Clearly no structural approach to management by a partnership will preclude the vagaries and interpersonal rivalries of partners and staff in a practice. For this reason the person occupying the role of executive partner should be an established principal whose credibility is based on commitment to, and personal standing in, the practice. In addition he or she should have demonstrated both an interest in tackling organizational problems and certain natural qualities of leadership, communication and decision making, which might in time be supplemented by appropriate management training. The partnership would vest powers over organizational matters in the executive partner, contractually if necessary. Time and possibly additional income would be attached to the post in order to provide status, incentive and opportunity to manage effectively.

As proposed the post is a powerful one. However, ultimate control must rest with the partnership, through regular assessment and a contractual capacity to override or even replace the executive partner. A limited number of agreed goals for the executive partner would help the partnership assess the quality of the individual and the usefulness of the post to the practice.

In the long run, however, if we are to understand and improve practice management then we must study the organization of practice as extensively as its clinical aspects. This will require methodologies[16] little used at present by medical research. Areas requiring study by such methods might include the process of policy and decision making, the management of change, innovation in practice, organizational performance review and fiscal control methods. If general practice is to meet both present and future demands then it must recognize its current managerial weaknesses, take note of the need for organizational innovation and research, and acknowledge the contribution management education and training has to the general practitioner's future role.

C.J. ATKINSON

*Wellcome Foundation Lecturer in Management Science, Department of General Practice, University of Liverpool*

## References

1. Fry J. *Trends in general practice.* London: Royal College of General Practitioners, 1979.
2. Fry J. *Present state and future needs in general practice.* London: Royal College of General Practitioners, 1983.
3. Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security. *Morbidity statistics from general practice 1981–82.* London: HMSO, 1986.
4. Fry J. Facts on general practice. In: The Royal College of General Practitioners. *1986 Members' Reference Book.* London: Royal College of General Practitioners, 1986.
5. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771).* London: HMSO, 1986.
6. Royal College of General Practitioners. *Quality in general practice. Policy statement 2.* London: RCGP, 1985.
7. Jones R. The impact of new technology on general practice. *J R Coll Gen Pract* 1986; **36:** 98-100.
8. Pritchard P, Low K, Whalen M. *Management in general practice.* Oxford University Press, 1984.
9. Jones RVH, Bolden KJ, Pereira Gray DJ, Hall MS. *Running a practice: a manual of practice management.* London: Croom Helm, 1985.
10. Martin P, Moulds AJ, Kerrigan PJC. *Towards better practice.* London: Churchill Livingstone, 1985.
11. British Medical Association. *Organising a practice. Articles from the British Medical Journal.* London: BMA, 1985.
12. Ellis N. *Employing staff.* London: British Medical Association, 1986.
13. Pritchard W. How to achieve change. In: Zander L (ed). *Change: the challenge for the future.* London: South London Faculty of the Royal College of General Practitioners, 1984: 94-100.
14. Fountain S. Practice management — common problems. *J R Coll Gen Pract* 1985; **35:** 155-158.
15. Williams RW. Introduction of a management structure in group general practice. *J Management Med* 1986; **1:** 158-166.
16. Checkland PB. *Systems thinking, systems practice.* Chichester: Wiley, 1984.

# Physiotherapy in the community

WITHIN the National Health Service most patients still receive physiotherapy in hospital departments, despite the considerable developments which have taken place in the community over the past 10 years. Although in 1984 80% of district physiotherapists in England and Wales reported having some community involvement,[1] many of the schemes were small and restricted. Some district physiotherapists only saw certain patient groups such as children or the elderly while others were limited to those with specific diagnoses such as stroke or multiple sclerosis. Geographical limitations were also imposed and patients were only accepted from within a specified area. However, 90% of all physiotherapists working in the NHS do not undertake any work in the community and therefore only a small proportion of patients in the country have access to community physiotherapy services.

In contrast to this picture of poor provision, a few health districts have reported community services with no restrictions or limitations — most patients attending for physiotherapy have the opportunity to be seen in the hospital or in the community, whichever is considered to be the most appropriate. From the work in these districts it appears that there are many people who, for different reasons, can benefit from community physiotherapy.

It is generally recognized that for frail elderly patients the long and often tiring journey to hospital for therapy may undo any beneficial effects,[2] but there are others for whom the hospital-based service is also inappropriate. Patients who have difficulty in maintaining independence at home and who are referred for problems of mobility may well benefit if the problems can be assessed by the therapist in the home, rather than trying to recreate the home situation in a hospital department. Visits from the physiotherapist to severely disabled adults or children who are cared for at home will involve all the carers in the home programme: their problems as well as those of the patient can then be considered in a practical way. Patients with acute exacerbations of chronic respiratory problems are another group who may benefit from physiotherapy at home. When there is a community physiotherapist in the primary health care team, admission to hospital with the attendant risks of secondary infections may often be avoided. In addition, patients who have had orthopaedic surgery can return home more quickly if physiotherapy supervision is available in the community.

New developments are always assumed to cost more but there is little evidence that community physiotherapy services, if well organized, cost more than hospital services, and they may well prove to be more cost effective.[3-5] Seeing some patients without delay where the problems are actually occurring may in the long run cost less than the traditional hospital visits three times a week for six weeks.

Physiotherapists in some parts of the county see patients in health centres and at general practice premises, mainly for the treatment of soft tissue injuries and conditions. Advice and treatment without delay may prevent the development of longer term disabilities and facilitate an early return to work for the patients.[6]

It is essential, with the present emphasis on care in the community, that physiotherapy services are made available when they are needed. In the early 1970s pressure from those working in primary health care for physiotherapy to be made available to patients outside the hospital first started the movement of physiotherapy into the community.[7] If all patients are to have

access to physiotherapy when they need it then more health districts must adopt a flexible approach in their organization of physiotherapy services. Perhaps pressure from those working in primary health care could help to accelerate this process. These developments do not necessarily need substantial extra funding, some flexibility can be introduced by reallocation of resources from hospital to community.

The hospital is needed as a resource centre, and a base from which physiotherapists can visit patients and assess their problems. Close liaison between hospital and community services is necessary so that patients and even staff can move from one to the other. In nursing and occupational therapy the division between hospital and community is greatly criticized and causes many problems. Such a division must not be allowed to develop in physiotherapy.

CECILY PARTRIDGE

*Senior Research Fellow, King's College, London*

## References

1. Partridge CJ. Access to physiotherapy services. *J R Coll Gen Pract* 1982; **32:** 634-636.
2. Mulley GP. *Practical management of stroke.* London: Croom Helm, 1985.
3. Pogson J, Wilson JB. Physiotherapy in rural practice. *Practitioner* 1982; **226:** 557-558.
4. Freedman JR, Charlewood JE, Dodds PA, York K. Physiotherapy in general practice. *J R Coll Gen Pract* 1975; **25:** 587-591.
5. Frazer FW. Domiciliary physiotherapy: cost and benefit. *Physiotherapy* 1980; **66:** 2-7.
6. Partridge CJ. *Community physiotherapy and direct access to physiotherapy services by general practitioners within the NHS.* DHSS report, King's College London, 1984.
7. Partridge CJ, Warren MD. *Physiotherapy in the community.* Canterbury: Health Services Research Unit, University of Kent at Canterbury, 1977.

# What is the cost of a prescription?

SOME commentators equate expensive prescribing with poor quality practice and cheap prescribing with high quality practice. Although the system of measuring the prescribing costs of individual practitioners has been in operation for decades it has never been objectively assessed. Regrettably, this crude system has been used to influence practitioners into giving priority to a matter which is really a responsibility of government.

It is understandable that governments should be concerned about drug costs, but for doctors, cost should be a secondary consideration. They must first decide whether a drug should be prescribed at all, and then choose the most appropriate preparation. Low prescribing costs are desirable, but the cost of a drug is no indication of its effectiveness.

Much attention has been focussed on product cost but this is only one aspect of cost. When absence from work is involved, the cost to the community includes loss of productivity and sometimes the cost of replacement labour. It has been shown that the cost of sickness benefit is greater than the prescription cost in most cases.[1] There are occasions when a patient will remain at work while taking medicine which he believes to be helpful. The humble cough mixture or simple analgesic may meet this need. Some practitioners argue that it is cost effective to withhold such prescriptions and to advise the patient to 'take a few days off work' instead.[2] Yet this is a very expensive management policy if sickness benefit and lost productivity are taken into account.

Sometimes a product is expensive because it contains two or more drugs. The strongest argument against such combinations is that they inhibit flexibility in prescribing the separate ingredients. But when flexibility is not at issue the higher cost of a combined preparation is partly offset by the single dispensing fee and such preparations also save the pharmacist's time. There may be other economic arguments in favour of combined preparations. Combinations aid compliance as a simple, infrequent dose schedule is more likely to be followed by a patient. Sometimes a difference in cost is a result of a more attractive taste or package. These factors should not be dismissed as luxuries if they enhance compliance.

The routine substitution of generic equivalents for proprietary drugs has been advocated as a means of cutting costs. Sometimes, however, patients and their practitioners suspect that a generic equivalent is less active than its proprietary alternative and there may indeed be a difference in bioavailability. Unless practitioners can be unequivocally assured that a generic drug and its proprietary alternative are truly equivalent, there is no case for generic substitution. Practitioners should be given more information about the testing of generic equivalents, particularly drugs which are imported. Careful consideration also needs to be given to the presentation and packaging of generic drugs, and their appearance, size and colour in order to avoid problems with compliance. A change from a long established preparation for reasons of cost alone may be unacceptable to the patient, particularly if he is satisfied with his health on the familiar medication. Subject to these provisos, a move to generic substitution might help the problem of product cost.[3] A tick box on the prescription form indicating the practitioner's agreement to generic substitution would meet this need. Even so, generic equivalents are not always available and are not necessarily cheaper than alternatives.[4,5]

Present methods of calculating the prescribing costs incurred by practitioners can produce misleading results. The figures produced by the Prescription Pricing Authority do not take into account the differences in morbidity which occur between practices nor the internal arrangements of partnerships. A study in a single practice has shown that one partner saw more elderly patients and more chronic sick, and consequently had higher prescribing costs than the other partners.[6] In contrast, a multipractice study[7] failed to show an association between prescribing costs and variables such as recorded morbidity or list size. Presumably other, as yet unknown, variables influence prescribing costs in different practices. The sensible way forward is to provide practitioners with much more detailed information about their prescribing patterns, with cost as just one of the items reported. Harris and colleagues have documented the changes in prescribing which occur if detailed information is combined with group discussions.[8]

In the final analysis, the cost of a drug will be determined by the manufacturer. It is only natural that this will include an element attributable to research and development and this is one reason why newer preparations tend to be more expensive than older ones. No one would wish to inhibit innovation. But cost is really a matter between government and the pharmaceutical industry; the practitioner is only the instrument of delivery. If the rising cost of drugs is a problem, the issue should be settled between government and the pharmaceutical industry and not by placing practitioners, whose priorities should be for clinical care, under pressure to police a peripheral matter. The responsibility for the cost of medicines is tripartite, involving the public, government and the profession. Hitherto it is the latter who have shouldered the main burden. It is time for a change.

ALBERT JACOB

*General Practitioner, Dundee*

## References

1. Fitton F, Temple B, Acheson HWK. The cost of prescribing in general practice. *Soc Sci Med* 1985; **21:** 1097-1105.
2. Marsh GN. Stringent prescribing in general practice. *Br Med J* 1981; **283:** 1159-1160.
3. Harding JM, Modell M, Freudenberg S, *et al.* Prescribing: the power to set limits. *Br Med J* 1985; **290:** 450-452.
4. Anderson RJ, Reilly PM. Generic alternatives in general practice. *Br Med J* 1984; **288:** 1129-1131.
5. Archer M. What use is generic prescribing? *J R Coll Gen Pract* 1985; **35:** 293-295.
6. Baumgard L, Frank P, Shearer K. Comparison of prescription costs within a group practice. *Br Med J* 1984; **289:** 1196-1197.
7. Taylor RJ. Prescribing costs and patterns of prescribing in general practice. *J R Coll Gen Pract* 1978; **28:** 531-535.
8. Harris CM, Jarman B, Woodman E, *et al. Prescribing — a suitable case for treatment. Occasional paper 24.* London: Royal College of General Practitioners, 1984.