to reimburse the cost of an intervention when resources are limited is laudable for many reasons. This policy as applied in Australia can be praised particularly for its theoretical objectives. However, use of this policy as a rationale for requiring often unrealistic proof of economic benefit must be challenged.

The experience of Australian manufacturers has not been as uncomplicated as the authors portray. The dominant theme common to most complaints received from manufacturers has been that, while the policy espoused is one of cost effectiveness, the policy applied becomes one of cost containment.

The cost containment part of the process in Australia arises from the need for negotiation over price after acceptance of the "proof" of cost effectiveness. This approach has several fundamental flaws. Firstly, no validated method is applied to determine the price premium that should be paid for increased relative effectiveness. Secondly, the price is usually negotiated down from the price that was accepted as cost effective previously. Thirdly—and this denigrates the policy of evaluating cost effectiveness—the operating margins of the manufacturer are considered in the pricing process.

Furthermore, and possibly as a tool of cost containment, not only does the onus of proof of cost effectiveness lie with the industry but the requirements for such proof can be onerous. These requirements may be a consequence of the dynamics of decision making by funders of health care (and probably more so with governments), where uncertainty is anathema. The result can be an impractical expectation of proof of cost effectiveness from applications for reimbursement. Examples include the desire by some evaluators for long term clinical trials to prove incremental cost effectiveness for diseases that require interventions today.²

As a caveat to the above, the process is still evolving. We believe that the success of the process is largely due to the continuing contribution of the industry to the practical modification of the guidelines.³

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1 Freemantle N, Henry D, Maynard A, Torrance G. Promoting cost effective prescribing. *BMJ* 1995;310:995-6. (15 April.)

2 Glasziou PP. Support for trials of promising medications through the pharmaceutical benefits scheme. A proposal for a new authority category. *Med J Aust* 1995;162:33-6.

3 Commonwealth of Australia. *Guidelines for the pharmaceutical industry on preparation of submissions to the Pharmaceutical Benefits Advisory Committee: including submissions involving economic analysis*. Canberra: Department of Health, Housing and Community Services, 1992.

Fundholding and prescribing

Fundholders with more modest prescribing history receive less recognition

EDITOR,—Jon S Dowell and colleagues report having achieved a saving in their drug budget of £137 712, much of which has been used to benefit their patients and their premises.¹ Their experience contrasts sharply with our experience of fundholding in the same health board area.

I work in a semirural practice that has five principals and 7800 patients. We embarked on fundholding in December 1991 as part of a pilot project among small practices. As the rules on list size for fundholding changed we became "live" fundholders on 1 April 1993. The proportion of patients on our list who are aged over 65 is higher than average; we treat around 650 temporary residents each year; and there has been a consider-

able increase in homes for frail ambulant people and nursing homes, one of which has 50 patients. Despite this, since before fundholding was announced the amount we spend per fully registered patient has consistently been below the averages in both Scotland and Tayside. The underspend has ranged from 20% to 11%, with a slow drift towards the mean. This may reflect increased awareness among colleagues in a need to review critically all prescribing and local factors such as our growing population in nursing homes, with its heavy demand for drugs, dressings, and appliances.

Constant review of patients plus regular debate about prescribing issues within the partnership, including our trainees and students, has achieved these efficiencies. Over the past four years we have moved steadily towards more generic prescribing when appropriate and after full discussion with our patients.

Despite all this our drug fund has been consistently overspent. Our allocation for 1992-3 was £52 per patient per year and our actual spend was £56.80. In 1993-4 the allocation was £58.36 (in Dowell and colleagues' study the figure was £88.96) and our actual spend was £62.14. Our fund for 1994-5 was set at £67, which included an abatement by the health board for poor performance in attaining its target for generic prescribing. The fund for 1994-5 is heading for an overspend of £13 000 even though the rate of generic prescribing has risen from 40% to just over 60% in the past year (in Dowell and colleagues' study the figure was 57.6%).

We believe that a historically modest prescribing practice is being denied recognition for its efforts. The winners in fundholding seem to be those practices that make sudden lurches towards our pattern of prescribing. As we prepare to negotiate next year's budget our patients will be looking forward to receiving some of those benefits provided by the windfall reported in the authors' study. After all, our patients have helped finance it.

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1 Dowell JS, Snadden D, Dunbar JA. Changing to generic formulary: how one fundholding practice reduced prescribing costs. *BMJ* 1995;310:505-8. (25 February.)

Similar savings in non-fundholding practices are not similarly rewarded

EDITOR,—As Jon S Dowell and colleagues observe, prescribing in general practice consumes vast quantities of NHS funds,¹ and any initiative that reduces this expenditure without adversely affecting patients' care is to be welcomed. Unfortunately, in their enthusiasm to publicise their efforts as a positive benefit stemming from their adoption of fundholding the authors seem to have a poor knowledge and understanding of the standards that many of their contemporaries accept as the norm.

The figure details the prescribing costs incurred by our partnership over the past six full financial years, derived from prescribing analysis and cost (PACT) returns. Our partnership has consistently saved over 25% each year when our costs are compared with the national average, resulting in a total saving of more than £1 000 000 over six years. Adjustment on the basis of the averages for the local family health services authority shows a marginally less rosy picture, with the sum saved dipping to £840 000. Our rate of generic prescribing has risen consistently and currently approaches 70% (Dowell and colleagues claim a one off figure of 58%). This level of performance is achieved without special effort or initiatives and simply reflects the standard that we have expected of ourselves for at least 15 years.

Comparative prescribing costs for Derby Road Surgery, 1989-94

Unlike the partners in the practice studied by Dowell and colleagues, we are not fundholders. For many reasons we remain principled non-fundholders, and despite a sustained performance, which by any yardstick must be of the highest standard, we have yet to see a penny of the saving reinvested in services to our patients.

Those of us who have striven to improve standards in general practice since long before the advent of fundholding continue to do so despite the financial disadvantages of remaining principled non-fundholders. We are not impressed by apparent attempts to promote fundholding as the main driving force for quality and cost effectiveness in primary care.

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Capitation payments would be fairer

EDITOR,—Jon S Dowell and colleagues' paper shows that generic substitution can be acceptable to patients but also shows the inequity of the budgeting process.¹ The practice budget shown of £573 802, or £89 per head, for 1993-4 seems astronomical. This compares with a projected spend in our fundholding practice of approximately £48.25 per head in 1994-5, with a budget allowance of approximately £50 per head. The fact that this huge difference is probably not due to practice demography is underlined by the savings of 24% in one year, which works out at £67 a head after the changes described. To me, this looks like a year of very expensive prescribing followed by a year of expensive prescribing.

The large sum of money released is then invested in the primary health care team; this does not resolve the inequity of funding in comparison with funding of other local practices. We do not know whose agenda is followed when decisions are made on how the savings are spent. We are told that £94 000 is invested in extra equipment and services, which may be a useful investment for local health gain, but we are not told who now owns the equity of the investment. If it is the general practitioners should they become the main beneficiaries of this process, as many seem to have done?

The practice in which I work has always been a low prescribing practice, so fundholding has not put us "on the winning side" in terms of generous budgets. What is needed is a nationally agreed budget based on capitation, which could be weighted to allow for local variations in deprivation, rates of disease, and the detection and follow up of chronic disease such as asthma. General

practitioners could then be offered appropriate financial incentives to change their prescribing. For many this will require a greater interest in pharmacology and cost-benefit analysis and a reappraisal of our relationship with the pharmaceutical industry.

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High spending practices may benefit most from fundholding

EDITOR,—Jon S Dowell and colleagues report having changed the prescribing post per patient from 20% over the average for their health board to 8% under the average with a rise in their generic prescribing from 36.8% to 57.6%.¹ In the same period, with no great effort, the practice in which I work was below the average for the family health services authority by 21% and below the average for England and Wales by 14% (the list of 15 833 on 1 April 1994 is shared among seven full time partners; actual spending on drugs from April 1993 to March 1994 was £859 377). We are non-fundholders, and our referral rate is below average.

My partners have shown that rates of generic prescribing of 71% can easily be consistently achieved. This year we are on track to underspend our "budget" of £60.90 per patient, while in Tayside fundholders' expenditure was £81. (The forecast out-turn for 1994-5 at end of February 1995 was £892 766, a rise of 3.89% over the previous year.)

We have always believed that the highest spending practices are also those most likely to profit from fundholding. The Downfield practice is to be congratulated for being unashamedly prepared to confirm this truth.

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1 Dowell JS, Snadden D, Dunbar JA. Changing to generic
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Patient dissatisfaction may be underreported

EDITOR,—Jon S Dowell and colleagues' study of the introduction of a generic formulary in a fundholding practice is a valuable addition to understanding of the process of changing prescribing policy.¹ However, we question their interpretation of their survey data on patients' satisfaction with the change.

They state that 20% of patients were "very unhappy." We believe that this underrepresents the extent of patients' dissatisfaction by excluding the further 26% who were "slightly unhappy." In total, twice as many patients expressed unhappiness (46%) as happiness (20%) with the change. Responses regarding communication were similar (44% unhappy, v 22% happy). We suggest that even these figures may underreport the true level of patients' unhappiness, given the reluctance of many patients to express criticism of their health care.² If we are correct the claim on the "This week in *BMJ*" page that "patients will accept prescription changes" misleads in so far as it implies that they welcome them.

Dowell and colleagues recognise that impotence is an important component of patients' dissatisfaction. It is all the more regrettable, therefore, that no attempt was made to inform patients or consult with them before prescribing policy was changed. We are aware of the practical difficulties

that this might entail but would argue that the principle of informed consent should apply when any change in prescribing policy is contemplated. The principle may be doubly relevant when change is motivated by financial considerations.

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2 Fitzpatrick R, Hopkins A. Problems in the conceptual framework of patient satisfaction research. *Sociology of Health and Illness*. 1983;4:297-311.

Prescribing practice may have been inefficient

EDITOR,—Jon S Dowell and colleagues show that a general practice can reduce its prescribing costs by 24%, with costs being reduced in 14 of the 18 categories of drug studied.¹ The authors note that the practice deliberately delayed attempts to contain prescribing costs until it became a fundholding practice. Indeed, the practice resisted previous efforts of the local prescribing adviser to reduce drug costs. In our view, there are important implications in this paper.

One implication is that before fundholding status was gained scarce NHS resources were being spent on expensive pharmaceutical products when an equally effective and cheaper alternative was available. The opportunity cost of such behaviour is that needy patients elsewhere in the NHS are deprived of health care resources. An alternative implication is that, when fundholding status is achieved, cheaper inferior pharmaceutical products are being prescribed to patients, which may lead to a decline in their overall health status compared with that when the more expensive and more effective products are used. In economic terms both of these scenarios are inefficient, and they raise important questions about care in the NHS.

The paper shows that, at least for this practice, budgetary considerations were prized more highly than either the greater welfare of all patients in the NHS if the first scenario is correct or the welfare of the practice's patients if the second scenario is true.

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Reorganisation of prescribing practices should not be delayed

EDITOR,—To us, Jon S Dowell and colleagues' paper epitomises everything that is wrong with fundholding as it is presently organised.¹ They describe a practice that has made huge savings on its fund by capitalising on its past prescribing policy—in effect catching up with many other practices that had made the effort, in the years before fundholding, to rationalise their prescribing and thereby save many millions of pounds for taxpayers. The authors even suggest that practices contemplating fundholding should consider not doing anything about their costs until they become fundholders, to gain the greatest benefit from the budget they will then receive.

As doctors we have a responsibility to our patients to ensure that our prescribing is as effective as possible, and as citizens we have a responsibility to ensure that it is as cost beneficial as possible. Any practice that puts off reorganising its prescribing habit for monetary gain is in our view doing a disservice to its patients and the state.

We too are a fundholding group in Tayside. Our prescribing costs per head are lower than those of the practice in the paper even after the authors' project. We, however, have made no profits on our fund as our budget was based on a low historical spend because we spent, and continue to spend, much of our time creating and revising our practice formulary. We believe our prescribing to be effective; we do not use expensive drugs when cheaper ones are as good. We are happy, however, to be able to prescribe our patients what they, as individuals, need whatever the cost.

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Most savings come from a small number of generic drugs

EDITOR,—The urban practice in Dundee reported on by Jon S Dowell and colleagues achieved impressive savings by introducing generic prescribing for all new and repeat prescriptions.¹ A practice formulary is not the same as a hospital one, and a prescription issued can be taken to any pharmacist in the United Kingdom, where a parallel import with packaging partly in another language may be issued. Many practitioners wish to retain individual freedoms within the bounds of rational prescribing and balk at total use of generic drugs. Such doctors are greatly relieved when shown that nearly all the financial savings achievable arise from generic prescribing of just 25 drugs and that all other drugs in a formulary may be prescribed by proprietary or generic name according to choice, with no material impact on the budget. The top 25 generic drugs yield 95% of savings.

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Authors' reply

EDITOR,—We are disappointed that the budget of the practice studied is the main issue in four letters (A D Shaw, A D Birchall and colleagues, R V Millard, and George Raitt) when it was not the focus of our paper. The impact of financial incentives on general practitioners is controversial, and this practice deserved credit for allowing its affairs to be scrutinised. We did not seek to promote fundholding but were honest in admitting that these changes would never have been attempted without the incentives it includes.

Roland Petchey and Tony Avery question our crude measure and interpretation of patients' satisfaction. However, no scale exists that could balance the level of dissatisfaction with a saving of £137 712 or measure the impact that this change had on the doctor-patient relationship. It could be argued that the 60% of respondents would include