From gentle persuasion to Thatcher's age of coercion

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In our series on the history of prescribing policy, Dr Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he describes how earlier efforts to control costs using persuasion were gradually replaced by policies based on coercion.

KEY EVENTS

- 1982 Health service reorganisation – 192 district health authorities introduced and FPCs were placed under authority of DHSS
- 1983 Conservative election victory – Landslide victory for Margaret Thatcher, following the British victory in the Falklands war
- 1983 Griffiths Report published – Griffiths suggests that the principles of general management be introduced within the NHS
- 1987 *Promoting Better Health* white paper introduced a range of financial incentives

Due to the unexpected growth in pharmaceutical costs during the first 12 months of the NHS, prescribing by GPs received attention from the government, academics and other interested parties from the outset. For instance, the Central and Scottish Health Services Councils established the Joint Committee on Prescribing in 1949.[1] A study produced by DM Dunlop and published in 1952 identified regional variations in prescribing not evident before the introduction of the health service.

In 1957, JP Martin produced his seminal text, *Social Aspects of Prescribing*,[2] containing a large statistical study that reported that, in the first year of the health service, expenditure on drugs was 39 per cent higher than expected. Therefore, there was 'considerable concern, and even fear, that this branch of the Health Service might be getting out of control'. However, it was 'not really known what was getting out of control'.

Cost-effective prescribing

In response to the spending crisis, Martin's study identified the factors linked to the rapid growth in prescribing costs. He reported that any system of 'controlling' prescribing has two main aspects, the 'persuasive' and the 'coercive'. For political reasons, he found that the former initially had pre-eminence in the NHS, with the latter focusing primarily on 'excessive prescribing' with sanctions only for the most extreme cases.

Although efforts were being made to persuade and coerce the prescriber, Martin reported that attention should be paid to the 'real problem' of meeting patient needs cost-effectively. Therefore, efforts should not focus solely on excessive prescribing but the government should directly promote the rational use of all pharmaceuticals because this was the out-of-control unknown.

Although he believed that pharmacists could have a role in directing GP prescribing, Martin suggested that longer-serving and busy practitioners may be resistant to such an intrusion. In order to change prescribing behaviour, Martin reported that ministerial policy at the time should place greater emphasis on information and advice rather than direct controls.

During the 1950s, policies were thereby limited to what was achievable by persuasion rather than what was enforceable by coercive means. Martin suggested, however, that what was politically feasible may not have been the best means of solving the real problem of promoting more appropriate, cost-effective prescribing.

The age of coercion

From the history of prescribing, evidence suggests that successive governments

were reluctant to risk political entanglement with prescribing doctors and their representatives. However, the Limited List episode in 1985 proved a valuable lesson for Margaret Thatcher's administration, which illustrated that family doctors could be confronted head-on without resorting to the usual rules of engagement with the profession.[3] Therefore, a four-decade wait for radical change was about to end.

Led by Margaret Thatcher, the Conservative government sought advice from management experts and economists on new, more efficient ways of running the NHS. As a result, by the end of the 1980s the UK government was ready to exert greater coercion over the prescribing doctor.

Before change could be implemented, however, there were several developments between the lessons of the Limited List and the announcement of the controversial 1991 NHS reforms.

The Conservative Party won a landslide victory over Labour at the 1983 general election. Just prior to the election, the Conservative government had reorganised the administrative structure of the NHS.[4] As part of this reform, area health authorities and districts were replaced with 192 district health authorities, and family practitioner committees (FPCs) were placed under the direct authority of the Department of Health and Social Security (DHSS).

In October 1983, the Griffiths Report suggested the introduction of the principles of general management into the NHS. It was not until the publication of a green paper in 1986, however, that general practice policy again become an issue for public debate.[5] Based upon the discussions that followed the publication of the green paper, the white paper *Promoting Better Health* announced the Conservative government's plans to introduce a range of financial incentives designed to encourage health promotion, regular care for the elderly, child health surveillance, minor surgery and postgraduate education for GPs.[6] These incentives may be interpreted as a growing awareness in government that better management and stronger incentives both had a place in running general practice within the NHS.

Although the Greenfield Committee was initiated in June 1980 to investigate prescribing in general practice, the committee's final report was not made publicly available by the Secretary of State for Social Services, Norman Fowler, until February 1983.[7] Once published, the Greenfield Report revealed that the joint committee had made a number of recommendations that it believed to be 'consistent with good medical practice and patient care, which leave the doctor free to make the final clinical decision but which also encourage a more economical approach to prescribing'.

With its emphasis on securing voluntary improvements in prescribing, the Greenfield Committee report must have seemed very traditional during a period when persuasion was losing ground to coercion in terms of being viewed as the best way of controlling family doctors.

As the 1980s progressed, prescribing policy moved into an era of coercion led by Margaret Thatcher and her cabinet colleagues. Instead of clinical freedom being the main determinant of practitioner behaviour, general practice would soon move into an age of budgets and incentives as the main controllers of prescribing behaviour and costs

Dispensing doctors

Soon after the publication of the Greenfield Report, the DHSS announced changes, taking effect from 1 April 1983, to the arrangements for dispensing doctors.[8] Although the dispensing practice scheme was originally introduced to improve patient access to medicines, during the early 1980s evidence suggested that a number of participating practices were generating substantial profits from the NHS.

	Capitation	Fee for service	Total dispensing
1964	1601	790	2391
1965	1503	929	2432
1966	1370	997	2367
1967	1308	1040	2348
1968	1239	1088	2327
1969	1122	1200	2322
1970	1017	1331	2348
1971	870	1509	2379
1972	767	1642	2409
1973	647	1799	2446
1974	585	1927	2512
1975	454	2063	2517
1976	352	2213	2565
1977	325	2296	2621
1978	288	2366	2654
1979	273	2439	2712
1980	258	2512	2770
1981	239	2586	2825
1982	177	2683	2860

Table 1. Number of capitation and fee-for-service dispensing doctors in England, 1964–82

Working under Norman Fowler, Secretary of State for Health Kenneth Clarke established an inquiry into the relationship between the prices that dispensing doctors paid for products dispensed and the rates at which they were reimbursed. In April 1984, the inquiry reported that, on average, dispensing practices were able to purchase drugs at rates approximately 5 per cent below those reimbursed.

In response, the DHSS, with agreement from the BMA, altered the rates at which dispensing doctors were paid and redistributed the savings generated across the incomes of all GPs. In a minor way, this move highlighted the link

Letters

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between drug spending and family doctors' incomes, which could be controlled by the government in the right circumstances.

By the mid-1980s, many dispensing doctors had become increasingly dissatisfied with the capitation system of remuneration that they had traditionally been encouraged to use. As Table 1 shows, since the mid-1960s the proportion of dispensing doctors reimbursed under the system had substantially declined as payments on a fee-per-service basis (similar to that used for pharmacists) became increasingly popular.

Given the increase in fee-per-service dispensing doctors, Kenneth Clarke responded by abolishing the capitation system in July 1984, stating that: 'the government and the profession are agreed that this option has outlived its usefulness'. The end of this incentive structure did not meet any political resistance because fees for items dispensed were more likely to benefit patients and dispensing doctors than a centrally-limited medicines cap.

References

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The next article in this series will look at challenges to the role of the prescribing GP and will outline Professor Alan Maynard's ideas for a budget-holding scheme.