Prescribing costs – whose responsibility?

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The New Zealand public spends over $700 million a year on prescription medicines and a significant proportion (about $500 million) is under the control of general practitioners. I do not want to debate the rights or wrongs of the quantum, however we do need to identify the rights and responsibilities that doctors have in relation to that level of expenditure.

Until two years ago I was in full-time general practice and large expenditure figures like these meant little to me. As far as I was concerned, if the country needed more money for pharmaceuticals it should simply find it because if a doctor said it was necessary that was the end of it. Now the majority of my time is spent on the other side of the fence and the view is very different. Like all of us, Government organisations work within a fixed budget and they have to be accountable not only for the budget they manage but also for the quality of the service they fund.

As with any budget we need to look not only at the costs and benefits of new therapies but also at the value we are getting from older 'off patent drugs'. To this end regulators are continually looking at the 'value of the portfolio' and testing to see if low value drugs are really worth the price paid for them. In clinical practice we do this when we change from one type of dressing or syringe to another. Basically, if another brand is of comparable quality and cheaper we have no issue about changing.

We need to ask why this should not be normal practice with pharmaceuticals. To use the parlance of the economists, most pharmaceutical expenditure carries few 'price signals' and indeed this is the whole point of the Welfare system. Absence of 'price signals' means that if a patient is sick he/she doesn't have the added burden of worrying about the cost of the medication. However, when the annual cost of a medication is, for example, up to $70 000 a year, we need to be sure that we really are spending our budget wisely. With a fixed budget and a variety of competing new therapies we need to ensure that we allocate these scarce resources in a fair and equitable manner.

Saving money on old drugs in order to fund new ones now seems very obvious, but three years ago, with the advent of reference pricing, that was a real ethical question for me. I guess the real question is: who has the ethical problem, the regulator or the drug company?

We now have many examples of drugs that have dropped in price by over 90% once they came off patent. If patients had been subjected to those 'price signals' and had to pay the full price they would have quickly made a quality versus price decision.

However, when the drugs are subsidised by the State, it is the State that must make the decision.

The unfortunate fact is that clinicians are often the meat in that sandwich and for that reason it is imperative that we fully understand not only the reasons for the subsidy changes but are also able to intelligently discuss the quality issues.

However, it is not just the patient who has been protected from 'price signals'. Within the constraints of the Pharmaceutical Schedule we have been able to prescribe according to what we consider to be best evidence and according to the needs of our patients. Although we are not personally accountable for the costs, a full-time practitioner is responsible for some hundreds of thousands of dollars. We need to ask how well we prescribe for our patients and how well we follow evidence based practice.

When I took on my role at PHARMAC I thought the answers to these questions were simple and it was just a matter of sorting out the bureaucrats. After all, I had been (and indeed still am part-time) in active practice.

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The reality is that these questions are more complex than they look and simple answers don't necessarily stand up too well to intense scrutiny. It is easy to dismiss those who fund and regulate as 'bureaucrats' who have no real understanding of the real world, but at the same time they are accountable to Government and are looking for answers to the same complex questions.

From the regulator's view it is a curious thing that clinicians have the right to prescribe and control public expenditure without accountability, which they see as a sort of 'droit de seignior'. The clinician argument is that for medicine 'the art is long', the training arduous and their true allegiance is to the patient. Added to that is the observation that there is no infrastructure to monitor this expenditure. The regulator on the other hand points out this is public money and should be accounted for; who pays the administrative costs for this accountability simply begs the question.

For me the right to prescribe is something that was bestowed on me by the State when I was granted a practising certificate by the New Zealand Medical Council. What surprises me is the length of time it has taken the State to demand accountability both in terms of safety and efficiency. Perhaps it is a tribute to the skills of medical professionals that they have been trusted to manage this area of expenditure for so long with minimal intervention.

With the arrival of nurse prescribing this question of rights and responsibility and accountability has taken a new twist as we ourselves argue whether nurses are responsible enough to have the 'right' to prescribe. The sad thing is that we should have been having that debate before the fact not after it.

As part of my role I talk to a number of groups, both lay people and health professionals. My impression is that most people can understand the concept of a fixed budget, but there is often tension around who gets what share. Real examples include:

- oncology groups critical of the amount of money spent on 'lifestyle drugs' such as statins
- cardiology groups critical of the amount of money spent on oncology drugs that do little for quantity of life
- neurological groups who believe that there is 'discrimination against the elderly'
- paediatric groups who identify children as being under-funded relative to other sections of society.

In an attempt to share out that budget there have been a number of formulae used to rationalise this debate and in New Zealand we have leant toward the concept of 'cost utility analysis'. It is the best economic model available, albeit not a perfect solution. However it forms the basis of a lot of pharmaceutical decision making and is something that clinicians should be familiar with. We should not be put off by the 'econospeak' and understand that 'utility' is a technical term to describe the benefits of a drug not only in terms of life or death but also in relation to 'quality of life'.

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We also need to understand the difference between 'need' and 'capacity to benefit'. The distinction is that just because there is a need for treatment it does not follow that the treatment will necessarily do much good. As an example, there is an undeniable need for treatments to prevent Alzheimer's disease but the difficult question is whether we currently have drug treatments that have a real impact.

Some questions I hear from our analysts on a regular basis are: 'If drug A is better than drug B, why do doctors use more of drug B?' Or: 'If drug X and drug Y are of equal benefit why do they use the more expensive one?' Or, 'If the evidence suggests that everyone should be on drug Z, why isn't everyone on it?'

Sometimes there is a good reason why the 'evidence' is not being followed, but sometimes it is because we as a group cannot or are not prepared to take responsibility for the actions of others. For whatever reason, unless there is some responsible action from us as clinicians, we are at risk of 'regulation'. Sometimes that regulation will be in the form of a proscriptive decision such as a Special Authority or a requirement for a specialist recommendation.

The reality is that the regulator is often acting on what they consider to be best practice and it is incumbent on us to take some responsibility.

General practice should be one of the key decision makers in pharmaceutical management. General practitioners have the scientific background and the generalist experience to balance the rigid evidence based approach to funding but with a humane approach. However they must understand the fiscal and economic effects of their advice.

General practice needs to make its voice heard in the funding debate, but if it is to make a real impact it has to be constructive as well as critical. At times that may mean that we recommend certain therapies are funded at the expense of others. And like it or not, if we are to maintain our credibility as a group with special expertise in the health field we will have to take responsibility for our collective actions. To that end we have to demonstrate that we are knowledgeable in our field and maintain our standards.

For me the issues were summed up by the New Zealand health economist Brian Easton in the 2000 PHARMAC Annual Review when he wrote:

'Clinicians...have to be involved too, and committed to a strategy of ensuring the therapies they use are not only clinically effective but are also cost effective. Otherwise economists and accountants will make the decisions for them, because the cost dimension cannot be ignored.'