

## FOCUS

### • RESTRICTING DRUGS

On April 1 the Government will introduce a bill to reduce the number of medicines available free on prescription in selected therapeutic categories (principally nasal decongestants, cough suppressants, expectorants, antacids, laxatives, minor analgesics, vitamins and the benzodiazepine hypnotics and tranquilisers). The Secretary of State for Social Services, in keeping with his Government's obsession for reducing public expenditure, gave cost cutting as the primary motive. This objective naturally concerned the Labour Party and the pharmaceutical industry, (uncomfortable bed fellows), while the British Medical Association seemed rather more alarmed at the threat to their members' clinical freedom. The possibility that such lists could have advantages to patients has had little airing although restricted lists have been recommended by the WHO, by The Royal Commission on the Health Service, and are already used at a national level in socially conscious countries such as Norway and New Zealand. The arguments that lists would improve patient welfare are as follows.

The number of drugs available to doctors in the UK vastly exceeds the number that are needed. About 6,000 drug forms are listed in the *British National Formulary* (a handbook provided free for doctors and published jointly by the British Medical Association and the Pharmaceutical Society) and 12,000 more have licences but are either not marketed or not considered of medicinal value. There are probably no more than a few hundred specific therapeutic manoeuvres susceptible to drugs. Take for example the treatment of anaemia. This is a common condition but one for which almost the only forms responsive to drug treatment are those in which there is a deficiency of iron, folic acid or vitamin B<sub>12</sub>. It would be quite sufficient to have about four or five formulations of each of these agents, enough to cover administration by mouth or injection in adults and children. There are available however over 100 preparations containing these ingredients either marketed as a single agent or as a combination preparation.

To cope with this excess doctors tend to prescribe only a fraction of the drugs available; a personal limited list of about 200-300 preparations is usual. Group practices, hospitals and districts also use lists each with



varying degrees of restriction. The question is not therefore whether doctors should use a limited number of the medicines available, but how the limited list should be derived, implemented and controlled.

To make a rational selection the doctor needs information concerning the *relative* efficacy, safety, convenience, quality and cost of each medicine. Until now little direct help on these matters has come from government. When a new drug is licensed (ie, when the minister gives approval for a drug to be marketed on the advice of the Committee on Safety of Medicines - CSM) scant attention is given to such relative properties. There is certainly no requirement for a consideration of 'need' in the terms of reference of the CSM, a requirement which would oblige these properties to be taken into account. Older drugs (those available before 1971) are treated differently in that they are licensed 'of right', and although their licences are being gradually reviewed with 'need' in mind, this process has been slow and few categories have been covered. Fortunately the CSM does require standards of quality, and after licensing the ministry does advise doctors on the relative prices of some drug groups but in the main these data have been presented in such a way as to be of little practical value.

Nevertheless with government assistance this sort of information has been provided by specialist journals, such as the *Drug and Therapeutics Bulletin* and the *Prescriber's*

*Journal* and by the *British National Formulary*, and at a local hospital level by Drug and Therapeutics Committees. However there is no obligation for doctors to take such advice, and it is well recognised that the pharmaceutical industry, using vast resources (£5000 per doctor per year) works hard to negate such information using biased and often misleading information coupled with inducements.

To the public it might seem strange that the necessary drug assessment cannot be carried out by individual doctors (whether in general practice or in hospitals), but in practice it is only larger groups of advisers that have the time, resources, knowledge, expertise and interest to make such analyses. It would be unrealistic to expect even the most dedicated of doctors to do this, although patients would assume that it was being done routinely.

Faced with these problems an obligatory list produced by experts offers an attractive mechanism for vetting drugs provided that the committee's primary concern is patient welfare and not reducing cost. Now that the details of the Government's list have been published (it will contain about 100 formulations chosen from a possible 1800) it is clear that the drugs selected reflect patients' needs rather than cutting costs; hence the £25 million short fall in the estimated savings. For these eight therapeutic categories the stranglehold of the pharmaceutical industry will have been loosened, and notice

given that government is prepared to shoulder new responsibility. As long as the committee convened to oversee the limited list has terms of reference that allows continuation of this healthy development, all patients should press for the list to be extended to cover all therapeutic groups.

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