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New drugs and the NHS: square pegs and a round hole

David Taylor

Drug development in psychiatry has famously been something of a stop-start process. First, there were no truly effective psychotherapeutic agents, then, in the 1950s, phenothiazines, monoamine oxidase inhibitors and tricyclics all appeared in the space of a few years. Then, virtually nothing: no substantial developments for 25 years. In the mid-1980s the first selective serotonin reuptake inhibitors appeared, heralding a new era in psychopharmacology. Then, in 1990 clozapine was re-introduced, to be followed by other atypical antipsychotics and by drugs such as donepezil and acamprosate for entirely new indications. In addition, research into antidepressant therapy has produced new agents with varied modes of action and new strategies for the treatment of refractory depression.

So, as we approach a new millennium we have, appropriately, more effective and less toxic drugs to treat schizophrenia; a huge variety of approaches to the treatment of depression; and, for the first time, effective agents (albeit moderately effective) to treat Alzheimer's disease and alcohol dependence. Surely this is an exciting time to be involved in psychiatry – the era of the second revolution in psychopharmacology. Oddly, though, nobody seems very excited: in my travels to meetings, conferences and other trusts, I note that conventional disgruntlement seems to prevail.

There are several possible reasons for this. Not the least is that drugs form only part of the holistic treatment of any psychiatric illness and other aspects of care, particularly community care, are in urgent need of re-examination and perhaps change. Nevertheless, even among biologically minded psychiatrists I have occasionally encountered notable cynicism. This is no doubt a product of decades without palpable progress in drug development during which time the pharmaceutical industry sometimes fallaciously claimed huge advances. Moreover, the withdrawal of zimeldine, nomifensine and remoxipride has done nothing to engender confidence in the safety of newly-introduced psychotropic agents. Clinicians are right to be cautious given these observations.

Arguably, however, the most important constraint on the use of new drugs is the absence or inadequacy of National Health Service (NHS) funding. This has perhaps been most clearly demonstrated by the National Schizophrenia Fellowship survey (Hogman, 1996) which showed that 55% of 719 psychiatrists felt that cost in some way inhibited their use of clozapine. This survey was completed in 1995, before the introduction of sertindole, olanzapine, quetiapine, amisulpride, reboxetine, mirtazapine, donepezil and acamprosate. It seems likely that restrictions on prescribing and, indeed, frank rationing are now much more common and widespread.

If we are to accept that at least some of the new drugs are an important step forward and that their use is currently inadequately funded, then it is clear that 'the system' has failed us and, sadly, failed those suffering from mental illness.

This failure cannot properly be understood without first understanding 'the system' – the NHS. An optimistic view is that the Government provides funding to local authorities or 'purchasers' who apportion funds to local services according to local needs and priorities. A cynic might say that the Government realised some years ago that the total cost of health care was much greater than that which could be raised by direct taxation (without losing elections). Rationing was therefore inevitable, so this task was devolved to local authorities, in the process distancing central Government from any unpopular decisions or actions. The purchasers, given insufficient funds to meet all local needs, then apportion funding to different services as best they can. These handouts are given, it is said, partly according to the quality of evidence supporting bids for funding (clinical efficacy, toxicity, cost-effectiveness, etc.). In reality, political considerations may be more important – purchasers may feel compelled to fund, for example, treatments for childhood cancer or HIV simply because not to fund them would cause a public furore.

Where does this leave psychiatry and the use of new drugs? Most would agree that psychiatry has been under-funded for decades. Traditional

drugs are cheap by any standards; no more than £10/patient/month in most cases, so the prices of some of the newer drugs comes as a culture-shock to both prescribers and purchasers. As well as this, there is little pressure for change because my observation is that at least some mental health charities are so against drug therapy *per se* that they appear not to recognise the advantages of the new agents and so do little or nothing to promote them. But, perhaps most importantly, there seems to me to be no public demand for new, more effective and safer treatments. I feel this is particularly true in schizophrenia, where the tabloid-led public demand for sufferers to be kept away from the public seems to be greater than their demand for sufferers to be better treated.

Health authorities' apparent reluctance to provide funding for new psychotherapeutic drugs is therefore not surprising. They certainly have much more pressing and politically-sensitive demands to meet. Nevertheless, it is difficult not to feel sympathy for purchasers who essentially now have the burden of resolving the universal problems of spiralling health care costs and demands coupled with inadequate funding. Any approaches to purchasers must therefore take account of their difficulties, priorities and sensitivities. Few, if any, health authorities would respond positively to demands for funding based on personal clinical experience alone. Requests for funding supported by research published in reputable journals are more likely to kick-start purposeful dialogue, but only if these requests are made through the correct channels. (Many authorities now only consider these funding requests as service developments and not, as they have so far been, cost pressures.) Sadly, few purchasers are in a position to fund the use of new drugs simply because they are more effective and less toxic than older, cheaper drugs. Robust pharmacoeconomic studies are now needed, especially ones which have direct reference to the local area (Taylor, 1997). But even these may not be enough – paper cost savings shown in research studies may not appear in practice. For example, clozapine very probably reduces greatly time spent in hospital and so is, in theory, cost-effective. However, this assumes that a hospital

bed vacated by a patient on clozapine remains empty, unstaffed and unheated, so-to-speak. In reality, the bed is used and the queue for beds is one person shorter. Costs actually grow through increased activity and these are the costs which should, in an ideal world, be met by health authorities. They are rarely met in the real world.

There is no obvious or immediate solution. When there is not enough money to go around some services will inevitably be under-funded. It is unfortunate to say the least that psychiatry remains under-funded, and it may be that any worthwhile, positive change can only be brought about by lobbying central Government. Entreaties to the pharmaceutical industry to reduce prices may also bear fruit. The price of a product is set to recoup research costs and to make profit, but there is no altruistic sentiment: the initial price is based largely on what the market will bear. (Ironically, torpid health authorities may thus inadvertently reduce drug prices by denying funding.)

The restriction on the use of new drugs in psychiatry is, some might say, nothing but a scandal; a scandal which, for once, has gone virtually unreported. This unacceptable situation clearly needs to be reported and to be acted upon. Health authorities need to be coerced into taking greater account of clinical need and paying less heed to public demand. Central Government needs to be made aware of the consequences of underfunding on those with serious mental illness. Surely it is our responsibility to make sure patients receive the best available therapies. Surely, then it is we who need to make sure that the system works fairly for those with mental illness.

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