–doctor contacts is at home. Presumably the reasons for requesting a home visit are comparable in all urban practices, although busy surgeries may induce more home visit requests.

If waiting-room congestion is an important factor affecting the patient–doctor contact, will appointment systems produce more work for the larger practices? As we introduced a full appointments system in October last year, we may find out any trend soon.

Do smaller practices give their patients a better service, or do they prescribe more frequently, but less effectively? Despite our below-average prescribing ratio per patient, our costs are also below average, so we are not prescribing large quantities on fewer prescriptions.

It is interesting how a set of apparently routine figures can reflect such a wide range of information, and possibly throw light on some problems in general practice.

REFERENCES

1. *Daily Telegraph*, 1966.
2. Office of Health Economics. *Letter*, 21 October 1966.
3. Noble, H. M. S. (1964). *J. Coll. gen. Practit.*, **8**, 60.

EMERGENCY BED SERVICE

G. F. Abercrombie, *V.R.D.*, M.D., has retired from the chairmanship of the Emergency Bed Service Committee of the King's Fund. During the 16 years that he was chairman, approximately one million patients have been admitted to hospitals through the Emergency Bed Service. F. Avery Jones, *C.B.E.*, M.D., F.R.C.P., succeeded him as chairman on 1 January 1968.