Limited list of drugs

Sir,

The introduction of the limited list of drugs seems to have caused few problems, either to patients or to ourselves. I think the hysteria was mainly created by the drug companies, and I think representatives of the medical profession should now sit down with the Government and extend the limited list to other categories of drugs. I think this can only be to the advantage of the patient, with a reduction in side-effects from the many tablets available, and an advantage to the National Health Service by reducing costs.

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Sir,

While in my fourth year general practitioner attachment as a medical student, I looked at all prescriptions for those drugs affected by the amended limited list. My aim was to assess the proportion of black-listed drugs which cannot adequately be replaced and to calculate the financial savings under the new legislation.

Doctors at a London inner-city practice serving 10380 patients took carbon copies of all prescriptions for drugs affected by the amended limited list over a two-week period. Where a feasible alternative to the black-listed drug was available on the white-list, the name of the drug was noted. Of the 220 relevant items prescribed over this period, 14 (six per cent) were considered not to have a suitable alternative.

The drugs for which no single replacement was found included Equagesic (Wyeth); in three cases out of four this could be replaced by a combination of two drugs together. It was difficult to find an exact equivalent for Orovite (Bencard) and Metatone (Parke-Davis) and the two cough mixtures Tixylix (May and Baker) and Linctifed Expectorant (Wellcome).

Fifty-three per cent of the drugs prescribed under the relevant categories required replacement with listed drugs. Where an equivalent was available, the amount saved by changing to a listed drug was calculated. This was done by use of the basic drug prices in the *Monthly Index of Medical Specialities* and basic generic prices from the Drug Tariff and Prescription Pricing Authority figures. However, these prices do not include pharmacists' costs and profits, making the actual values, depending on the chemist, almost twice the cost of the drug bill for these categories.

In the practice studied the current drug bill for these categories was found to be £9150 per annum, from which a saving of £1260 (14 per cent) would be made as a result of the new legislation (assuming the two weeks to be representative of the rest of the year). This saving is mainly due to generic substitution.

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Table 1. Ranges of immunization rates for general practitioner and health authority services in South West Durham Health Authority for the 1982 cohort of children.

	Immunization rates (%)		
	Diphtheria tetanus and polio	Pertussis	Measles
General practitioner services	*76.2–100.0*	*42.9–90.9*	*33.3–90.9*
Health authority child health clinics	*82.4–100.0*	*52.2–85.7*	*50.0–88.6*

Collaboration or fragmentation?

Sir,

One major objective of the independence of family practitioner committees as expressed in the *Report of the joint working group on collaboration between family practitioner committees and district health authorities*[1] is 'to bring the district health authorities and family practitioner committees into a close working partnership to serve the interests of the community . . .' An article in the *British Medical Journal* has considered the implications of independence.[2] The observation was made that the definition of the word 'collaboration' implies the act of assisting or cooperating with the enemy.

Many health objectives are common to general practice and the health authorities, especially in the areas of child development, immunization and vaccination, cervical screening and family planning. The latter topic was recently raised in the *Journal*,[3] where the authors made explicit the widely held view that 'there appears to be acrimony or even open hostility between the professionals who provide the two services [in general practice and in the family planning clinics], with a noticeable lack of cooperation and communication between them'. The same can be said for the other services identified.

What is presently seen as a parasitic relationship of community services feeding off primary care must somehow be converted into a symbiotic relationship with the common theme being to provide comprehensive services for the whole community. Insular and traditional attitudes must be abandoned if rational health services are to be provided.

An example of a dual service is the vaccination and immunization programme in South West Durham Health District. The total population of 156 000 includes 9700 children aged between one and four years, and there are 2000 births a year. Eighty-one general practitioners serve the district from 40 locations. There are also 22 child health clinics scattered throughout the district.

Analysis of the immunization records of the 1982 cohort of children shows that the primary course of immunizations was performed by general practitioners in 37 per cent of children and the remainder by the child health clinics.

Overall immunization rates achieved were 94 per cent for diphtheria, tetanus and polio, 76 per cent for measles and 68 per cent for pertussis; no statistical significance was evident between the general practitioner and the child health clinic rates.

Gross percentages, however, disguise the range of values between different centres indicating different levels of performance. Table 1 illustrates the ranges of immunization status achieved in those centres immunizing more than 20 children per year. The variation for both general practitioners and child health clinics indicates the potential for improvement.

In an ideal world, general practitioners who are adequately trained, motivated and equipped, with the time to devote to this role, would organize their practices and perform all immunizations, cervical smears, and carry out paediatric surveillance. Skills in the monitoring of services and standardization of results would allow meaningful comparisons and evaluation of the services to be made. However, will practising general practitioners have the time or expertise to undertake this planning role?

In the real world, deficiencies in primary care provision must be filled by the district health authorities to maintain