thy of note, is that one of the best ways of raising funds is through the local Mayor of your locality. The great advantage of involving the Mayor is that he or she will have the ability and often the resources to form an effective fund raising committee, and local papers are much more likely to back a Mayor's appeal than one that emanates from a hospital. We would therefore recommend fund raisers to explore this avenue. But it has to be planned well in advance and the Mayor needs to be persuaded that a particular piece of equipment is absolutely vital to the local community and that it is a worthwhile cause.

This will still involve everyone in a great deal of work but it does provide a central pillar for a successful appeal.

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Therapeutic Conservatism

Sir—International comparisons of prescribing can be misleading, and can be distorted to make political points. Griffin and Griffin (April 1993, pages 121–6) point to the numbers of prescriptions received by patients in various countries, and show that in the UK patients receive only 7.6 prescription items per year compared to 38 in France: this is an invalid comparison. In the UK, about one fifth of the total value of the pharmaceutical market comes from over-the-counter sales of relatively inexpensive items; comparable figures for France, Italy and Portugal (which top Griffin and Griffin's table for numbers of prescriptions) are 5–10%. Clearly, many items bought over the counter in the UK are prescribed in France. Within the UK, the same point applies: Griffin and Griffin comment that regions such as Oxford in which relatively high cost items are prescribed have, overall, lower total drug expenditure per head of population than regions where the cost per item is lower, such as Mersey or North Western. This ignores the differing demography and morbidity of the populations of these regions, as well as their socioeconomic structure. For instance, in less prosperous areas, relatively inexpensive items such as paracetamol are commonly prescribed rather than bought over the counter as is the case in more affluent areas; this inevitably decreases the average cost per prescription and increases prescribing rates.

Furthermore, the use of 'items prescribed' instead of a true marker of pharmaceutical utilisation, such as defined daily doses, makes the interpretation of prescribing data difficult, both nationally and internationally: an 'item' could be 10 paracetamol tablets or could be three months' supply of ACE inhibitors. A better comparison of relative consumption of pharmaceuticals in Europe is the Table drawn up by Taylor [1] which suggests that the use of prescribed drugs in the Netherlands (omitted from Griffin and Griffin's Table) is 70% of that in the UK, in Denmark 80%, but in France 270%, and in Italy 210% above the UK level.

These differences are in part due to cultural and professional traditions for which there are several examples; the widespread use of drugs, such as peripheral vasodilators in France, or tonics in Italy, which are generally considered in the UK to be of little therapeutic value; the very high levels of use of benzodiazepines in France, about three times higher than in the UK [1]; while in the Netherlands, prescriptions are issued at 56% of GP consultations, compared to 74% in the UK and 86% in Belgium [2].

Griffin and Griffin bemoan the limitation on drug company promotional budgets imposed by the pharmaceutical price regulatory scheme in the UK, and look enviously at unlimited advertising expenditure in other European countries. This can reach ludicrous extremes: in Belgium, a newly established GP may see more drug company representatives than patients in a day (J de Maessener, personal communication). The pharmaceutical industry spends about £250 million per year on promotional activities in the UK; the Department of Health spends £800,000 for the *Drugs and Therapeutics Bulletin* and £400,000 for the *Medicines Resource Centre Bulletin*, the main sources of independent advice on pharmaceutical products for most doctors. Since Griffin and Griffin are concerned about how little information doctors receive, perhaps they would support a levy of 1% on pharmaceutical promotion which could be used to allow a 200% increase in the independent information about drugs reaching doctors.

The virtues of conservative prescribing by British doctors have already been defended in this *Journal* [3,4] and need not be repeated. Griffin and Griffin point to the smaller number of products now available to and actually used by British doctors than in 1971: many of the products which had licences of right in 1971 were rejected by the Committee for Review of Medicines when scientific evidence for their use was sought: others had their licence severely curtailed (for instance, dipyridamole), while others were dropped by their manufacturers and never put to the Committee [5]. The relatively small number of drugs which account for the majority of prescribing reflect the fact that most doctors work within a limited range of drugs which allows them to know the drug well: I see this as a matter for praise, not criticism, and a mark of the quality of training of British doctors.

Finally, Griffin and Griffin assume that new drugs are more cost effective than older drugs. Cost effectiveness evaluations are clearly essential in ensuring that the resources currently put into prescribing are properly utilised, and should be actively supported by the industry and by the NHS. Questions remain about who should do these assessments, how they should be done, and what action should be taken to promote the

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.

References

1 Taylor D. Prescribing in Europe—forces for change. *Br Med J* 1992;**304**:239–42.
2 Anon. Who spends what on medicines? *Scrip*, 3 March 1993; No. 1800: p3–4.
3 Walley T. Therapeutic conservatism. *J R Coll Physicians Lond* 1993;**27**:198–9.
4 Watt A. Therapeutic conservatism. *J R Coll Physicians Lond* 1993;**27**:199.
5 Winship K, Hepburn D, Lawson DH. The review of medicines in the United Kingdom. *Br J Clin Pharmacol* 1992;**33**:583–7.

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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?

References

1 Payer L. *Medicine and culture.* London: Victor Gollancz, 1989.
2 Enthoven AC. What can Europeans learn from Americans? In: *Health care systems in transition.* Paris: OECD, 1990.
3 Louis WJ. Conflict over drug policy in Australia. *Br Med J* 1989;**298**:472–3.
4 Oliver MF. Cholesterol and coronary disease—outstanding questions. *Cardiovasc Drugs Therapy* 1992;**6**:131–6.
5 Spencer PS. New medicines are better medicines. *Pharm J* 1992;**249**:315–20.
6 Song F, Freemantle N, Sheldon TA *et al.* Selective serotonin reuptake inhibitors: efficacy, acceptability and effectiveness, a meta-analysis. *Br Med J* 1993;**306**:683–7.

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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