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

head of the population were lowest in the UK and Denmark of the EC countries, and highest in France and Italy. I have elsewhere [1] suggested that one explanation for this difference is that the UK has the highest number of senior academic clinical pharmacology staff per medical school in the EC, while France and Italy are among the lowest. It is tempting to suggest that three decades of clinical pharmacology education in the medical schools of this country have led to a more rational approach to drug prescribing by UK medical graduates, and to an intelligent but cautious interest in the benefit/risk information available on new products.

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Sir—Your correspondents Walley and Watt (April 1993, pages 198–9) ask if therapeutic conservatism, as described in my earlier paper, has wasted NHS funds or harmed patients.

In the space available I gladly offer some examples where such conservatism is costly to the NHS. A recent study showed that when the more expensive idarubicin was used instead of daunorubicin for the treatment of cancer there was an overall saving of £870.00 per patient treated, taking into account the extra cost of idarubicin at £607.00 per patient against consequent savings in hospital costs of £1,477.00 per patient [1].

Immunisation against hepatitis B was not encouraged by the DoH for its medical staff until 1988, largely on the grounds of cost. However, two patients infected by surgeons carrying hepatitis B cost the NHS more than if it had vaccinated all surgeons in the UK in the first place. Compensating the two surgeons, recalling 2,000 patients and consequent counselling, and compensation for infected patients is likely to be of the order of £5 million.

Patients are frequently disadvantaged by the lack of take-up of new medicines, such as ACE inhibitors in hypertension. Progress in hypertension treatment has not moved forward in the UK at the same pace as in other major European countries. In Italy ACE inhibitors are now the leading therapy. Is this because the British are more ready than Italians to accept drug-induced impotence (and lethargy, dyspnoea, and cold hands and feet) associated with β-adrenergic blockers?

The report of the second working party of the British Hypertension Society has drawn attention to the advantages of both calcium antagonists and ACE inhibitors over older treatments as first line treatment for patients with diabetes, gout, dyslipidaemia, ischaemic heart disease, heart failure and asthma [3].

Erythropoietin is one of the leading products on the German market but many patients who could benefit from it in Britain are denied it because of its perceived expense [4]. In Britain '. . . the annual cost of treatment with erythropoietin is £2,000–4,000 which can be offset against the cost of transfusions and hospital admissions... The improvement in the quality of life for these patients is such that nephrologists argue strongly for erythropoietin to be made widely available'. (Winearls 1992) [5].

Guidelines issued to consultant oncologists at the Royal Marsden Hospital, London state: 'Ondansetron is undoubtedly an effective antiemetic and has the advantage of being virtually devoid of side-effects. However, because of the significantly higher cost of ondansetron, we felt its use should be restricted'. A consultant oncologist in a London teaching hospital adds: 'Ondansetron is similar to the erythropoietin situation . . . The problem with ondansetron is worse'.

Dr Mallick of the Royal Infirmary, Manchester, speaking at a conference on 'Rationing health care in medicine', pointed out 'the gross underprovision of services for the treatment of end-stage renal failure in the UK in comparison with Western Europe. Poor planning has been responsible for rationing, with the result that many thousands had died prematurely. Further, if resources are inadequate in the early stages of chronic renal disease, this results in greater morbidity' [6].

Government constantly defends moves to restrict prescribing, such as the Limited List, by arguing that it does not result in damage to patient care. Could anyone, please, produce evidence to support such statements?

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Clinical geratology

Sir—Professor Stout (April 1993, page 192) is concerned for the future of the human species now that the University of Oxford has designated our subject as