

DEPARTMENT OF HEALTH,
P.O. BOX 5013,
WELLINGTON.

21 September 1967

Clinical Services Letter No. 73
TO MEDICAL PRACTITIONERS

Dear Doctor,

THE COST OF DRUGS

The annual report of the Department of Health (Clinical Services Division) mentions an inquiry into the prescribing costs of doctors who are well regarded by their colleagues, and comments as follows:

“This inquiry helps to explain why it is so difficult to keep down the cost of pharmaceutical benefits. This, as never before, is the era of drug treatment. To ask most doctors to keep a curb on their prescribing is like asking a boxer not to use his fists. A doctor who got a reputation for being a niggardly prescriber would soon find his practice dwindling away. All new drugs are relatively expensive, and there is a certain prestige about using them; ‘We must keep up to date’. If the more highly respected doctors are average prescribers (or a shade above average) it is little wonder that the average keeps rising year by year—for new drugs are being introduced all the time.

“In recent years the Department has enjoyed, on the whole, excellent co-operation from the profession at large in its efforts to control costs. But there are limits to what can be achieved in that way. More attention must be paid in future to the prices paid for drugs, and the terms upon which they are included in the Drug Tariff. At the same time we must, of course, continue to encourage doctors to take an active interest in the relative costs of the drugs they prescribe.”

In brief, we want to take the heat off the doctors, and concentrate on negotiating prices with the drug firms.

In the last resort, in this connection we have only two effective weapons:

- Setting a price which, if not accepted, involves a part-charge.
- Taking the drug right out of the Drug Tariff.

Part-charges

When a part-charge is imposed on a drug, it generally means that we have failed to persuade the firm to meet what we believe is a reasonable price.

In everyday matters it is the customer who decides whether or not a price is reasonable. If he believes it is not, he does not buy.

It is the same here. We have a duty to the taxpayer not to pay more than we believe the drug is worth. We compare the price with:

- The price on the U.K. market, plus a margin of up to 30 percent.
- The cost of other drugs in the same therapeutic class.
- The price of a similar preparation compounded by a retail chemist.

If negotiations fail, the alternative to a part-charge (unless the firms are to have it all their own way) is to remove the drug from the Tariff altogether.

It is unfair to say, as people sometimes do, that a drug with a part-charge "has been taken out of the free list". Certainly it is no longer "free", but (with a very few exceptions) the greater part of the cost still comes from public funds.

Part-charges therefore represent an attempt to protect the long-term interests of your patients as taxpayers—and your interests as doctors and taxpayers, too.

We look to you for moral support.

Nobody hears of the innumerable instances where prices are lowered successfully by these methods.

Removal of Items from the Drug Tariff

To delete any commonly used drug from the Tariff is a serious step. It could not be done without good reason.

The reason may be that some new and unsuspected risk has come to light. This has usually been discovered through study of hospital records on a very large scale, or through reports from general practitioners to an organisation like the Adverse Drug Reactions Committee.

The risk with an established drug is generally so small that only a tiny minority of doctors can have met with it. So *ad hoc* inquiries from the profession at large are seldom helpful. Comments on the drug's usefulness are obviously irrelevant until the degree of risk has been assessed.

Not long before the thalidomide situation blew wide open, the firm sent us lists of 65 doctors in New Zealand "who had conducted evaluation trials", and a further 114 who were using the drug. Not one of these doctors ever mentioned the complication of peripheral neuritis which had caused the rejection on two successive occasions of applications for the drug to be included in the Drug Tariff. The enthusiastic reports on the file make strange reading today.

The pharmaceutical industry is justly proud of its achievements, understandably sensitive to criticism, and touchy about prices. It is rich and powerful. Only a fool would tangle with it without being sure of his ground. He would be liable to get hurt.

Nobody can be right the whole time, but in this business it could be dangerous to be very far wrong.

RESERPINE-DIURETIC COMBINATIONS

The Pharmacology and Therapeutics Committee has examined evidence from New Zealand and overseas, and has decided to recommend no change in the Drug Tariff in respect of these tablets.

In 1965* doctors were advised that although the Committee felt that "the use of drugs in fixed combinations is generally undesirable", combinations with special advantages may be acceptable; "for example, tablets of reserpine, thiazide, and potassium were included (in the Drug Tariff) in order to reduce the necessity for old people to take several tablets at a time".

The reason for reconsidering this decision was that there was evidence that the onset of a dangerous depression (from the reserpine content) might be overlooked when using these tablets. Instances of depressed patients in whom the association with reserpine had not been recognised have been reported to the Department from time to time. The fact that not one of the many critics who rose in defence of the combined tablets made any reference to this possibility does suggest that some doctors may not be as alive to it as they ought to be.

The Committee recommends that before prescribing reserpine in combination, the separate components should be given a trial, to see if reserpine has a depressive effect in that particular patient. The possibility of depression should be kept in mind whenever this drug is used, either separately or in combination.

Depression is believed to be one of the commonest of missed diagnoses today.

TETRACYCLINES

The following capsules and tablets of 250 mg strength (or equivalent) carry no part-charge:

Chlortetracycline (Aureomycin).

Lymecycline (Tetralysal).

Oxytetracycline (Berkmycen, Imperacin, Ossitetra GL, Oxycycline).

Tetracycline (Achromycin, Achromycin V, Hostacycline P, Panmycin HCl, Panmycin M, Panmycin P, Steclin).

Demethylchlortetracycline (Ledermycin).

This list may not be complete, as other brands are about to be marketed. Further price changes may be expected shortly. If you order by official name, there will be no part-charge.

Yours faithfully,



(A. W. S. Thompson)
Director,



(T. L. Hayes)
Assistant Director,

Division of Clinical Services.

*Clinical Services Letter No. 51, 12 May 1965.