TALKING POINT

Cost of drug treatment in the NHS

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Drug treatment in the NHS is confused and it is time that its cost was rationalised. Let us admit straight away that the prescription charge is nothing less than a tax, a means of raising revenue to help pay for the Health Service. There is nothing wrong in this but the whole method of charging patients and the extraordinary exemptions and omissions permitted are in my view illogical.

Prescription charges

Prescription charges were recently fixed at the arbitrary figure of 45p for no clear reason. In any case, 60% of prescriptions dispensed attract no payment, which suggests that the system is either misconceived or grossly misapplied. I think that the latter is the case, as the following anomalies show.

A patient ill in bed at home and looked after by his own GP pays a prescription charge for any drugs administered. His brother, on the other hand, is ill in hospital, where the overall costs are greater to the NHS and less to the individual patient. But no charge is made for drugs administered while he is an inpatient. Why not?

A patient has his thyroid removed but requires the modest replacement treatment of a thyroid tablet morning and evening for the rest of his life. If he develops pneumonia, heart failure, arthritis, or any other illness he will receive all necessary drugs without paying any prescription charge. He is assured of total exemption for ever. By contrast, his neighbour, a sufferer from chronic bronchitis as a result of whooping cough as a child, pays for each prescription whenever he requires treatment. Where is the logic in that?

A judge retires with a near-five-figure index-linked pension. He pays no prescription charges because he is over 65. His neighbour, a working man of 59, who has just had a coronary thrombosis and who, incidentally, is getting less than £3000 a year as a farm worker, pays out for five separate prescriptions each month. Is this fair?

A professional colleague has a child of 13 susceptible to tonsillitis. We both earn roughly the same but he pays no prescription charge as all children under 16 are exempt. My child, three years older, earning nothing and costing more, has to pay (at least his father does). Is this sound economics?

Mrs Bloggs has a prescription for 300 diazepam tablets to keep her away from her doctor for as long as possible. Mrs Snooks has 30 tablets and is seen once a week. Mrs Snooks, I submit, has the better doctor, but over a 10-week period she pays 10 times as much for the privilege. Does this encourage good practice under the NHS?

A patient discharged from hospital to the care of his GP is given sufficient drugs to last for only three days, though he has

another appointment in two weeks' time and his treatment is to remain unchanged. Asked why he is so parsimonious the indignant hospital doctor will tell you that the cost of these drugs falls on the hospital budget and the fewer tablets he dispenses the better it is for the hospital's finances. He ignores the fact that the patient has to get a further prescription from his GP at additional cost to the State and himself. Is this not wasteful of time and money?

Possible solutions

The easy way out is to argue that the NHS should be free to all and paid for out of general taxation, and that all prescription charges should be scrapped. But this has been tried and it has failed; there simply is not sufficient money to run the NHS at a satisfactory standard. The working population resents having to pay more and more tax to benefit others. They have now reached the stage of preferring to do less work, earning less money but paying less tax and having more time to spare for leisure. This is fair enough, but it does not pay for the NHS. The only solution I can see is part payment by general taxation and part payment by the users of the service. This has the advantage that under certain circumstances the less the service is used the less it costs. This is true where drug costs are concerned for there is a direct link between prescription expenses and prescribing rates: reduce the latter and the former falls; charge for the service and the income rises.

On financial grounds there is sense in divorcing medical diagnosis from medical treatment, a proposition that is not as illogical as it seems at first sight. A patient may, for example, have a painful ankle. He wants to know why, for as a layman he has no idea whether his condition is potentially dangerous or relatively trivial. He goes to a doctor for diagnosis and advice. Arguably this should be free under the NHS, which is basically an immensely civilised system of care introduced to alleviate fear and suffering. The diagnosis is made—it is mild osteoarthritis, let us say—and the patient is told. He is also told that little can be done but that certain pills will ease the pain and may help generally. It is up to him to decide whether he wants them. Is it now unreasonable to say to the patient that if he does want the pills he must bear a fair proportion of their cost? He may think that they are not worth the cost and prefer to put up with the pain or he may be grateful and accept them. Either way the decision is his. But it must be made clear to him that the country cannot afford to give them to him free unless he is so poor that he genuinely cannot contribute towards their cost.

This is a simple example of a relatively minor condition and in matters of life or death other factors prevail, but it is the principle I am trying to establish. Patients often complain that they are not adequately told about their illnesses but this may be difficult when investigations as an aid to diagnosis are being carried out. There are many occasions when the doctor cannot take the patient completely into his confidence for fear of alarming him unduly. Often it is not until the diagnosis has been fully established that his condition can be discussed objectively. At

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this stage, when he is invited to contribute to the cost of his treatment, the patient can decide whether he wants certain treatment, at a cost to himself, or whether he thinks that the explanations he has received are sufficient. How many patients on tranquillisers or pain killers would wish to take them if they had to pay a realistic fee when the tablets were purchased? All too often they accept the prescription without thought or demur, not wishing to offend the doctor but not really wanting the treatment. Remember that 60% of patients do not pay charges.

Action

If these principles are acceptable the following action would correct many of the existing anomalies.

The pharmaceutical side of the NHS, which includes drugs and dressings, should be costed as a whole. There should not be separate budgeting for the costs of general practitioners, hospitals, and pharmacists; the whole bill should be met by one department of the DHSS, which should explore the most economical way of providing for the needs of patients, in or out of hospital. In deciding the source from which patients obtain their drugs, a balance would have to be struck between convenience to the individual and economy to the State. In different circumstances a hospital pharmacy, a dispensing doctor, a chemist, or a hospital outpatient department may be appropriate. The overriding criteria should be efficiency and economy.

Prescription charges should be levied as a percentage of the total drug bill, the balance being paid from general taxation. The Government would have to decide what percentage of the bill should be met by prescription charges, and the amount the patients would have to pay would be calculated accordingly. As the prescription charge would be levied to pay a percentage of the drug bill, the charge would have to rise if the overall national bill rose but it should be reduced if the overall bill went down. This would show the public that a reduction in usage would mean a reduction in the amount they had to pay.

Central auditing for educational purposes only, and with no penal clauses except for dishonesty or illegality, should be introduced. The auditing process should cover not only GPs but also the prescribing habits of senior and junior hospital doctors and comparisons should be made about the cost effectiveness, in prescribing terms, of teaching hospitals, district general hospitals, community hospitals, and GP units. Advice, not direction, on the suitability and relative costs of differing preparations should be freely and easily available.

As all taxpayers in the United Kingdom contribute to the

costs of the NHS everyone should be entitled to drugs under the NHS. Private and NHS patients would not have to be treated differently if the supply of drugs were considered separately. At present many patients are prepared to make a contribution towards the cost of their medical treatment but cannot afford to pay for all their drugs. Parliament has decided that a compromise is not permissible so many patients see two doctors, one privately for investigation and diagnosis, and an NHS doctor for their drug treatment. This is bad medicine, wasteful of medical manpower, and means that the NHS pays unnecessarily for a dual service. If drug treatment were considered separately more people would become private patients, to the financial advantage of the Service.

Foreign visitors should be eligible for emergency treatment under the NHS but should pay the whole cost of their drug treatment. On arrival they could be offered a voluntary insurance policy to cover the cost of any treatment they might require but it would be up to the individual whether he subscribed to this scheme or not.

Prescription charges should be levied on all drugs prescribed for inpatients and outpatients. The charge in hospital would cover an agreed period, say all drugs given over seven days, and for outpatients would be related to a specific period of time, say 14-28 days. Similarly, GPs' prescriptions would attract a charge based on the number of days' treatment given—for example, 28 days or less, 45p; 56 days, 90p; etc. Repeat prescription forms would have to be available for the convenience of doctors and patients. "Season ticket" payments should be offered to any patient who required them.

No patient would be exempt from charges unless genuine financial hardship was established, such as people receiving family income supplements, certain single parents, those receiving supplementary benefits, and pensioners whose total income was below an agreed level.

Some of these suggestions would be unpopular but if we are to pay our way we must contribute realistically to the cost of the services we use, while retaining the option of doing without if we want to. Many patients today accept drugs without really wanting them, in part so as not to offend the doctor and in part because they are free. A realistic charge levied on all, with repayment to those who genuinely cannot afford to pay, would greatly reduce the national drug bill and result in a fairer and better NHS.

The views expressed in this paper are my own and should not be taken as representing those of the General Medical Services Committee, of which I am chairman.

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Revised payments for GPs in hospital

After agreement with the General Medical Services Committee the DHSS has agreed to implement a new payment structure for GPs who provide casualty services. Separate payments are to be made into a staff fund for inpatient and casualty services provided by GPs acting on their own responsibility in community and cottage hospitals and in specified GP units in other hospitals. In some hospitals payments may be appropriate only in respect either of inpatient or of casualty work.

The new arrangements, set out in circular HC(PC)(79)5, are subject to local agreement but cannot be backdated to before 1 April 1979 or by more than eight months. GPs who wish

to transfer to the new arrangements should urge their employing authority to take action quickly.

Payments

Payment for providing the service will consist of a flat-rate payment (per hospital unit and not per doctor) to recognise provision of an on-call service *plus* a sum calculated according to the annual number of notional half-days required by the authority to provide the service. Where the number of casualties is less than 200 a year £5 will be paid for each casualty seen.

Payment for provision of a casualty service	Rate per annum £
Higher rate (24-hour service)	1540
Lower rate (12-hour service)	770
12-hour service, Monday to Friday	550
Payment for each notional half-day of clinical work per week	882
Payment for one hour or less of clinical work per week	231
Payment for one hour, but not more than two hours of clinical work per week	462