CONTROVERSY

One way of reducing prescribing costs

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The prescribing bill seems to be of increasing concern and there have been many suggestions for reducing its cost. Some of these are difficult for the general practitioner to influence directly, but repeat prescribing, which forms a significant part of the overall drug bill, is much more tangible.

REPEAT prescribing varies from less than ten to over two hundred prescriptions per doctor per week—the average is 22 per doctor. Much of this is initiated by hospital prescribing. A recent analysis of my own prescriptions showed that the largest amount of the expensive items was started in this way.

Many of the drugs prescribed by hospital colleagues are newly available or are being evaluated. They are therefore very expensive, for example danazol, cimetidine, ranitidine and some beta blockers. Hospital initiated prescriptions are difficult to control. There is the impression that the consultant makes on the patient, whom it is difficult to convince, after he has undergone thorough and technical investigation, that his hospital initiated prescription should not be perpetuated *ad infinitum*. Even worse are outpatient appointments, particularly follow-up clinics by hospital junior staff, where the tendency is to even less discriminatory prescribing.

Our branch of the NHS is of excellent and increasing value—in the last decade expenditure on general medical services fell from 10 per cent to 6 per cent of total NHS costs and though the number of prescriptions rose from 224 million in 1949 to 374 million in 1980,[1] the cost of prescribing as a proportion of total NHS costs fell from 10.2 per cent in 1959 to 9.4 per cent in 1980. But no matter how we try to reduce the cost of our self-initiated prescriptions, our efforts are undermined by the obligation to repeat those initiated in hospital. How can prescribing for this particular group of patients be improved?

A Collaborative Prescribing Committee

A collaborative prescribing committee might be one way of achieving this. Its membership would include representatives from hospital consultants and general practitioners as well as the hospital pharmacist. The hospital pharmacist can control hospital prescribing and can influence the choice of drugs by identifying cheaper alternatives to hospital staff. The committee would agree an acceptable drug list as a guide to consultants for inpatient prescribing.

Outpatient prescribing should be reduced to a minimum, and wherever possible should be replaced by a letter of advice to the general practitioner, leaving to him the decision whether or not to prescribe. The committee would review from time to time the use of particular drugs, so that consultants and general practitioners could be kept fully informed of their prescribing.

Such work is admirably suitable for initiation by local College faculties.

Reference

1. Office of Health Economics. *Compendium of Health Statistics, 4th Edition*. London: OHE, 1981.

ASPECTS OF PRACTICE

Prestel for the general practitioner

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