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.

R V MILLARD
General practitioner

Denmead Health Centre,
Denmead,
Hampshire PO7 6NN

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.)

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.

GEORGE RAITT
General practitioner

Carlisle CA1 1DY

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.)

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.

ROLAND PETCHEY
Lecturer in general practice

TONY AVERY
Senior lecturer in general practice

Department of General Practice,
Faculty of Medicine,
Medical School,
Queen's Medical Centre,
Nottingham NG7 2UH

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.)

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.

DAVID J TORGERSON
Research fellow

ALAN MAYNARD
Professor

Centre for Health Economics,
University of York,
York YO1 5DD

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.)

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.

A D MCKENDRICK E McNAUGHTON

H LESLIE L J MORTON

P W THORNTON General practitioners

F R G CROSBY J E HUNTER

A I M EASTON S P FLANZ

Trainees

Carmoustie Medical Group,
Health Centre,
Carmoustie,
Angus DD7 7RB

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.)

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.

JEFFREY EASTON
Fundholding general practitioner

Harcourt Medical Centre,
Salisbury,
Wiltshire SP2 7TJ

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

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