The selected list

*Diversion rather than threat*

The selected (limited) list is to be expanded. This expansion seems unlikely to have much impact on overall drug use within the NHS, although there is a risk that it will divert doctors' attention away from ways of limiting the upward trend in prescribing costs—just as the introduction of the original list did in the mid-1980s.

The first selected list, announced by Norman Fowler in November 1984, contained 30 products in seven therapeutic categories (box). NHS prescriptions would only be dispensed for listed products in these categories. This very restricted list provoked considerable disquiet, and by the time it was implemented in April 1985 the final list contained 129 preparations. The introduction of the scheme resulted in professional discontent, although to hospital doctors accustomed to working with hospital formularies it held no threat and few surprises.

In 1984 the principal reason given for introducing the list was the rapidly increasing drugs bill, which had risen from £250m in 1974 to £1.4bn in 1984 (an increase of 79% after adjusting for inflation using the retail price index). The Department of Health estimated in 1984 that limiting prescriptions in the seven selected groups could save the NHS up to £100m a year but subsequently downgraded this estimate to £75m a year. How these figures were arrived at remains a mystery as many patients would have been shifted to products that remained available for prescription within the NHS, and assessing the impact of such changes is almost impossible. The original list has been reviewed in subsequent years and now contains about 150 preparations.

The Department of Health still faces the same problems that it did in 1984. The cost of drugs prescribed in the NHS has consistently risen well ahead of inflation and for the past five years has been around 12% a year. The department's initial attempts to tackle the problem head on included the indicative prescribing scheme and the arrangements for paying the drug bill of general practice fundholders. Another plank in this strategy was the extension of the selected list to a further 10 categories. The reasons given for this extension are the same as those in 1984: by 1992 England's total drug bill was over £3bn.

All other countries face escalating drug costs. Member states of the European Community have adopted selected lists of their own, and some American health insurance companies have restricted the drugs that they will pay for. Britain is therefore not alone in its response. Britain's Department of Health, however, faces a conflict of interest. Not only does it set the price of drugs through the Pharmaceutical Pricing Regulation Scheme and meet the subsequent bill but it also supports the interests of the British pharmaceutical industry, a successful exporter and innovator in research.

Health ministers continue to emphasise their commitment to maintaining "patients' ability to receive the medicines they need when they need them, and for as long as they need them." This time the department hopes to head off controversy over the final list of products and has announced the expansion of the Advisory Committee on NHS Drugs.

The pharmaceutical industry is not taking the proposed expansion to the selected list lying down and has responded with an advertising campaign. Some individual companies are also lobbying heavily. When examining the therapeutic groups included in the original selected list—such as cough and cold remedies and bitters and tonics—doctors will be amused by the pharmaceutical industry's claim that patients are being denied "the best medicines."

Although predictions that research and innovation in therapeutics will be cut and investment reduced are worrying, some of the evidence provided for this by the industry—such as the lack of recent innovation in the seven categories on the present limited list (for example, tonics and bitters)—are unconvincing. If the changes impede research in, for example, contraception and skin disease, there would be cause for concern, but to date the list has allowed examples of all important categories of treatment: true innovation should therefore be rewarded.

The original selected list was a useful way of taking off NHS prescription many preparations which were of little or no
Many are losing out by default

Diabetes is common in elderly British people, with a prevalence of between 3% and 6%. Elderly (mainly non-insulin dependent) diabetic patients therefore represent the largest sector of the diabetic population, with several thousand in an average health district. Nearly a decade ago it was recognised that diabetes in elderly people was neglected and that many patients were being denied specialist care until a medical crisis supervened. Several recent community studies of diabetes have also shown that these patients suffer a disproportionate burden of ill health and are responsible for increased economic and social demands on society. These studies provide evidence that diabetes in elderly people is associated with inadequate and unstructured care, severe disability, and many unmet needs.

The belief that diabetes in older patients is a mild disease is wrong. One survey showed that microangiopathic complications were as common as in younger patients but macroangiopathy (such as ischaemic heart disease) was significantly more common. In addition, elderly diabetic patients have more complications at the time of diagnosis, with retinopathy being detectable in over 10%. Whether diabetes in elderly patients is a different disease from that in younger patients is arguable, but some complications such as diabetic amyotrophy and hyperosmolar non-ketotic coma occur mainly in elderly diabetic patients. Coexisting and often chronic medical problems such as cerebrovascular disease, arthritis, Parkinson’s disease, and dementia exacerbate the impact of diabetes, increase the level of disability, and hinder management.

The view that the only aims of treatment in this group are relieving the symptoms of hyperglycaemia and preventing hypoglycaemia is outmoded. Increased life expectancy means that many elderly diabetic patients live long enough to suffer from disabling (potentially preventable) complications such as blindness, foot ulceration, and lower limb amputation.

Given the special demands of these patients, can busy diabetic clinics meet their needs? Time is required not only to consider glycaemic control but also to discuss problems such as increased immobility and dependency, transfer to a residential or nursing home, and so on. To cope with these, doctors require training and experience in rehabilitation and medical care of elderly people as well as diabetes. In addition, there may be no systematic follow up of these patients, as who is primarily responsible for their management (diabetologist, general physician, geriatrician, or general practitioner) is unclear. Poor follow up means inadequate screening for complications, failure to provide sufficient information and education to both patients and carers, and an increased rate of admission to hospital.

How can we improve the future delivery of diabetic care to this large and vulnerable group of patients? Firstly, we need to recognise that management must include assessing the impact of coexisting disease and maintaining the patient’s wellbeing and quality of life. More emphasis should be placed on screening programmes, which will require cooperation among the hospital doctor, general practitioner, diabetes specialist nurse, and district nursing service as well as the patient and carer. Annual screening programmes should be established for foot problems and for visual problems, with special attention being given to visual acuity, diabetic retinal disease (especially maculopathy), and cataracts. These screening services should be incorporated into educational programmes specially tailored for elderly patients and their carers. Realistic and achievable goals for glyca-

Therapeutic benefit, and the proposed expansion continues in the main to address marginal therapeutic areas. But selected lists are only one approach to reducing prescribing costs. What is needed is an overall strategy that addresses the way that drugs are priced, how they are marketed, and the artificial division between funding and pricing of drugs in hospital and primary care.

With increasing downward pressure on prescribing budgets, general practitioners may be expected to save money by prescribing generically and using treatment protocols that take the cost of drugs into account. The revised selected list may help them to make a small proportion of the savings that are needed. As individual companies have been given the right to make representations to the advisory committee the list may not emerge for some months.

This still leaves the question of what we should look for in a new selected list. Obviously, effective “best buys” should be available on NHS prescription in all therapeutic areas. As with the present list some products may in future be allowable on NHS prescription only if prescribed generically: this will not harm patients or doctors, though it will have financial consequences for some companies. Some of these concerns could be addressed through the Pharmaceutical Pricing Regulations Scheme, although this will reduce the possible financial savings. Some patients and doctors may not continue to have their favourite preparation available on the NHS, with most controversy likely to arise from any limitation of the range of oral contraceptives.

Doctors need to concentrate on their prescribing policies where growth in the volume and cost of prescriptions has been high and marketing aggressive and the therapeutic advantage of new products is questionable. New drugs for depression, asthma, peptic ulceration, and hyperlipidaemia fall into this category. The selected list is not the solution to the problem of escalating prescribing costs, and the danger is that it will distract prescribers from what they need to do. Finally, it seems likely that the expanded list will be introduced too late this financial year to have anything like its intended financial impact.

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8 ABPI. What the new limited list will mean for NHS patients and the British pharmaceutical industry (advertisement). New Statesman and Society 1993 March 12-4.

Special needs of elderly diabetic patients

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