Profitability and improved patient care—the physician's viewpoint

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Introduction

The title of the theme which I have been invited to discuss carries the implication that 'the physician' can or should, have a view on the relationship between improved patient care and the profitability of the pharmaceutical industry, and that this view has been conditioned by his professional experience rather than by his political convictions. Such an implication cannot be accepted without question, however. While it is generally agreed that physicians are concerned with improving the care of their patients, many, if not most, are not trained in, or familiar with, the complex economic issues involved in the costs of drug development and marketing. An eminent overseas physician recently remarked: 'Clinical professors are never good businessmen'. Indeed, many of our colleagues within the National Health Service would associate themselves with the words of a colleague: 'The industry's profits or NHS solvency are not my business; my interests are in my patient'.

Accepting for the moment, however, that the physician may have a particular view on this matter, what are the relationships between improved patient care and the industry's profitability which will concern him? They include the following:

(i) The profitability of the pharmaceutical industry is a major factor influencing its investment in research on new therapeutic agents. Vane (1982) has expressed it clearly; 'The research based industry depends on profits to support its research and development search for new medicines, and any erosion of those profits will necessarily reduce its capacity to find new drugs of any kind for anybody . . .' Yarrow (1984) is more blunt; 'Expectations of future sales and profits are the determining factor in long-term investment.'

(ii) Determination of the industry's profitability is a complex matter involving several different factors including, in Britain, the pharmaceutical price regulation scheme, but the ex-

tent of drugs sales is a very important determinant.

(iii) The physician's prescribing, determined by concern for his patient's best care, influences drug sales and so the industry's profitability.

Whether he realises it or not, or likes it or not, therefore, the physician is caught up in a pharmaceutical 'La Ronde' in which he influences the drug industry's profitability through his prescribing, and so influences in turn the industry's ability to develop new drugs for him to prescribe.

Quantification of patient care and industry's profitability

Patient care and its improvement by drugs or other therapeutic measures may be quantified in financial terms at least to some extent. Among the many examples which could be quoted, several studies have shown the cost effectiveness of treatment of peptic ulceration with histamine H₂-receptor blocking drugs such as cimetidine when compared with surgical treatment (Binns, 1983; Maynard, 1983). The cost effectiveness of arresting premature labour with β -adrenoceptor agonist drugs has recently been quantified, showing that in the United States, the expected savings per surviving infant between 20 and 25 weeks of gestation were \$39,000, and between 26 and 33 weeks of gestation \$11,240 per birth (Korenbroet *et al.*, 1984). Such exercises in economic analyses, though exceedingly complex, are more straightforward than the assessment of measurement of individual and social benefits of psychotherapeutic agents such as benzodiazepines and their comparison with alternative treatments, such as that attempted by Marks (1983).

The quantification of profit is difficult, however, and is an exercise beyond the expertise of most clinicians. What level of profitability is acceptable for the manufacturer of drugs which

take their place alongside other forms of treatment in health care? What, for example, is a fair price to pay for cyclosporin A, which has raised the success rate of renal transplants from 60 to 80%, but at a cost of £2,500 per patient per year (Pharmaceutical Journal, 1984)? This obviously depends to a great extent on one's political persuasions particularly how much of that profit should be channelled into research and development rather than dividends to shareholders. Most physicians would, I believe, accept that the profitability of the pharmaceutical industry should not be greater than that of other research based industries. However, this level of profitability is determined in Britain by the government in consultation with the industry, and physicians generally have no say in the matter. Their involvement lies at the local hospital level, where, because the drug budget is part of the overall hospital budget, money spent on drugs and medicines reduces that available for other items such as salaries, services or equipment. Physicians, therefore, cannot ignore the sometimes unacceptably large price differences between branded and generic forms of the same drug when bioavailability is not a critical issue. Nor can they ignore the large differences in treatment costs between different drugs within the same therapeutic class when there is no objective evidence of differences in efficacy or safety between them. Even accepting the improvement in compliance provided by some combination products, they cannot close their eyes to the differences, sometimes large, between the price of such a combination and the prices of the individual ingredients for an equivalent treatment period. In many hospitals, such information, and therapeutic decisions or recommendations based on it, is provided by drugs and therapeutics committees (Turner, 1984), but often the physician himself has to seek out this information in general terms from the British National Formulary, or in more detail from the Monthly Index of Medical Specialities (MIMS). Whether it be through his representatives on the drugs and therapeutics committees, or as an individual physician, he has to make a value judgement on the extent to which on the one hand he contributes to the profitability, and hopefully the research investment, of a particular pharmaceutical company, and on the other hand he reduces as far as possible his own share of his hospital's expenditure on drugs, without prejudicing his patient's best interests, in order to make more resources available to his colleagues.

Our friends in the research based companies will point out that the cheapest alternatives are often produced by companies without much re-

search and development expenditure, and that the use of such alternatives does not, therefore, contribute to the development of new therapeutic agents. The solution to this problem, surely, lies outside the responsibility of the prescribing doctor but with the government who must ensure adequate protection of the research based industry through providing more realistic patent terms than apply at present (Hutt, 1982). It can also ensure, as some governments do already, that a company's monopoly on a new drug will not be prejudiced by a long period of post-marketing surveillance which may be required.

Drugs and therapeutics committees

There is an increasing realisation that the concept of clinical freedom so dearly held by earlier generations of doctors, and still, unfortunately, by a remnant of the present generation, is dead (Hampton, 1983). Furthermore, the introduction and aggressive marketing of more expensive new drugs will require greater expertise and care in their assessment and decisions about their usage in our health care system. As Smith (1984) has said recently: 'Doctors are remarkably simple minded in their recognition that science and marketing methods are incompatible bedfellows.'

The information and advisory roles of drugs and therapeutics committees has already been referred to, but it is certain, I believe, that their role in influencing and, indeed, determining drug expenditure will become very much more important in the next few years. The question must arise, therefore, of the involvement of physicians in what are, in fact, managerial activities. Most physicians would agree with Shrank (1984) that as they have the use of the resources provided by the State, it is they who should show that they use them responsibly and in the best interests of the patients. In fact, of course, the responsible use of drugs and the best interests of the patients cannot be separated. As Chant (1984) has said, 'The main constraint of our clinical freedom is still to do the best for our patient'. The important role of clinicians in unit management is emphasised in the recent DHSS document (1984) discussing Health Service Management. Whether or not we agree with Chant that 'practising doctors should not manage', it has to be accepted however, that most physicians have not been trained either in the scientific or managerial expertise required to develop and implement local or national prescribing policies. This is, surely, an area of responsibility in which clinical pharmacology should become heavily involved. The training of clinical pharmacologists

should include experience of the work of drugs and therapeutic committees, with involvement in the financial as well as therapeutic aspects of their work. Furthermore, while it may be true that, as a generalisation, most physicians do not wish to become involved in the finances of health care, there are exceptions to this, and there are many examples of clinicians with entrepreneurial flair, who have made important contributions to the financial success of various institutions. There is no reason to think that such an individual will not find job-satisfaction in a managerial capacity, which includes decision making in the field of drug treatment after advice and consultation with his clinical colleagues.

Finally, while the present generation of physicians may have little intent of involving them-

selves personally in the financial aspects of drug therapy, developments now taking place will inevitably mean that physicians of the future will, of necessity, have to include such considerations in their decision making. 'Clinical freedom is not a licence to ignore considerations of cost and resources, yet medical students receive no systematic education on the implications of economic factors' (Owen, 1984). Perhaps clinical pharmacologists in our medical schools should now be taking responsibility for providing such systematic education on the financial aspects of drug treatment to the next generation of physicians in this country. Hopefully, their view on this complex question will then be more enlightened than that of our own generation.

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