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.

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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.

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