The NHS drug budget inquiry

A note for the Commons Health Select Committee

The House of Commons Select Committee on Health has been in existence since the 1970s. It enables Members of the House to study health matters in greater depth than is normally possible. It is a non-party committee with its own secretariat, responsible to the House as a whole, and can question civil servants and others. The subjects for its inquiries are chosen because they seem topical, important and baffling, and are manageable in the time available. The inquiry into the National Health Service (NHS) drug budget was announced in August 1993 and is to be completed in spring 1994. This brief paper concerns some widely neglected but relevant issues.

Appropriate use of medicines

The Prescription Pricing Authority (PPA) gathers data only on the drugs prescribed by general practitioners (GPs), in what quantities, and their cost. The NHS has no data on what the drugs are prescribed for, in what dosage or for how long, though these data are needed to assess appropriateness. It should take an active interest in properly designed scientific research on drug utilisation instead of the largely cost-driven approach exemplified by the PPA.

While many medical advisers of family health services authorities (FHSAs) do concern themselves with the appropriate use of medicines, they lack data and a coherent policy on how to assess this. These lacunae can be filled by the development of science-based therapeutic (and diagnostic) guidelines. In some fields, for example asthma and diabetes, such guidelines already exist. The NHS should commission their development for all common therapeutic and diagnostic problems.

Diagnostic processes and procedures are also relevant to the drug budget because the perceived diagnosis is the main determinant of treatment, and the diagnostic process determines what diagnosis is made and its reliability. An example is hypertension which some doctors diagnose too readily and prescribe a drug when none is needed, whereas others do not diagnose it when it is severe enough to require drug treatment. Current data on prescribing can detect neither error.

Some investigations are also misused, for example endoscopy of patients with suspected oesophageal reflux. The endoscopy findings in this condition hardly ever influence the choice of treatment. Endoscopy is unpleasant as well as expensive and its use for this purpose is unjustified.

Clinical research on important therapeutic questions.

Pharmaceutical companies sponsor and fund most of the clinical trials involving drugs. Their research programmes aim to:

- provide data in support of applications for product licences so that the drug can be marketed
- establish a scientific basis for the ‘marketing platform’ (ie the distinctive promotional claims which the company intends to make to position its product in the market)
- familiarise doctors with the product and to enthuse them to prescribe it

Relatively few trials are undertaken after a drug has been marketed except for a new indication. The trials are thus closely entwined with marketing considerations.

Questions of interest to doctors, patients and the NHS which remain largely unaddressed include the long term effectiveness and hazards of treatments, especially their effects on clinical outcomes, as opposed to intermediate or ‘surrogate’ outcomes which are often used to try to predict long term clinical outcomes. Surrogate outcomes have been disappointingly poor predictors of clinical outcome, for example lowering of plasma cholesterol, and reduction in the number of episodes of heart irregularities detected by ECG monitoring.

Other types of trial unattractive to industry are comparisons against competing drugs that might turn out to be better, and studies of lower dosages than those recommended by the manufacturer. Companies rarely fund trials designed to clarify the best ways of managing a disease, or to resolve problems affecting one group of patients which may require combinations of drugs and/or other treatment modalities.

The NHS research and development (R&D) programme is beginning to examine these issues but a coherent approach to drug trials has not yet emerged, perhaps because the Department of Health division concerned with the drug budget, which is preoccupied with the family health services, has little substantive contact with the R&D division (RDD). The division responsible for hospital and community services rarely seems to consider drugs. It lacks separate data on drug

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use, and drug budgets in hospitals are mostly managed at district level. It may thus have no incentive to discuss drug research with the RDD.

Quantification of harm

All drugs, like all surgical procedures, can do harm: there is no such thing as a ‘safe’ drug. The cost to the NHS, to individuals and to society of adverse effects of drugs and of other forms of care has never been quantified—although it is substantial. Health professionals and the NHS must do their best to minimise the harm of what they do, but this cannot be achieved without a proper system for measuring the harm done by different treatments. Such a system would require a taxonomy of different kinds of harm, standard methods of their quantification in both human and economic terms, a better reporting and recording system than presently exists, and easy access to such information for professionals, including managers, and the public. Only then will it be possible to weigh the benefits of treatment against the harm, to prevent harm more effectively and to minimise unavoidable harm. The risk of harm greatly depends upon how a drug is used—for what purpose, in what kind of patient with what disease or predisposition—so the task of quantification will be complex and difficult.

The Department of Health should provide estimates of the cost of adverse drug reactions (ADRs) to the NHS, to individuals and to society. Examples include the:

- number of hospital admissions per year attributed to ADRs (a widely accepted estimate is about 5%)
- number of days lost from work from ADRs
- costs of defending/settling legal actions arising from ADRs
- number of complaints arising from ADRs received by FHSAs and district health authorities from or on behalf of patients
- cost of management time spent in dealing with them.

This information may not exist centrally now, but improvement cannot be expected without it.

Research is needed in the NHS on the detection, quantification, prevention and minimisation of harm from treatments. The Medicines Control Agency (MCA) and the Committee on Safety of Medicines have virtually no research budget and their task is to implement the Medicines Act, not to worry about improving the use of medicines in the NHS. The existence of the MCA however has created a general feeling that the Department of Health is doing what is necessary to manage the problem. The MCA and the industry seem remarkably satisfied with what they are doing, but the NHS should not accept this. One solution might be for the RDD to be given the responsibility for this research—in which case it would be inappropriate to expect the extra cost to be covered by its existing budget.

Medicines for self-care

Medicines that people buy for themselves cost the NHS nothing. Dispensing fees and the cost of unnecessary GP consultations are saved. Patients are helped because it is easier to visit a pharmacy than to go to a GP for a prescription. Pharmacists earn some profit from these sales and they can also advise patients about the use of these medicines.

However, for patients the financial advantages are limited. Medicines needed only in small amounts that cost no more than the prescription charge are worth buying for people who would have to pay the charge, though not for those who are exempt. If a medicine in the amount required costs more than the prescription charge it is worth getting it prescribed. Most GPs will issue a repeat prescription within 48 hours.

Self-care should be encouraged, but good self-care should fit well with what the NHS provides in terms of medicines and in other ways. The better the information and advice on self-care which the public gets in pharmacies, the more patients who will find that advice relevant and useful when they need to use the NHS. Pharmacies now offer little independent professional advice on self-medication. Almost all information is promotional and rational choice at the point of sale is impossible for ordinary people. They face a bewildering array of products purporting to differ in important ways when the differences are mostly irrelevant. Further, no adequate arrangements exist for helping people to use over-the-counter medicines to the best effect, to prevent or minimise unwanted effects, or even to detect them. This is a public health matter so far completely ignored by the Department of Health.

Community pharmacists are trained to help customers choose and use medicines well. Their contract with the NHS should encourage them to offer this help. Pharmacists are a grossly underused resource and the NHS should harness their skills.

To what extent changing the status of a prescription-only medicine to pharmacy medicine may help or disadvantage patients or doctors is hard to predict. (See the teasing finale of Dollery’s Harveian Oration [1].) The decision to buy a pharmacy medicine may be less soundly based and less well supported by properly informed advice than a GP’s decision to prescribe it, even though in practice many prescriptions are still written with too little thought. An example of an absurd change from prescription-only to pharmacy medicine is the case of Buscopan (hyoscine butylbromide) tablets. These are claimed to be antispasmodic, but have never been convincingly shown to work. The British National Formulary has for a long time listed them in small type—now gullible pharmacists can sell them to gullible customers. But even armchair rationality is not enough. Operational research is required
so that the benefit of such changes can be maximised and the harm minimised.

Educating the public

Only better education about medicines can lead to more balanced attitudes to them. Without some understanding of the basic principles underlying the use of medicines it is not possible to assimilate the detailed information about individual medicines that is now increasingly provided. This information must be put into its proper context if it is to be used optimally as intended.

Everybody needs to grasp the following essential facts and ideas:

- how drugs get into the body and what happens to them there
- how the body gets rid of drugs, and how long this takes
- the bigger the dose taken the bigger the effect up to a ceiling, and also the bigger the dose the greater the variety of different effects—most of them unwelcome
- the weighing of benefit against inconvenience and risks
- treatment may be symptomatic, curative, preventive, etc, and whichever it is determines how and for how long a medicine is used.

These simple principles would easily fit into the school science curriculum. Adult education experts need to advise how best to reach and teach all the medicinally ignorant adults. Patients would then understand what information they need about their particular medicines in order to use them as effectively and safely as possible (which includes intelligent ‘non-compliance’). If the doctor or pharmacist does not explain all the necessary points, knowledge of the principles should enable the patient to ask the right questions. If lists of these questions were distributed in waiting rooms and pharmacies, doctors and pharmacists would soon learn to give this information of their own accord, or at least to answer this questions easily when asked.

Spoken and written information must be provided against the background knowledge which enables it to be used actively. The professionals must take the initiative for improving communication with their patients.

Reference

1 Dollery C. Medicine and the pharmacological revolution. J Roy Coll Physicians London 1994;28:59-69.

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