use of cost effective therapies: the purchaser provider split may promote this in the UK, although elsewhere, such as Australia and Ontario, pharmacoeconomic evaluations have become necessary for drug licensing.

What about the future of the pharmaceutical industry and research? Undoubtedly, difficult times are ahead because of international pressure on pharmaceutical costs. EC regulations on the protection of patent life will help, but the resourcefulness of the industry will be its main protection: companies need to develop truly innovative products and not 'me-too' drugs, and may need specific incentives to encourage development of drugs in some therapeutic areas which might not otherwise give an adequate return on their development, eg, new antimalarials etc. In general, the industry has served the NHS and the British economy well but to continue to do so it must adapt to the more rigorous evaluation of its products in terms of effectiveness, safety and economic implications. Therapeutic conservatism in the UK will promote a leaner but fitter indigenous industry, better able to compete internationally.

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Sir—J P Griffin and T D Griffin, in their article on the economic implications of therapeutic conservatism (April 1993, pages 121–6), argue that the prescribing habits of British doctors may have adverse effects on patients. We disagree. We interpret the conservatism of British doctors as a success for rational prescribing, with an unwillingness to adopt the latest 'me too' drug as a result of inducements by the pharmaceutical industry where there are no clear benefits for the patient. The comparison with prescribing patterns in other countries assumes that they are right and we are wrong, a view at odds with the evidence [1]. The idea that we should emulate the American health care system is regarded by most American commentators as ludicrous [2].

The Griffins' arguments rely heavily on the contention that 'new medicines are cost-effective'. The evidence produced to support this statement is selective and some, such as the quotation from Louis [3], is anecdotal. To take the other two examples cited, the simple statement on the use of cholesterol reducing drugs ignores the complexity of this issue [4], and the view that the introduction of new psychotropic drugs improves care and NHS costs [5] is clearly untrue for selective serotonin reuptake inhibitors, as demonstrated in a recent meta-analysis [6].

The argument that failure to use the most effective treatment available may lead to legal action is unsubstantiated. There is at least as good a case for arguing that a doctor may be sued for using a new drug with unpredictable side-effects rather than an older one with which there is more experience.

Each time a new and more expensive drug is substituted for an older, cheaper one, fewer patients can be treated. These decisions are driven by the marketing activities of the pharmaceutical industry. The tragedy of the debate on priority setting in the UK is that, by concentrating on the role of governments and health authorities, it has largely ignored the extent to which the priorities are really being set by the industry.

We agree with the authors that the costs and benefits of new medicines should be established but we go further and argue that those with no advantage over existing preparations should not be purchased by the NHS. The authors' arguments in favour of what are effectively greater government subsidies are interesting. Do they propose that increased government funds should also be given to other sectors, such as education and rail transport, where investment may save more lives? If the government is expected to subsidise research, should it not have a say in how the money is spent?

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Sir—The interesting and perceptive comments of Wally and Watt (April 1993, pages 198–9) on the paper by Griffin and Chew (January 1993, pages 54–5), and prescribing information in the paper by Dr John Griffin and his economist son T D Griffin (April 1993, pages 121–6), suggest a possible explanation for the apparent therapeutic conservatism of UK doctors. Griffin and Griffin show that prescription items per