HEALTH AND SPORT COMMITTEE

THE SUPPLY AND DEMAND FOR MEDICINES

SUBMISSION FROM Henry Robb

Three bullet points

• Drugs are not a panacea
• Drug funding should compete with all other therapies including alternative therapies (weight loss, exercise regimens etc) as well as increased staff numbers, equipment (of all types) and so on.
• A single national electronic drug management system should be introduced that is clinically effective and that allows detailed audit of drug use

1. No – we are heavily focused on “drugs” and surgery as a panacea. Personal responsibility is critical but the NHS does not walk the walk, simply talks the talk through leaflets, adverts and so on – from the government down. Pharmacy budgets should support alternative (more effective therapies) for many including gym membership, community halls and meeting places etc These all need fully assessed but are likely to be cheaper and more effective especially over the longer term.

2. No

3. Politicians should follow the principals of realistic medicine and appropriate national medical guidance (Scotland and UK - where appropriate) on expensive drugs rather than creating “funds” to ensure new and often poorly tested drugs are offered to vulnerable patients. “Big Pharma” should be banned from supporting patient and other groups (as doctors, quite rightly, have already been banned from receiving “gifts” from Big Pharma).

4. Follow medical guidance and the principals of realistic medicine: focusing on ‘good enough’ re medicine classes. NHS Scotland should fund trials (where necessary) for comparative assessment and empower themselves to offer licences for drugs for use in other areas (consider avastin vs lucentis)

• A single effective electronic prescribing system should be funded and implemented across Primary and Secondary Care as a matter of urgency. The system must be clinically functional and effective (unlike TrakCare which requires “front-ends”). The system should also allow audit at multiple levels across the Scottish NHS but the focus must be primarily on clinical effectiveness/use. The system should be a “teaching requirement” for graduation (as should other systems in common use e.g. PACS). Without this the Sports Committee, the NHS, Prescribers etc will remain in the dark re the reality of prescribing. Why is the NHS in the IT stone age?
• Single processes for common conditions/ situations/ should be introduced and mandated to ensure effective medication is given. Where a group of senior doctors (and there are many different Board guidelines across Scotland for single
conditions despite the fact that Scotland’s population is the size of a single SHA in England. An example would be cardiology conditions where we have failed to agree on a single national pharmacological treatment regimen for many conditions. If the benefits or A vs B is clearly marginal – impose the cheaper option and stop these inane discussions/variance. Variance is harmful and trainees moving from A to B are expected to immediately change taught practice. Why do “we” allow this? In essence Doctors should be required to justify the use of expensive drugs where cheaper alternatives are available.

- Drugs should have to compete with ALL other therapies e.g. physiotherapy, weight loss, gym membership etc and if not proven more effective, not used as frontline treatments. All other therapies including monitoring equipment, point of car testing etc. “New” anything monies should be in a single box (staff, equipment, drugs, alternative therapies – gym, weight loss etc) and those proven most effective funded nationally.
- Stop using surrogate measures unless the measure is clearly linked to an outcome (blood pressure is a reasonable test re strokes etc but many other surrogates are not as clearly linked). Patient experience/ well being/ self esteem etc are all important and should be measured during drug trials and over the longer term – medication for blood pressure works however exercise and weight loss are more effective. It may be appropriate to treat hypertension initially but failing to support lifestyle change is even more costly: do both and the long term treatment of hypertension may not be necessary. Beta blockers (a class of drug) are associated with unwanted side-effects: if weight loss, exercise had been prioritised perhaps these would not be “required” and the patient’s well being better maintained e.g. improved sexual function, activity and son on.
- Cancer waiting times are critical – although we need to ensure that we do not waste resources on the “worried well”. We should stop focusing waiting times per se. I appreciate waiting times in the NHS is bigger than surgical procedures but there is a huge focus on this. For example, many would benefit more from weight loss than surgery. Discretionary spend should look system wide re benefit.
- Environmental improvement would likely benefit many – why are we not focusing on developing public transport (in poorer areas first) and gradually pricing cars out of our transport system: reduce pollution = reduced respiratory conditions: better environment = better health. Start where the help is needed in the poor parts of society
- It is not just medicine. This needs a focus on prevention, not cure.