Prescribing — future possibilities

IT is one year since the Government introduced limitations on the drugs prescribable under the National Health Service in specified therapeutic groups. Now that the furore created by the imposition of the 'limited list' on an unwilling profession has died down it is an appropriate time to question whether a coherent policy is emerging which will lead to more rational and effective prescribing. Patients, doctors, pharmacists, the pharmaceutical industry and the government all have a part to play in getting value for money out of medicines. In comparison with other countries the total drugs bill in the United Kingdom is not high but a high proportion is borne by the State.[1] It was the alarming rate of increase in the drugs bill which led to the imposition of the limited list, yet it remains uncertain whether this *ad hoc* approach to the problem of increasing drug costs will have any long-lasting effect.

Increasing the direct cost to patients is one way of reducing demand on the health service or of changing patients' behaviour. For example, before the introduction of the limited list it was difficult to persuade patients to accept generic equivalents of hypnotic drugs, yet patients are now willing to take them rather than purchase the proprietary forms of these drugs. In this issue of the *Journal,* Birch[2] looks at the effects of successive increases in prescription charges on consumption of prescriptions. The majority of patients, however, pay no prescription charges, so these economic constraints do not apply. Similarly, there are no real incentives for general practitioners to contain their prescribing costs. Furthermore, present administrative arrangements make it difficult for general practitioners to monitor their prescribing. In spite of this many doctors are seeking to reduce the cost of their prescribing. Marsh[3] showed that it was possible to reduce his prescribing costs by approximately £20 000 per annum by stringent control. Committed doctors can monitor their prescribing patterns from carbon copies of prescriptions or the delayed feedback which is possible from the Prescription Pricing Authority.[4] However, if a significant impact on the National Health Service drugs bill is to be achieved, such feedback needs to be made available to practitioners on a routine basis. Computerization will make such monitoring possible: for example, printing prescriptions by computer in the practice makes up-to-the-minute analysis of prescribing patterns available[5] and the Prescription Pricing Authority should be able to provide detailed analyses and comparisons with regional and national figures.

The large number of responses to the College's request for information about practice prescribing policies shows that general practitioners are active in creating and implementing clinical policies. Perhaps the most important effect of the exercise is not that it may reduce prescribing costs but that it inevitably involves discussion about the management of clinical problems and so becomes part of continuing medical education. Furthermore, the detailed feedback on prescribing which should become available from the Prescription Pricing Authority will not necessarily lead to improvements unless the practitioner is willing to share the information with colleagues. At present the review of prescribing costs is seen as a regulatory procedure. In future it would be better to perceive it as part of routine professional appraisal. The lesson to be learned from the imposition of the limited list is that governments can and will take arbitrary action unless the profession demonstrates that effective self-regulation is already taking place.

In many practices the first consideration when creating a prescribing policy is whether to prescribe drugs by generic name. The present arrangements for prescribing and dispensing generic drugs are a mess. Archer[6] has shown that the decision to prescribe drugs by generic name in effect transfers the decision about which particular brand of medication is dispensed from the doctor to the pharmacist. In rural and in some urban areas this is not a problem because a single pharmacist dispenses all the prescriptions from one doctor and effective communication between doctor and pharmacist ensures that the patient receives the same generic tablet each time it is dispensed. In areas where patients go to different pharmacists, they may receive a different brand of the generic drug with each prescription.

Does this matter? The present answer is that we do not know. Although the clinical consequences of differences in bio-availability of different formulations of the same drug are not well-documented, anecdotal evidence suggests that some patients do notice different effects with different brands. The problems are compounded by the apparent ease with which imported generic drugs are accepted for dispensing in the United Kingdom.

Just as some general practitioners prescribe in an uncritical and profligate manner, there is also a small minority of pharmacists who seek increased profits by dispensing the cheapest generic formulations they can find. Pharmacists have a strong and valued place in primary health care in the United Kingdom. There is evidence that patients more often seek advice from pharmacists than they do from general practitioners.[7] It is in the interests of general practitioners and the National Health Service to sustain and encourage pharmacists in their professional role. The system of separating prescribing and dispensing in most of the UK is beneficial in providing a double check on the appropriateness, dosage and safety of prescribed medications.

With the loss of traditional dispensing skills there is a danger that pharmacists may become undervalued. Little as yet has appeared in the medical press on the subject of original pack dispensing which is under consideration by the Association of British Pharmaceutical Industry and other groups. If the proposals are implemented, patients will receive sealed containers which have been prepared and packed by the manufacturer. The intention is to ensure the purity and quality of the product and prevent it from being compromised by repeated handling by wholesalers and retail pharmacists. A further advantage is that manufacturers can include information for consumers in the package. There are drawbacks to this system, however. It does not allow for flexibility in dosage or in length of course of treatment. Original pack dispensing may also undermine the contribution that pharmacists can make to an individual's health. Information needs to be given in a personal way as well as in the form of standard leaflets. There would seem to be much to gain from enhancing the role of pharmacists by placing the onus on them to provide appropriate information about medicines rather than bypassing them by putting the responsibility on the shoulders of the manufacturers.

The pharmaceutical industry has had a confusing path to follow in recent years. The government as monopoly purchaser as well as tax gatherer has dictated pricing policies for drugs to the industry. Individual companies have had to try and recoup losses sustained as a result of the introduction of the limited list. The present position is uncertain with continuing fears that further therapeutic groups may be added to the limited list. This is unsatisfactory and makes forward planning difficult for the industry. A sensible policy would seem to be for the government to encourage the prescribing of generic drugs by improving the criteria for their acceptance. More rigorous standardization of bio-availability should be introduced. Standard colours and code letters for the drugs would minimize confusion for the consumer. Along with these changes, an experiment in generic substitu-

tion could be undertaken, as proposed by the medical profession in Scotland. The implementation of this recommendation of the Greenfield report[8] would take advantage of the separate administrative structure of the health service in Scotland and give good data on which to base further developments.

To balance this shift to generic prescribing, the pharmaceutical industry needs to be given greater protection for its new products by extending the length of patent rights. This would not only ensure that research and development costs could be recouped over a longer period but would also enable the marketing of new drugs to be more gradual and allow more effective post-marketing surveillance to take place. It is in the interest of all concerned that a coherent strategy on prescribing should be defined and agreed upon. The delay in the publication of the government's Green Paper on primary care should not block developments which could encourage more effective and economic prescribing.

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References

1. Chew R, Tealing-Smith G, Wells N. *Pharmaceuticals in seven nations.* London: Office of Health Economics, 1985.
2. Birch S. Relationship between increasing prescription charges and consumption in groups not exempt from charges. *J R Coll Gen Pract* 1986; **36:** 154-156.
3. Marsh GN. Stringent prescribing in general practice. *Br Med J* 1981; **283:** 1159-1160.
4. Royal College of General Practitioners. *Prescribing — a suitable case for treatment, Occasional paper 24.* London: RCGP, 1984.
5. Donald JB. On-line prescribing by computer. *Br Med J* 1986, in press.
6. Archer M. What use is generic prescribing? *J R Coll Gen Pract* 1985; **35:** 293-295.
7. Hannay DR. *The symptom iceberg.* London: Routledge and Kegan Paul, 1979.
8. Department of Health and Social Security. *Report of the informal working group on effective prescribing (Greenfield report).* London: DHSS, 1983.

Prescribers' Journal — the first 25 years

IN 1961 in an introduction to the first volume of *Prescribers' Journal,* Professor Max Rosenheim expressed the hope that a need of the practising doctor would be filled by the publication of signed review articles discussing trends in modern treatment. How well this has succeeded can be judged by the fact that since then virtually every readership survey looking at information about drugs has placed *Prescribers' Journal* in the top bracket for client acceptability.

The construction of the content of each volume has remained unchanged. Topics are chosen by a committee of management who then commission an author. The resulting article is then worked on by the committee whose aim is to produce succinct and practical guidance for all prescribers. There are usually two general practitioners on the committee, each serving for three years, so that, since its inception, 19 general practitioners have held office.

The first volume was sent free to all general practitioners, hospital doctors and clinical students, and others could obtain it for 6d a copy, post-free! It is still distributed free in the UK but is much more widely sold, mostly to overseas subscribers at £2.74 a volume. It is reproduced in Pakistan and more selectively in many other countries.

It has been an outstanding success in terms of publicity and the gratitude of practising doctors should go to the Editor, Dr J.L. Hunt, who has steered every volume out to print and to all those who have devoted time and expertise to supporting Max Rosenheim's original aim of 'promoting good prescribing'.

11th Conference of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

The organizing committee of the 1986 WONCA Conference was pleased to hear at its last meeting that the 'break even' point in the numbers of registered delegates had been achieved. This will ensure the financial success of the conference. Much of the credit for this relates to the considerable financial support received from the pharmaceutical industry and other bodies. At a time of financial stringency affecting in particular the pharmaceutical industry, this support is evidence of the high regard in which the College is held. Support has also been forthcoming from the World Health Organization, the British Council and the Department of Health and Social Security.

At the most recent count delegates were registered from 32 different countries, with a particularly impressive number from Northern Europe and Australasia. As host organization, there is a particular responsibility on College members to give a welcome to their colleagues from overseas. This will be the largest international gathering of general practitioners/family physicians ever held in the United Kingdom, but the programme has been so arranged that there will be an opportunity for participation by everyone who so wishes. The accompanying social programme has been carefully arranged to offer delegates and their guests the opportunity to join in many traditional British activities.

The College is particularly pleased that the patron of the conference, Her Majesty the Queen, has consented to attend the government reception at the Science Museum on the last evening of the conference. She will be accompanied by the Duke of Edinburgh, the patron of the College.

There is still time to register. Please contact the Conference Secretariat, Conference Associates WONCA, 27A Medway Street, London SW1P 2BD.