information would be useful, as both sides benefit—the health authority so that it may plan its approach to a drug, and the company so that the market may be more receptive to its product. Purchasers and pharmaceutical companies therefore need to cooperate in managing new drugs—though some constructive tension between the two is appropriate.

Purchasers also need detailed economic analysis of the costs and benefits of a treatment compared with other treatments. Guidelines for such analyses have been produced and require disaggregated reports so that societal costs and costs to the health service are shown.[19] These studies are often conducted by a pharmaceutical company, encouraged by the Department of Health. But such studies may be biased and early studies will be based on clinical trials rather than on practical experience in the real world. Some means of validating these reports for use within the NHS would be helpful.[20]

Purchasers need access to expertise in clinical pharmacology, medicine, and health economics to interpret the data with which they are presented.[2] It is particularly difficult for an individual fundholding general practitioner to cope with all of this, and a cooperative approach with other purchasers is essential. Finally, purchasers need real power as well as responsibility, which may mean a unified locally held cash limited budget for drug treatment in both primary and secondary care.[15] A report on the needs of purchasers in relation to drug treatment has been prepared for the Department of Health.[20a]

The scenario outlined above is only one of many which will face purchasers in the future, and policies to deal with them need to be considered[21] before medical practice is firmly established. In the absence of specific action by purchasers the most likely approach in Britain to such problems will be a combination of the first two options noted above—that is, general practitioners prescribing largely but not entirely on the advice of specialists. The third model—direct prescribing within a fixed budget by specialists—seems to us more appropriate, though we recognise that there would be problems of equity of access to neurologists and hence to the drug, in supplying the drug to a patient who lives at a distance from the hospital, of doctors' autonomy, and of financing the policy under the existing arrangements. None of these is insurmountable.

The application of evidence based medicine in the case of interferon beta-1b—that is, its use in accordance with the evidence in trials concerning patient selection—would ensure the maximum benefit from the use of limited resources. This will avoid rationing by doctor's whim but does not solve the problem of the need to consider the benefits and costs of interferon beta-1b alongside those of other interventions. Rationing of any medical service is uncomfortable, and many doctors might prefer if the issue were not their responsibility.[22] When rationing is inevitable it should be explicit and planned rather than occur by default. We believe that rationing of high cost drug treatment in some form is inevitable and that we do our patients—both those with and without multiple sclerosis—a serious disservice by avoiding these issues.

Summary points

- Rationing drug treatment in Britain is difficult for government, health authorities, and doctors
- Expensive drugs may consume inappropriately large amounts of NHS resources
- Purchasers will be required to control expenditure on drugs and need to define policies to help them

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Correction

Benign positional vertigo: recognition and treatment

An editorial error occurred in this Fortnightly Review by Thomas Lempert and colleagues (19 August, pp 489-91). In figure 3 the second and third photographs were rotated. The correct version of the figure is published here.

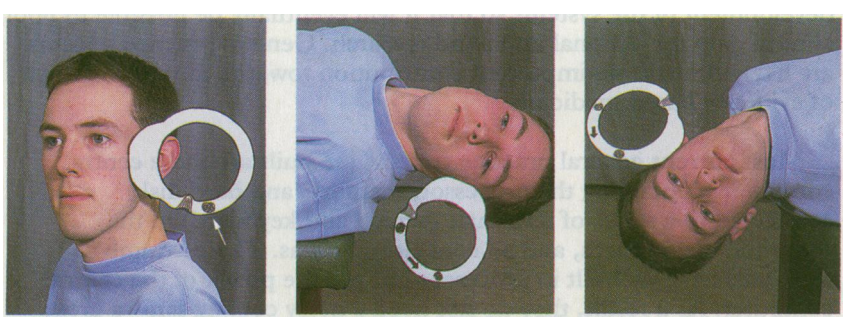

FIG 3—*Canalolithiasis theory of benign positional vertigo. From left to right: Orientation of posterior canal in head upright position with debris shown resting in bottom canal (arrow). When head is moved to dependent position the debris sinks in the canal under the influence of gravity to cause flow of endolymph. Treatment by positional manoeuvres aims at orienting canal so that debris is directed towards canal opening into utricle*