Transferring the costs of expensive treatments from secondary to primary care

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General practitioners, especially fundholders, are becoming increasingly concerned about being asked to prescribe treatments for their patients that are outside their therapeutic experience. They are concerned about the clinical responsibility for such prescribing and the effects on their budgets. In some specialties transferring the costs of expensive treatments from secondary to primary care (cost shifting) has become partly institutionalised because of the separate sources of funding for drugs prescribed in the two sectors. With increased efforts to control the rising costs of the drugs budget and the emergence of new expensive treatments, cost shifting will be a challenge to clinicians and purchasers as they strive for rational, cost effective prescribing. A review of the funding mechanisms for drugs prescribing and of the relation between the licensing process and the decision to support the use of a treatment in primary or secondary care is needed.

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For many years hospital doctors have worked to strictly cash limited budgets, but only with the introduction of fundholding have some general practitioners had cash limited drug budgets. Since the introduction of prescribing analysis and cost (PACT) data general practitioners have become more aware of the unit cost of individual drugs and begun to identify the extent to which prescribing initiated by hospital consultants has affected their overall budget. These factors have led some general practitioners to become increasingly concerned at being asked to write prescriptions for particular treatments when they have not been part of the decision making for their use and when clinical monitoring continues at the hospital.

In some areas of care, such as the management of chronic renal failure, transferring the cost of prescribing from cash limited hospital budgets to the primary care prescribing budget (cost shifting) has become partly institutionalised. In this and other therapeutic areas shared care protocols have been developed so that general practitioners, who in signing the prescriptions accept clinical responsibility, become better informed about the need to monitor patients and side effects. Most general practitioners will, however, use such drugs and treatments rarely, and the existence of a protocol is not of itself protection if problems arise. Indeed some general practitioners see protocols as a double edged sword.

General practitioners may feel resentful that they have become a cipher: simply the means of obtaining a prescription. This is particularly true when patients are asked to take the drug back to the hospital so that it can be used there or general practitioners are first informed of the matter by their patient ("the hospital says will you write the prescription").

When used sensitively cost shifting could be a practical example of how primary care should be developed. It ensures that general practitioners are adequately informed and funded so that appropriate care can be given safely in the community. New factors in the equation, however, are the concerted effort being made by the government to control expenditure on drugs and the emergence of a range of high technology treatments. The government is trying to control costs by introducing indicative prescribing amounts, monitoring prescribing patterns, and promoting fundholding, which places budgetary responsibility firmly on general practitioners.

This new responsibility has made fundholders re-evaluate their role in accepting the recommendations of hospital consultants. Previously, a consultant's prescribing recommendation for specialist care was accepted by most general practitioners, who valued this specialist knowledge. As purchasers, however, general practitioners increasingly recognise that they are responsible for the whole care of the patient and the optimal use of the drugs budget. They now question the appropriateness of some proposed treatment options when the health gain may be small. Fundholders need support to become confident in expressing these concerns to specialists and to draw up guidelines with them on the use of such treatments. Neither can the ramifications of the degree of risk be ignored: a practice working methodically to stay within budget can be blown off course by such requests. Better risk management is needed.

Any management system that separates the commitment of resources from budgetary responsibility is not likely to consider carefully the optimal use of resources. This may be a particular issue when pressure from patients and carers affects decision making. For example, the use of growth hormone in the United States is already partly the result of social pressure rather than hormone deficiency.

Expensive treatments

We have taken expensive treatments to be those costing more than £2000 per patient year. The table gives examples of such treatments and the estimated annual spending in primary and secondary care in the West Midlands region. It shows the extent to which the primary care budget bears the brunt of the cost of expensive treatments. The prescription of risperidone and recombinant human deoxyribonuclease also illustrates this effect.

Total expenditure (£) on selected items in primary and secondary care for West Midlands Regional Health Authority, 1993-4

	Primary care	Secondary care
Growth hormone	2 156 969	226 006
Cyclosporin	3 031 028	350 637
Fluids for continuous ambulatory peritoneal dialysis	4 388 566	232 042
Erythropoietin	420 555	227 545

To treat acute and chronic schizophrenia with risperidone would cost around £3700 a year at the maximum dose. Currently, patients with schizophrenia that is resistant to treatment receive clozapine, which has to be prescribed at the hospital because of the need to take blood samples to monitor for agranulocytosis. Such monitoring is not required with risperidone, which could therefore be prescribed by general practitioners. Here lies an opportunity for cost shifting.

Recombinant human deoxyribonuclease was first licensed in April 1994 to treat patients with cystic fibrosis who have a forced vital capacity greater than 40% of predicted values. This treatment is likely to improve the care of these patients, many of whom are children, but the annual cost is probably more than £7000 per patient. In the United Kingdom most care for cystic fibrosis is concentrated in a number of key referral centres, which were given free supplies of the drug in research studies before the licence was granted. In the West Midlands regional centres have no funding for the continued use of the product, and they have been asking general practitioners to take on prescribing at the end of the trial. Thus the licence to market the product has become synonymous with the requirement to prescribe, which is less than satisfactory. The development of gene therapy means that several high cost treatments will be available in the next five years for patients who will be treated in the community. There is an urgent need for purchasers to evaluate and manage the appropriate introduction of such medicines.

We emphasise, however, that a high cost for a treatment does not necessarily imply bad value for money. Indeed, most of the treatments we have mentioned confer benefits to patients and may generate cost savings. These savings need to be balanced against the cost of the treatment itself. It may also be inappropriate to focus on the cost of a few expensive treatments when a high rate of prescription for cheaper drugs may have a bigger overall impact on health care budgets. For example, in the West Midlands region during 1993-4 there was increasing concern about the use of expensive treatments, but they consumed only 3·5% of the total drugs budget and an additional spend of £10m on primary care prescriptions for one gastrointestinal drug was passed without comment.

The reason why the use of high cost treatments merits attention is that in the presence of cost shifting the costs and benefits of giving treatment may not be adequately considered. Firstly, the pressure is taken off the consultant, who does not have to consider rationing treatment as he or she has open access to someone else's budget or debate on the evidence for using new products with local clinical and managerial colleagues. Contrast this with the rigour with which a clinical directorate or hospital drug and therapeutics committee would debate such a development in hospital prescribing. Secondly, the full costs of such treatments will not be reflected in the costs of contracts placed by purchasers if the costs of the products are transferred to general practitioners. Therefore, purchasers may place more contracts for these services than they otherwise might. Finally, there is the risk that general practitioners, faced with patients requiring expensive treatments, may try to limit the care available because of budgetary constraints.

Current funding of drug expenditure

The Treasury funding for hospital services (the hospital and community health services budget) and the allocation of resources for fundholding are both firm budgets. The allocation of resources to indicative prescribing—that is, prescribing for non-fundholding general practitioners—is not cash limited, although pressure to control the rise in expenditure is increasing. Thus any overspend in the allocation for indicative prescribing continues to be funded centrally. Conversely, any saving made in this budget is not retained by the NHS region making the saving but remains with the Treasury.

The development of joint health commissions is a strong reason for merging budgets in primary and secondary care to ensure the cost effective use of resources. When, and if, such merging occurs the combined fund will probably be cash limited, which would necessitate the same rigour being brought to prioritising expenditure on drugs as on any other NHS development. Purchasers will be able to agree the allocation of resource for expensive treatments, as for other treatments, and to plan accordingly with providers and general practitioners.

In the short term, however, there is potential for great destabilisation if some fundholders withdraw cooperation from prescribing expensive treatments for their patients. Fundholders need to be reassured that their concerns are being addressed with some urgency.

Options for funding mechanisms

Whatever the outcome of decisions on the nature of the drugs budget for commissions we will need a system to encourage the rational consideration of the costs and benefits of expensive products in the context of treatment for other categories of patients. This will put in perspective the emotion surrounding the use of expensive treatments and will ensure that patients receiving them are not targeted for cost saving because of the visibility of the cost of their treatments. Maintaining the status quo clearly does not fulfil this criterion, and the problems are likely to increase as more expensive treatments become available. Any changes from the current system would need to be judged against three key criteria: (*a*) the potential for control over the total prescribing budget and the consideration of priorities, (*b*) the extent to which the freedom of the prescriber is preserved, and (*c*) the potential for generating good data on cost effectiveness as a basis for decision making.

One option for change would be to make more financial provision to fundholding general practitioners who have patients receiving expensive treatments. Currently, general practitioners are not financially responsible for care given to an individual patient of above £5000 a year, though this provision extends only to the purchase of secondary care. This cut off point is currently under review and could be extended to the drugs budget. This would presumably leave health commissions to find the additional revenue and is likely to be seen as arbitrary in its effect. Also, general practitioners may not welcome the total clinical responsibility for patients receiving high cost treatments since their concerns about prescribing for these patients relate to more than just money. Although this option might preserve prescribing freedom, it is unlikely to help overall budgetary control, to enable more rational priority setting, or to encourage the collection of data on cost effectiveness.

A second option would be to top slice funds from fundholder budgets (and, by implication, adjust indicative prescribing amounts) to set aside money to finance expensive drug treatments. The rules of fundholding are such that this pool could be created only from savings made on the drugs budget and that the savings would have to be allocated voluntarily by fundholders. Once a pool had been created new high cost medicines would not, at least initially, be prescribed by general practitioners. Access to these funds would be based on presenting a good clinical and

managerial case for the introduction of a new drug to a group comprising professional advisers, general practitioners, and purchaser chief executives. The money would be given to purchasers, who would then have to pay the full costs of treatment because providers would not be able to shift costs to the primary care sector. For the reasons already stated, any withdrawal of allocation for high cost drugs in the indicative prescribing budget would be lost to the region and new money would have to be found for the patients of non-fundholding general practitioners. This is likely to be difficult for many purchasers unless legislative changes occur. None the less, such a measure would be popular with many fundholding general practitioners in the short term.

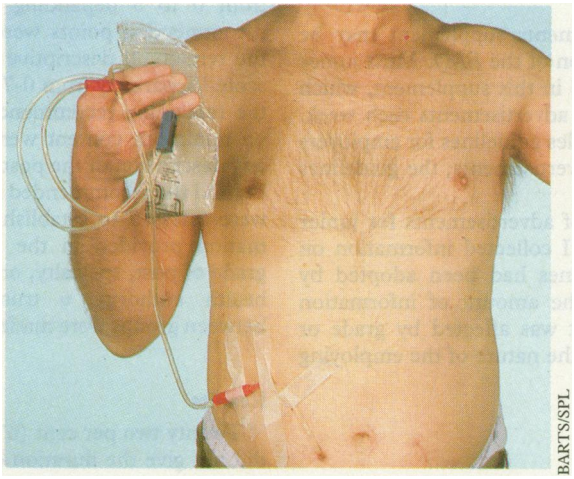
Clearly, the status of individual drugs would have to be regularly reviewed as the use of the products became better established and general practitioners more confident in their use. This review could take the form of an authorisation process similar to those operated by health maintenance organisations in the United States, where approval needs to be acquired before a general practitioner can prescribe one of the identified drugs. Such a scheme is being developed regionally in the West Midlands and could operate prospectively for new treatments as they become available, thus overcoming the need to establish an initial pool of resources from primary care drug budgets.

Although this approach undoubtedly reduces the freedom of the prescriber, it is more likely to control expenditure. Additionally, pharmaceutical companies wishing to extend the market for their products would need to provide high quality data on cost effectiveness for the authorisation body to consider.

Both of these options offer the scope for a more rational consideration of the costs and benefits of high cost treatments. For them to work, however, more consideration needs to be given to the assessments that would be required to identify which high cost treatments give good value for money and which patients will benefit most. Although such assessments might be undertaken by providers, input from both purchasers and general practitioners is obviously required. Within a health service region, or across the NHS more generally, it should be possible to assemble the appropriate evaluative skills and to devise the appropriate structure to arrive at such decisions. Coordination of the collation of data will also be necessary.

Stimulating adequate assessments

Purchasers will need to be more interested than they have been in the cost of drugs in the contracts they place, and this is already beginning to happen. This greater interest does imply the need for particular analytical skills, including those of pharmacists and clinical pharmacologists, which are most commonly found among providers. In addition, the skills associated with health technology assessment and health economics will need to be accessed. In each case academic departments may be able to help, but it makes sense for purchasers to collaborate in establishing an agreed range of treatments to be included in such a scheme and to establish the necessary support for the work. Clinicians in the affected clinical specialties will need access to the process, though in the end it will be purchasers who will have to balance the funding of expanded programmes or new treatments against other priorities.



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Cost shifting has become almost institutionalised in the management of chronic renal failure

The key to the rational use of expensive treatments lies in the development of an appropriate assessment process and its integration with decision making about health care. In the United Kingdom, unlike many countries, a drug becomes freely available in the NHS once it is licensed. Licensing decisions are made on the basis of quality, safety, and efficacy, and therefore no opportunity exists to evaluate the comparative effectiveness or cost effectiveness of drugs before they are marketed.

One approach would be to change the licensing procedure to include assessment of cost effectiveness. Decisions about whether products should be marketed, however, should not be confused with decisions about whether they should attract public subsidy. Also, the licensing of pharmaceutical products is rapidly becoming a European rather than a national matter. The economic diversity of member states and the variety of health care systems make global assessments of cost effectiveness extremely difficult.[1]

An early warning system could be developed through the licensing system, whereby the NHS receives notice of expensive products in the pipeline. Such a scheme is in fact envisaged through the Prescription Pricing Authority, but under current arrangements the likely impact of a new drug will not be clear until the price is fixed. For understandable commercial reasons this rarely occurs before the licence is granted. A robust scheme not only would help to limit the use of expensive products offering no significant advantage but also could allow authorities to make adequate financial provision for those offering good value for money. None the less, if the licensing procedure is unlikely to entail an assessment of cost effectiveness then other ways of stimulating such an assessment must be considered.

Perhaps the best opportunity for securing adequate assessments of cost effectiveness is through the NHS research and development initiative. The Central Research and Development Committee's Standing Group on Health Technology has recently drawn up priorities for assessment.[2] None of the top 26 priorities relates to high cost drug treatments, but there is clearly potential through this network to ensure that timely assessments take place, provided that the initiative is adequately funded. Of course, not all the relevant costs and benefits of medicines may become apparent until they have been used in regular clinical practice.[3] Therefore the evidence of cost effectiveness and the protocols based on it would need to be reviewed periodically. It would also be unrealistic to suggest that all new products could be submitted to such a national review, and a mechanism will be needed to identify which treatments will be dealt with at this level.

Conclusion

As drugs budgets tighten and purchasing decisions become more explicit, the impact on some practice budgets of cost shifting of expensive treatments is

being challenged. In the interests of the patients who need such treatments and of stability for the providers who prescribe them, the funding mechanisms for this aspect of care need to be urgently reviewed. Purchasers need to become more interested and more skilled in taking rational decisions about new products as they come on to the market. Those who wish to prescribe and those who wish to market such products will need to accept that the granting of a product licence is not in itself sufficient reason for a product to be used at public expense. Coordinated studies of cost effectiveness with the controlled introduction of selected treatments will be needed. National coordination, through the research and development initiative for major new treatments, and more locally organised schemes to authorise prescription of expensive products before they reach the primary care marketplace seem most likely to allow high cost treatments to be introduced effectively and manageably.

We emphasise that the difficulties in ensuring a rational use of health technologies apply more widely than just to expensive treatments. We have drawn particular attention to this case because of the potential for cost shifting and the possibility that the care given to patients may be dependent on the extent of cost shifting in their area and the willingness of their general practitioner to bear the cost on his or her budget.

1 Drummond MF, Rutten FFH, Brenna A, Gouveia Pinto C, Horisberge B, *et al.* Economic evaluation of pharmaceuticals: a European perspective. *Pharmaco-Economics* 1993;4:173-86.
2 CRDC Standing Group on Health Technology. *First report to the Central Reseach and Development Committee.* Leeds: CRDC, 1993.

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Content of advertisements for junior doctors: is there sufficient detail?

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Abstract

***Objective*—To determine whether employers follow BMA guidelines on advertisements when advertising for junior doctors.**

***Design*—Survey of advertisements for junior doctors in the *BMJ's* classified advertisements supplement from 12 March to 14 May 1994.**

***Subjects*—300 advertisements for substantive posts for junior doctors.**

***Outcome measures*—Compliance with BMA guidelines, compared by grade, specialty, and employer (trust or regional health authority); observation of any useful information not included in the guidelines.**

***Results*—Only eight advertisements included all the recommended information. Amount of information given was related to grade, specialty, or employer in only one respect: advertisements for basic trainees were more likely than those for higher specialist trainees to include information on pay and hours of work ($P < 0.001$).**

***Conclusion*—Advertisements for junior doctors in the *BMJ* do not comply with BMA guidelines and often contain little useful information for potential applicants.**

Introduction

The classified advertisements supplement may be the most widely read section of the *BMJ*. Most junior doctor posts are advertised in this supplement, which contains around 500 such advertisements each week. The supplement also includes guidelines for employers on the content of these advertisements; the guidelines reflect BMA policy.

I analysed the content of advertisements for junior doctor posts in the *BMJ*. I collected information on whether the BMA guidelines had been adopted by advertisers and whether the amount of information given in the advertisement was affected by grade or specialty of the post or by the nature of the employing authority.

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Methods

I selected 300 advertisements (every 10th advertisement, starting with a random number) for substantive training grade posts advertised in the *BMJ* between 12 March and 14 May 1994. I recorded information on grade, specialty, employer, rotation, duration of post, and any description given. I assessed the advertisers' compliance with the BMA guidelines on content. These guidelines recommend that, at a minimum, advertisements should include:

- job title
- information on pay and hours of work:
  - the number of contracted hours
  - the number of additional duty hours
  - the class of additional duty hours
  - the work pattern
  - whether prospective cover is included
- a statement that a post has college or training approval
- a statement that a job description is available
- the closing date for applications
- the interview date
- the start date
- a contact name for further information.

In addition, the BMA guidelines encourage inclusion of details of ancillary back up (for example, phlebotomy); standard of on call accommodation; out of hours catering facilities; and whether 24 hour locum cover is provided for leave.

Information on pay and hours of work was scored from 0 to 5 depending on how many of the five recommended points were included. Information on the remaining descriptive content of the adverts was scored separately from 0-7 depending on how many of the remaining recommendations (excluding job title) on minimum content were followed and on whether any description of the post was given. Any information beyond the recommended minimum was noted. Scores were assessed to establish whether the level of information provided in the advertisements varied with grade of post, specialty, or employer—that is, regional health authority *v* trust. Statistical comparisons between groups were made with the χ^2 test.

Results

Twenty two per cent (67/300) of the advertisements did not give the duration of the post. Where duration was given, senior registrar and registrar posts were for at least a year whereas most of the senior house officer