

*The Consumer Movement,  
Health,  
and the Pharmaceutical Industry*

The sixth in a series of  
Office of Health Economics monographs  
dealing with aspects of the  
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## Office of Health Economics

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# Introduction

In his *Inquiry into the Nature and Causes of the Wealth of Nations*, which was first published in 1776, Adam Smith placed special emphasis on the assertion that the ultimate purpose of producing any good (or service) is to meet the needs of its consumers. The economists of Western Europe and North America who have built on such thinking over the past two centuries have developed it into what is often referred to as the theory of consumer sovereignty. This claims that economic prosperity may be most efficiently pursued within societies which permit consumers maximum freedom to spend their money as they choose and which allow producers an equivalent freedom to compete to meet the market's demands.

The suggested advantages of this type of social system are two-fold. First, where free competition is working in a fair, or 'perfect', manner, resources will be allocated to those areas where expressed needs are greatest. Second, because free markets give individual citizens discretion in their consumption they prevent excessive power building up in the hands of political leaders and other elite groups. Thus all freedoms are protected.

However, in practice 'perfect' competition is rarely achievable. Smith himself, for instance, stressed (in some respects questionably) the need to stop producers gaining monopolistic positions and so resisting change and charging excessive prices. He was also aware of the difficulties facing consumers trying to get objective information about even the eighteenth-century market place. In the complex conditions of the twentieth century many commentators are doubtful about consumers' abilities to make rational purchasing decisions even when the facts about products and services are fully available.

In view of these and other difficulties it is now widely accepted that sophisticated economies have in many instances to be regulated by the state, or by voluntary or semi-official bodies, to ensure that they run relatively effectively. Health is an obvious example of an area where few would deny the value of extensive legal and financial interventions designed to protect those in need of care and support from the hazards of an untrammelled market. Yet at the same time a strong case can still be made to the effect that wherever possible direct consumer sovereignty should be encouraged to act as a powerful, if not the only, guiding force in the community.

The relatively recent emergence in the countries of North America and Europe of organised groups which aim both to distribute unbiased information about products and services and to represent consumer interests in the political arena is one mechanism by which consumer sovereignty may be supported in the markets of the late twentieth century. The evolution of the consumer movement may consequently be thought to be a natural adaptation based firmly on the underlying traditions of the free world democracies. Some 'consumerists' may, of course, over-estimate the limitations of the market place and are unduly critical or even hostile towards industry. Yet the goal of the majority is constructively to enhance the working of Western society.

This fact is unfortunately not always appreciated by members of the industrial community, who may particularly resent consumer groups which work in an organised manner to alter the structure and 'ground rules' of the market place. Manifestations of such feeling may even include suggestions that 'consumerism' and 'communism'

## **BOX I Industry's reactions to the consumer movement**

Esther Peterson held positions as a union lobbyist, as an Assistant US Secretary of Labour, as President Johnson's special assistant for consumer affairs and as head of the President's Committee on Consumer Interests. She then joined Giant Foods Inc., as Consumer Advisor to its president. As a respected figure in both the consumer movement and the commercial world her views are worthy of special attention. The text below is based on an essay she wrote in 1974; it describes business reaction to consumer pressure as a five step progression.

Step I When a consumer group makes a charge it is categorically denied. Even when there is evidence against a company or industry the initial philosophical and emotional barriers to accepting the charge are too great for those responsible to overcome them.

Step II Attempts are made to discredit those making the charge. As most people in business do not doubt their own sincerity, they question the motives of those criticising them.

Step III If the consumers are making a credible charge, pressure for legal reform may emerge. Business opposes this, and does not see that genuine voluntary reform is the best course.

Step IV If law(s) are passed or are near to passing, business attempts to 'defang' them by various strategies. In the US one may be to get an opponent of the law(s) to administer them.

Step V Business works to resolve the original problem. The learning process involved in the above steps has gone on long enough for initial psychic defences to have been broken down and for values to change. Business leaders realise that in Western society industrial survival ultimately hinges on meeting consumer needs and expectations. Responsible consumer leaders are given a fair hearing, and constructive action is taken.

The above model may appear too simplistic to some commentators. Others may deny its validity completely. But on balance it appears to provide a useful introductory insight into the evolutionary cycles which characterise the relationship between organised consumer groups and all free-enterprise industries.

Sources: Peterson 1974, Adamson 1982.

are more or less synonymous. And more generally, Jeremy Mitchell, a former director of Consumer Affairs at the Office of Fair Trading and currently the Director of the National Consumer Council, has noted that business is 'almost always negative, rarely positive' in relation to the consumer movement (Mitchell 1976 – see also Box I). He urges industry and industry funded organisations to enter into a more constructive dialogue with consumers about matters of common interest.

This is the goal of the Office of Health Economics in producing this paper. It offers first a general review of the development and structure of the British and European consumer movements, which is supplemented by the data contained in the appendix. It then focuses more precisely on health care and medicine provision. The analysis provided highlights the special nature of pharmaceuticals as consumer goods and the difficulties inherent in attempting to create consumer sovereignty in the health sector.

The concluding section examines the particular responsibilities of and difficulties faced by the pharmaceutical industry in communicating with the public. It emphasises that, in the final analysis, there is an element of self-care involved in virtually all interactions between sick individuals and health care providers. It also argues that consumer power can play its most valuable and responsible role in circumstances where people have some insight into their condition and the care options open, and where they themselves actively participate in the processes of prevention, diagnosis and treatment. Thus although the diffusion throughout the population of information about topics like the proper use of medicines is a slow and problematic process there is a sound reason for all those involved in the health sector, including medicine makers, to participate in efforts aimed at overcoming the barriers to communication and effective health education.

# The development of the consumer movement

Laws designed to protect consumers from undesirable trading practices such as giving 'short measure' have existed throughout the world for many centuries. In Britain, for instance, statutory controls on the quality and quantities of ale sold in public houses date back to the early middle ages; whilst the 1677 Statute of Frauds is taken by some academic researchers to mark the start of the evolution of today's comprehensive array of legal regulations affecting the general market place.

The development of the latter was particularly rapid in the last half of the nineteenth century. This was in part because the country was adjusting to the impact of industrialisation and the shift of population out of old-established rural communities into the new, relatively anonymous urban areas. Not only did these changes destroy previously satisfactory informal purchasing arrangements and create a plethora of new, unfamiliar goods and choices. They may also have broken down old patterns of unquestioning acceptance and created new expectations. The Food and Drugs Act of 1860; the Weights and Measures Act 1878; the Merchandise Marks Act 1887; the Sale of Goods Act 1893; all were attempts to draw together or extend common law rights in such a way as to make them comprehensible in and relevant to the challenging conditions of Victorian society.

One celebrated case which may be taken to illustrate the process of changing standards related to an advertisement issued by the Carbolic Smoke Ball Company. It contracted to pay £100 to anyone who caught influenza whilst using the company's 'prophylactic' medication in the right manner and for at least a fortnight. A Mrs Cahill succumbed to the disease in just such circumstances and in 1893 sued successfully when the company failed to honour its offer. Other examples exist in the context of the regulation of the insurance industry, which was rapidly expanding at the end of the nineteenth century. Controls then implemented may in retrospect be seen to be the heralds of a degree of state involvement in the overall market place which few British commentators would then have believed desirable or compatible with a 'free' society.

But it is in the United States that perhaps the most significant roots of the modern consumer movement lie. Pioneering legislation there included the 1890 Sherman Act (the original anti-trust law) and the formation in 1914 of the Federal Trade Commission, which subsequently played a major role in maintaining fair competition. And on the consumer side some Americans, even before the Sherman Act, had shown themselves prepared to use their economic influence for social ends through, for instance, boycotting 'sweat shop' employers.

In 1928 Consumer Research Incorporated, the progenitor of today's consumer research organisations, was formed with the goal of providing people with comparative information about various types of goods on the market. However, the economic environment of the early 1930s was a difficult one, and the organisation itself suffered from internal disputes. It split in 1936, after some staff members had attempted to form a trade union. The latter formed a new organisation, called the Consumers Union (CU). Through its magazine *Consumer Reports* it began disseminating information to the public, and rapidly became dominant in the field. The CU's early work pioneered comparative testing techniques, although in

the late 1930s it was subjected to the charge of being a 'communist plot'.

In fact its appeal was, as the CU staff realised with regret, largely confined to an élite of better off, better educated consumers. Despite early attempts at a popular approach, CU's membership was only 150,000 in 1946. But with post-war prosperity it grew to nearly 900,000 in 1960. Today, with a membership of some 2,000,000, CU is by far the world's largest independent consumer organisation.

In 1962 President Kennedy made a formal statement encouraging consumers to seek rights of safety, redress, information and self-expression. This in some respects may be seen as an acknowledgement of the President's awareness that the time was right for a 'second wave' of consumer legislation and activity in the United States, as indeed proved also to be the case in Britain and some of the richer European nations. But a unique phase of North American consumerism began in 1965 with the publication of Ralph Nader's *Unsafe at any Speed*.

This assault on the motor industry giant General Motors shifted us consumer representation into a higher gear. Nader's<sup>1</sup> brand of entrepreneurialism, charismatic leadership and particularly vigorous attack on large transnational corporations which he sees as threatening public interests in part helps to account for the distinct flavour which North American consumer affairs acquired in the 1970s.

Another factor underlying the divergence of the US from the British and European consumer movements in the last decade or so has been the special role which the courts play in the former society as mechanisms for channelling compensatory payments to people who have been victims of misfortune. European countries, with longer traditions of direct state involvement in care and welfare provision, tend to have followed a different path. However, it is possible that European legislation in areas like product liability coupled with the common experience of consolidation rather than growth currently shared by consumer movements both here and in America will lead to some reconvergence during the 1980s.

## British experience – the 1940s to the 1980s

Although the British economy enjoyed some significant growth in the late 1930s a consumer movement analogous to that which had started to emerge in the United States did not appear in the pre-war period. As in other developed countries British consumerism did not genuinely 'take-off' until the mid 1950s. However, there were before then some significant, seminal moves.

In the late 1940s the then Labour government attempted to 'mobilise the country for peace'. As part of this effort Sir Stafford Cripps, on being moved from the Presidency of the Board of Trade to the Treasury, decided to fund a unit intended to educate the population about the realities of Britain's economic position. The Chancellor was particularly anxious to create awareness of the nation's need to export and build up a favourable balance of trade (Roberts 1981), against a background in which it

1 Nader was a CU board member for a short period. The development of consumerism into its late 1960s/1970s form was essentially an evolution rather than a radical revolution, based to a considerable degree on the groundwork done by CU. In the health sphere Nader helped to form the Health Research Group, which under Dr Sidney Wolfe is one of the United States' more active consumer bodies.

was feared that war-time controls may have undermined the discriminatory powers of British purchasers.

Feed-back from this unit's contacts with bodies like branches of the Women's Institute supported the belief that war-time experience had indeed reduced the quality and critical edge of consumer judgement in Britain. This, it was thought, might well reduce the efficiency of the home market as a mechanism through which incentives for product improvement could be generated. Hence, in the long term, Britain's capability as a successful exporter might be threatened.

The stage was thus set for the growth of a consumer movement which would receive government blessing. Indeed, the 1945-50 Labour administration had already made some moves towards creating such a movement through the establishment of Nationalised Industry Consultative and Consumer Councils in fields like coal, gas and transport. Yet arguably these had little effective power and did not provide a substantive answer to Conservative Party fears that nationalisation would undermine consumer sovereignty.

In 1950 Michael Young (then secretary of the Labour Party Policy Committee) was instrumental in ensuring that a proposal for a government 'Consumer Advisory Service' was included in the Party's general election manifesto. Some commentators may suggest that this step in part reflected Labour's concern to try and focus critical attention on the working of the private sector rather than the public one. But it is possible that had Young's proposal been implemented in the early 1950s Britain would have developed a consumer information and protection system more like those of Norway and Sweden. There the Forbrukerraadet (Norwegian Consumer Council) and the Konsumentverket (Swedish National Board for Consumer Policies) are largely state funded.<sup>2</sup> However, a Conservative government was elected.

With the economic expansion of the early and mid 1950s (which resulted both in increased purchasing power and an increased range of goods entering the market place) demand for improved consumer information began to grow. At the same time in the health sector Britain's charities were adjusting to the formation of the NHS. A number of key organisations, such as the Spastics Society and the Royal Society of Mentally Handicapped Children and Adults, emerged during this period. These and bodies like them have played an important role in representing the interests of particular groups of health service users.

Increasing wealth meant that society was more able to support financially agencies which work to meet the needs of consumers for knowledge and legal protection. In 1957 two organisations, acting independently, began to operate consumer information services.

One was the British Standards Institution (the BSI), which had become more closely involved in testing and setting standards for a wide range of products during the 1940s, following an initiative by the Retail Trading Standards Association. In 1951 the BSI (with Board of Trade encouragement) established its Women's Advisory Committee to advise its executive board on consumer

affairs. In 1955 the BSI Consumer Advisory Council was formed, and in 1957 BSI began publishing *Shoppers' Guide*, Britain's first comparative testing magazine. Its editor was Elizabeth Gundry, a former *News Chronicle* journalist who had originally proposed the concept.

The second channel by which well researched information about consumer goods became available to the British general public was initially created by an American, Dorothy Goodman. On finding when she came to Britain that no equivalent to the US Consumers Union's *Consumer Reports* was available she, in 1956, formed a group intended to provide such a service. In 1957, the Consumers' Association (CA) was officially formed, and soon after *Which?* entered the market.

Eirlys Roberts became editor. She had worked in Cripps' Treasury unit in the 1940s and had been responsible, with Marghanita Laski, for some important articles on consumer topics in the mid 1950s. When Goodman returned to the United States Michael Young took over the chairmanship of the CA. He became its first honorary President in 1965.

The Conservative government responded to these events by, in 1959, establishing the Molony Committee on Consumer Protection. The latter reported in 1962. The next year the Consumer Council (1963-71) was formed, with Elizabeth Ackroyd (until then a senior civil servant) as its director. The Council's intended role was to inform itself about consumers' problems and interests, to promote action to deal with those problems and to further such interests, and to provide general guidance and advice. The CC encouraged manufacturers and retailers voluntarily to improve standards and services. Although the next Conservative government seven years later disbanded the Consumer Council, largely because of a desire for cost savings and the belief that its work overlapped with that of other independent agencies, its establishment may conveniently be seen as the point in history where Britain's current consumer movement 'came of age'. As Tables I and II show, the two decades which have followed have been ones of intense activity in the consumer affairs and consumer legislation fields.

Regarding the formation of today's main consumer institutions there were three important events in the early 1970s. The first was, following the Trade Descriptions Act and local government reorganisation, the establishment in their current format of the local authority Consumer Protection/Trading Standards Departments (formerly the Weights and Measures Inspectorates). These now have responsibility for enforcing a number of consumer laws and also run most of the remaining Consumer Advice Centres, which were initially introduced about a decade ago.

The second was the establishment in 1973 by Sir Geoffrey Howe, then the pioneer Minister of Consumer Affairs, of the Office of Fair Trading (OFT). And the third was the setting up in 1975 of the National Consumer Councils (NCC). The Minister responsible at that time was Shirley Williams, as Secretary of State for Prices and Consumer Protection. Figure 1 outlines the relationships between these bodies and other key institutions in the British consumer movement.

**European and international consumer organisations.** Perhaps the most important transnational body involved

<sup>2</sup> The 'Nordic' model of consumer protection also involves tiered systems of redress, including complaints boards, ombudsmen and market courts (*Business International* 1980).



**Table 1** *Main events in the development of the British consumer movement 1938–82*

<i>Year(s)</i>	<i>Event</i>	<i>Year(s)</i>	<i>Event</i>
1939–45	The Citizen's Advice Bureaux (CABs) service first established in 1939. The British Standards Institution (BSI) becomes closely involved in defining basic utility standards for a wide range of products.	1968	The Medicines Act enables the establishment of the Medicines Commission at the start of the 1970s.
1946	Domestic Coal Consumer's Council (DCCC) established.	1969	The Post Office Users National Council (POUNC) is formed. In Kentish Town CA establishes the first Consumer Advice Centre (CAC) in the UK.
1947	Central Transport Consultative Council (renamed the National Transport Consumers Council in 1978) formed. Regional Transport Users Consultative Councils (TUCCS) provided for in the same Act.	1970	The Consumer Council is abolished. The Institute for Consumer Ergonomics at Loughborough is founded by CA.
1948	Electricity and Gas Consumers/Consultative Councils set up. In the same year Heathrow Consultative Committee has its first meeting. Subsequently, in 1965, the British Airports Authority was required to establish consultation facilities at all its sites.	1971	Social Audit Ltd and the Public Interest Research Centre (PIRC) come into being.
1951	BSI forms its Women's Advisory Committee.	1972	Local government reorganisation promotes the development of Trading Standards/Consumer Protection Departments. The first LA funded CAC is opened. Sir Geoffrey Howe is appointed first Minister for Trade and Consumer Affairs.
1956	The Consumers' Association (CA) is established.	1973	The Fair Trading Act leads to the formation of the Office of Fair Trading and the associated Consumer Protection Advisory Committee (CPAC). The Price Commission was also set up under counter inflation legislation. A new Airline Users Committee was formed. In Europe BEUC establishes a permanent office in Brussels with Eirlys Roberts as chief executive. The Consumers Consultative Committee (CCC) is formed.
1957	<i>Shoppers' Guide</i> (BSI) and <i>Which?</i> (CA) commence publication. The original Pharmaceutical Price Regulation Scheme is first implemented.	1974	The short lived Department of Prices and Consumer Protection (DPCP) is created. NHS reorganisation leads to the formation of Community Health Councils (CHCs) and allied bodies.
1958	ABPI establishes its Code of Practice Committee to regulate prescription medicine advertising.	1975	Shirley Williams, then Secretary of State for Prices and Consumer Protection, sets up the National Consumer Council (NCC). Similar bodies are formed in Scotland, Wales and Northern Ireland.
1959	Molony Committee on Consumer Protection begins its enquiries.	1978	The Consumers in the European Community Group (CECG) is created, formalising a loose association of UK bodies established in 1972.
1960	IOCU, the International Organisation of Consumers Unions, formed by CA, the American CU and the independent consumer bodies of Belgium, Netherlands and Australia.	1979	DPCP is disbanded, together with the Price Commission. Mrs Sally Oppenheim is made Minister of State at the Department of Trade with responsibility for consumer affairs.
1962	The first British edition of the Medical Letter is produced – leading to the CA's <i>Drug and Therapeutics Bulletin</i> . The Advertising Association establishes the Advertising Standards Authority Ltd. In Europe the Bureau European des Unions des Consommateurs (BEUC) is formed.	1981	An initiative led by IOCU results in the formation of Health Action International (HAI). Dr Gerard Vaughan moves from the DHSS to become Minister of State for Consumer Affairs.
1963	In response to the Molony Committee's report the Consumer Council is established. So to are the National Federation of Consumer Groups, the Research Institute for Consumer Affairs and the Patients Association.		
1967	The Sainsbury Commission on the supply of medicines to the NHS reports. It leads to a strengthening of the PPRS.		

in the consumer movement is the International Organisation of Consumer Unions. This is an independently financed body, founded in 1960 by the Consumers Union, the Consumers' Association, the Australian Consumers Association, the Consumentenbond (Netherlands) and the Association des Consommateurs (Belgium). It now has over 125 members (some 40 of which are full subscribers) and has played a valuable role in helping to foster consumer movements in the third world. Recently, it has provided organisational support for the formation and running of Health Action International, an informal grouping of bodies which has focused its attention on the topic of medicine use in poor nations. (See the appendix).

Less well known, but nevertheless significant, international initiatives in this field include the Scandinavian governments' Nordic Committee of Senior Officials on Consumer Affairs and the OECD's Committee on Consumer Policy. The latter organisation, established in 1969, in part acts as an international information exchange about dangerous products. The Council of Europe has also taken an interest in certain consumer areas like, for instance, legislation on product liability.

In the specific context of the European Economic Community the timing of the consumer movement's emergence has roughly corresponded with that of events in

Britain, though the precise structural characteristics vary between nations. In France, for example, the independent Union Federale des Consommateurs (UFC) was formed in 1951 and the state funded Institut National de la Consommation (INC) in 1968. Yet there are also a number of large trade union backed groups, one of which, the Organisation Generale des Consommateurs (ORGECO), provides (together with UFC) French representation at the EEC level – see below. Germany's Arbeitsgemeinschaft der Verbraucher (AgV) was formed in 1953 and the comparative testing organisation Stiftung Warentest in 1967. Both receive government support.

Holland, Belgium and Denmark also have strong consumer bodies and legal consumer protection systems. Countries like Ireland, Italy, Greece (and Spain) are developing consumer laws, but are generally less advanced. However, all the EEC nations have some form of representation within the independent Bureau European des Unions des Consommateurs (BEUC). This defends the interests of the consumer organisations in Brussels.

The Community's official involvement in this field stems back to 1962, when a Consumer Contact Committee was first established. By the late 1960s the Competition Directorate had within it a small consumer affairs unit, which in the Spring of 1973 became, in a slightly modified

**Table 2** *Recent UK consumer protection legislation – a selective summary***Foods and Drugs Act 1955**

The first legislation in this area was in 1860. The comprehensive 1955 Act was intended to ensure that food offered for sale for human consumption is clean and wholesome, and that descriptions are accurate. Subsequent regulations based on the Act have extending controls on advertising and labelling

**Consumer Protection Act 1961**

Enabled the formation of regulations aimed at ensuring the safety of particular classes of goods. Now largely replaced by the Consumer Safety Act – see below.

**Weights and Measures Act 1963**

Consolidated legislation enacted over the course of a century. It made it a criminal offence to give inaccurate measures/ weights, and laid down a wide range of detailed requirements about how goods should be sold. See also the 1979 Act below.

**Trades Descriptions Act 1968 (and 1972)**

Prohibits the misdescription of goods, services, accommodation and facilities provided in the course of trade and requires clear and accurate pricing. The 1972 Act required foreign goods to be conspicuously so identified.

**The Medicines Act 1968**

This brought together much past legislation on medicines, including the Pharmacy and Medicines Act, the Pharmacy and Poisons Act and the Therapeutic Substances Act. It created three types of medicines, those available only on prescription (POMS), those obtained through a pharmacy only (ps) and those on the General Sales List. It also radically extended the state's capacity to control the development and marketing of medicines. The considerable new powers conferred on Ministers are mainly expressed via the DHSS, which (contrary to Sainsbury Report recommendations) is the licensing body which permits the trial and sale of new pharmaceuticals. The Medicines Commission, also created by the Act, serves primarily as an advisory body in its enforcement. Its subsidiary bodies include the Committee on the Review of (existing) Medicines, the Committee on Dental and Surgical Materials, the British Pharmacopoeia Commission, the Veterinary Products Committee and the Committee on the Safety of Medicines. The latter replaced the voluntary Committee on the Safety of Drugs formed in 1964, just two years after the thalidomide tragedy.

**Supply of Goods (Implied Terms) Act 1973**

voids any contract of sale of goods which releases retailers from their obligation to supply goods which are a) of merchantable quality b) which meet the description supplied and c) which are fit for the purpose implied in their sale.

*Note* The above list is not intended to be comprehensive. It excludes many Acts which may be thought relevant to consumer affairs, such as, say, the Insurance Companies Act of 1974, the Air Travel Reserve Fund

**Fair Trading Act 1973**

This led to the establishment of Office of Fair Trading (OFT – see Part II) and associated bodies like the Consumer Protection Advisory Committee. The envisaged role of the OFT was to inform and educate the public and to control or abolish harmful trade practices more quickly than previously had been possible. The Act also required OFT to administer the Consumer Credit Act, then shortly to receive assent.

**Consumer Credit Act 1974**

This gives consumers protection in credit and hire transactions. Businesses involved in such activity must be licensed and provide information about the true cost of the credit they offer.

**Unfair Contract Terms Act 1977**

Renders ineffective exclusions seeking to avoid liability for harm caused by negligence. Applies in a variety of associated cases.

**Consumer Safety Act 1978**

Extends the powers conferred on the Secretary of State for trade by the 1961 Consumer Protection Act. Regulations currently apply to products ranging from nightdresses and toys to tear gas capsules and electrical appliances. The Act also provides for the banning of unsafe goods and the issuing of warnings about those already made available.

**The Sale of Goods Act 1979**

This consolidates earlier measures, including sections of the Supply of Goods (Implied Terms) Act 1973. It ensures that buyers have a civil law right to expect that sellers have a right to sell, and that the goods they obtain are of merchantable quality, are fit for their purpose and meet their descriptions. These rights cannot be removed from the consumer.

**Weights and Measures Act 1979**

This provided for a new system of quantity control for pre-packed goods based on the concept of average contents.

**The Competition Act 1980**

Strengthened the Fair Trading Act of 1973 by providing for the investigation and control of individual (rather than general) anti-competitive practices and efficiency audits of certain public sector bodies

**Supply of Goods and Services Act 1982**

Part I of this Act, which will come into effect in January 1983, ensures that consumers who acquire title to goods by means other than purchase or hire purchase, (for example, barter) are protected by the normal implied terms of suitability, merchantability and compliance with their description. Part II provides that, unless it is agreed otherwise, consumers will be able to expect those who supply services to do so with reasonable care, in a reasonable time, and at a reasonable charge. It is questionable whether the latter actually extends existing common law protection, although it is clearly useful in making explicit such entitlements.

and the Policy Holder Protection Acts of 1975 and the Estate Agents Act of 1979. But it does give a general overview of legislative developments in the last two decades or so.

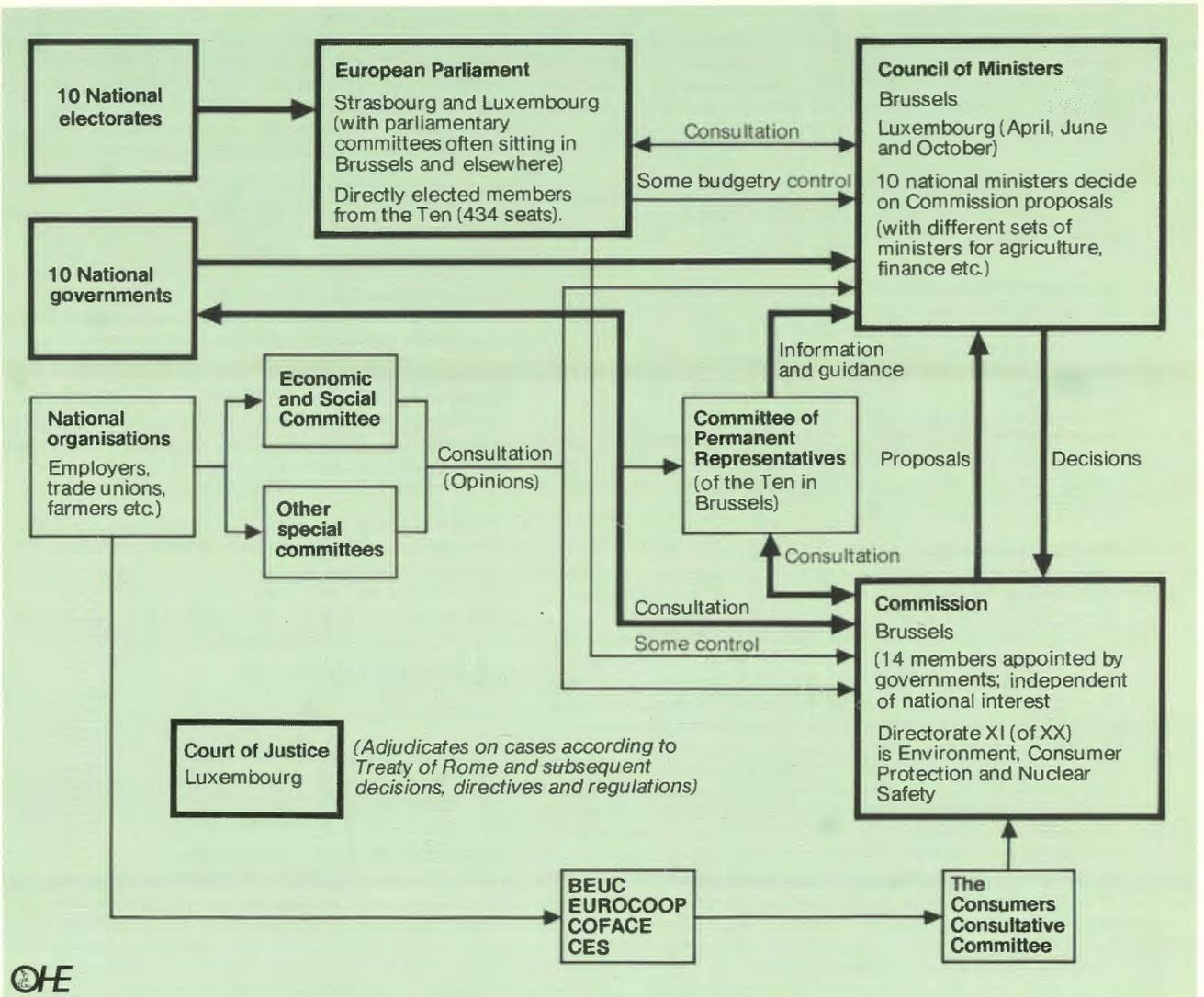
and expanded form, the EEC's Environment and Consumer Protection Service. Subsequently, in 1981, it gained Directorate status. This gradual evolution towards independence has been welcomed, not least because competition law in the EEC is sometimes seen as biased towards producer rather than consumer protection.

It was also in 1973 that the Contact Committee was replaced by a larger and more influential body, the Consumers Consultative Committee (CCC – see the appendix). Represented in this were (and are) four groups; the trade union movement, the co-operative movement, family organisations and the consumer groups belonging to BEUC. The latter was, just prior to the entry of Britain to the EEC, strengthened by inputs from the Consumers' Association which helped to establish the BEUC secretariat in Brussels, under the direction at that time of Eirlys Roberts.

In 1975 the first EEC consumer protection programme was published. Somewhat redolent on Kennedy's Charter of over a decade previously, it laid down consumer 'rights' of protection against health and safety hazards and economic exploitation. It also emphasised the need for consumer advice, redress, education, consultation and representation.

But despite the ambitious tone of this first initiative relatively little was achieved in practical terms in the period 1975–80. In 1981 a second, seemingly less assertive, programme was approved by the Council of Ministers. It may be that the economic downturn of recent years, coupled with changes in political complexion of the European Parliament and a general realisation of the difficulty of gaining an international harmony of attitudes towards topics like product liability or advertising regulation, has somewhat muted the EEC stance on consumer issues.

## 2 EEC Organisation in 1982



Source The Economist Diary 1983.

Innovation is much more easily initiated at the level of individual nations.

However, this is not to say that the consumer voice as expressed through organisations like BEUC has failed to influence the EEC at various points in the complex structure outlined in Figure 2. Nor should it be assumed that the European consumer movement will ignore the lessons of the 1970s. Rather, the more realistic expectations these are likely to generate may enable it to be more effective in the coming decade.

# Achievements, limitations and prospects of the UK consumer movement

The prosperous years of the 1960s and the early 1970s saw many initiatives designed to improve the quality of life for the citizens of all the major Western economies. In Britain, for instance, the passing of the 1970 Chronically Sick and Disabled Persons Act triggered many measures intended to improve the support available to physically impaired members of the population. The 1974 Health and Safety at Work Act reflected new concerns regarding the wellbeing of workers. And legislation on sexual and racial discrimination is a third area in which citizen's legal rights were extended.

To an extent, therefore, the introduction of the 'consumer laws' outlined in Table 2 may be seen as part of a broader social shift generated by a variety of complex forces. Yet few commentators would deny that the consumer movement played a significant part in this process, and that it was instrumental in shaping and promoting many of the legal protections now on the statute book.

In addition there can be little question that the type of information supplied by the Consumers' Association has been of value to those able to employ it during the course of their purchasing decisions. Even just the background presence of comparative testing and allied bodies in the market place has probably caused manufacturers of goods to revise standards in order to avoid criticism. And it has probably increased manufacturers' readiness to participate voluntarily in various measures aimed at reform.

The latter include the OFT's efforts to encourage industries through Trade Associations to develop comprehensive, self-regulated codes of conduct. Such measures were in the context of promotion pioneered by bodies like the Association of the British Pharmaceutical Industry in the 1950s. Here self-regulation against a critical background has unquestionably been effective. Regarding the OFT inspired codes of practice there has been criticism of their value from the Consumers' Association (CA 1981) but it would nevertheless seem foolhardy to deny that they have brought some significant benefits (see Adamson 1982).

Finally the Consumer Advice Centres, Citizen's Advice Bureaux and local authority Trading Standards and Consumer Protection Departments handle over a half a million complaints a year, according to OFT statistics. Added to this (minimum) estimate should be the 70,000 plus complaints/enquiries made to NICCS, and the many other consumer contacts made by independent advisory agencies and, of course, the media. Programmes like *Checkpoint* and *That's Life* have helped to augment the wide network of systems which in the UK can assist individual consumers to find redress when they have been unfairly treated.

All this amounts to a very considerable record of achievement by the consumer movement. But even so there are commentators who are critical of some of its basic tenets and assumptions; and there are others who believe that its useful role is virtually completed.

The latter point out that consumerism seems to be less fashionable than it was. In recent years, for example, the membership of the Consumer' Association has fallen from a 1975 peak of 715,000 to around 650,000 whilst local authorities have failed to maintain the funding of many Consumer Advice Centres. It can be argued that virtually all the legislation needed to give the public reasonable protection and powers of redress against the producers of goods or providers of credit and insurance is now in

place. Those taking this line argue that the swing from 'buyer beware' (*caveat emptor*) to 'seller beware' (*caveat venditor*) has gone far enough, and that the recession in Europe and the United States could send 'consumerism' into a permanent decline.

However, a detailed examination casts considerable doubt on this view. It would seem quite wrong, for example, to suggest that the more active sections of the public have abandoned their concerns about the legal protection of consumers, product hazards and the behaviour of powerful, and in particular international, companies. In Britain recent debate has surrounded topics like garage servicing, home improvement standards, shop opening hours and the recommendations of the Cork Report on the law relating to insolvency. In Europe, as a whole, issues like the use of hormones and antibiotics in animal husbandry and the pricing of motor vehicles are centres of current controversy; whilst worldwide the supply of medicines to poor populations is a matter of considerable interest.

With regard to British experience it may also be pointed out that although CACs have lost government support, the CABs have received almost £1 million additional funding. The underlying reason for this policy shift appears to be based on considerations of economic efficiency, not a desire to withdraw consumer services. Also, the passing of the 1982 Supply of Goods and Services Act (which was strongly supported by the NCC and CA) will not signal an end to the desire for fresh legislation. In the service context, recent developments in fact offer the consumer little extra protection, and still leave service suppliers free to contract out of what might appear basic obligations. A further strengthening of 'rights' is already being advocated and the Law Commission is actively investigating the service area and the concept of merchantability.

A balanced view of the area would thus seem to be that current downturns in consumerist activity are not the result of a fundamental loss of public interest or scope for intervention. Rather, perhaps, any lull should be seen as a period of consolidation, preparatory to a fresh wave of campaigning. A key task for the observer who believes this scenario to be accurate is to identify goals of the coming 'new wave', and perhaps also to determine those areas of principle or ideology in which new or corrected thinking might be needed within the consumer movement.

## Questioning assumptions

Some commentators have suggested that certain of the ideas underlying consumerist policies are confused and or contradictory. Fulop (1977) has argued that the consumer movement has suffered from growing in too uncritical an environment, a situation which she attempted to remedy in a study published by the Advertising Association.

Briefly, Fulop claimed to identify five basic assumptions often made by consumer bodies:

That 'confusion' (ie, complexity) in the market place always affects consumers badly, and that therefore wherever possible the selection of products and choices facing consumers should be minimised and simplified.

That consumers have uniform needs and preferences.

That advertising undermines consumer sovereignty through enabling producers to manage peoples' wants.

That price rather than quality should be the key consideration in product choice.

That consumer bodies are representative of consumers.

Consumer leaders have strongly rejected Fulop's analysis, arguing that their true objective is to help markets to function better and so allow individuals greater freedom of choice. (Mitchell 1982, Grosse 1982). The CA's shift away from declaring certain products best buys in *Which?* may be taken as evidence of an increased awareness that people with different income levels, living in different circumstances, are likely to display different preferences for goods and services.

However, against this it may be noted that no criticism of a movement as plural and diverse as consumerism, whose members range from old-established and well-funded organisations such as the Women's Institute to new, small, pressure groups, can be universally true. There is, a disinterested observer might well feel, a degree of credibility in Fulop's general remarks; and to that extent consumerism may actually represent a threat to the efficient working of the market place.

Those in the consumer movement wishing to deny this conclusion may be forced to accept the alternative that they have failed to communicate the message that consumerism has a constructive, perhaps vital, role to play in the market, not just to business, but also to many politicians and much of the general public. The sub-sections below discuss some other suggested limitations of and prospects for the British consumer movement prior to a more detailed analysis of consumerism in the context of health care and medicine usage. The background they provide emphasises that many of the concerns and problems sometimes thought specific to the latter area are mirrored throughout the consumer affairs sphere.

### Which consumer – who is represented?

Amongst industrialists a commonly expressed criticism of the consumer movement is that it is unrepresentative of the mass of the population. There is a considerable body of research which tends to indicate that typical members of mainstream consumer groups such as the Consumers' Association are better educated and better off than most people (see, for instance, Thorelli *et al* 1975). And the ideas and the ideals of the staff and leadership of smaller, more 'radical' consumer organisations are unlikely to represent the views of the average member of the community.

To some extent this is inevitable and acceptable. 'Activists' are by definition unusual people. Without the leadership of strong, self-confident individuals it is difficult to see how any sort of reform can take place. Businessmen who are hostile to the allegedly atypical anti-commerce, anti-market bias of certain consumerists might well do well to reflect on the fact that a major survey by the Marketing Science Institute (1977) indicated that those likely to deviate most from mean public opinion on a wide range of consumer related topics are the leaders of industry.<sup>3</sup>

However, there may be a danger that general public interests are not reflected in consumer campaigns in areas where the different social classes show marked variations in taste and/or belief. For example, at a fairly trivial level there may be conflicts as to the entertainment and informational material which the mass media should present. More seriously, trade unionists may feel that the

policies urged by bodies like the CA may sometimes have ignored the economic interests of less advantaged people employed in hard-pressed industries like, say, textiles.

### Economics and consumerism

In addition to the points noted above, Fulop's 1977 paper accused sections of the consumer movement of having too limited a grasp of basic economics. Other critics have suggested that the policies of bodies like CA are sometimes excessively one-sided in that they do not emphasise enough that producers and consumers share many common interests and that most individuals play both roles in society. And the Confederation of British Industry has claimed (on the basis of an unpublished and not entirely convincing EIU survey) that the costs of consumer legislation are verging on the excessive.

It is of note in this last context that recent work published by OHE showed that the cost of the Medicines Act alone to the British Pharmaceutical Industry, and so ultimately to the consumer, is in the order of £30–80 million annually (Hartley and Maynard 1982). But against this, of course, have to be balanced the probable social and political benefits of such legislation. These are extremely difficult to measure in objective economic terms. So much so, in fact, that it seems impossible to answer scientifically questions like 'is current consumer legislation cost effective?'

The most reasonable conclusion to draw here is that both industry and the consumer movement have tended to in the past avoid rigorous economic assessments of the value of their activities to society. More work in this area is to be welcomed. Some agencies, such as the Health and Safety Commission (1982), the National Radiological Protection Board (1980) and certain major pharmaceutical houses, are already attempting to meet this challenge.

Turning back to the charge that consumerists tend to be economically 'illiterate', such claims are similarly of limited value. For instance, with regard to the debate on protectionism touched on above both the CA and the NCC take a rather more flexible and pragmatic view than is occasionally indicated. (See, for example, NCC 1978.)

Yet perhaps one field of economic analysis in which there may still be room for an expansion of consumer understanding is that relating to technological innovations. The latter rarely take place under those conditions traditionally referred to as 'perfect competition'. Rather, in part because of the time and resources needed for the creation of new intellectual capital, the most effective innovators are often large firms, operating in an immediate environment which they, or perhaps just a few other similar organisations, tend to dominate.

The competition which occurs then is of the type referred to by Schumpeter as 'creative destruction' (Schumpeter 1976). Other economists have stressed that such 'workable' competition takes place between as well as within industrial sectors, as unrelated agencies create new technologies which make existing methods and products obsolete (Fulop 1981). It is this process which has brought North America, Western Europe and Japan wealth which eighteenth-century economists like Adam

3 In fact when questioned generally most of the industrialists interviewed in the MSI Survey (for Sentry Insurance) felt that the consumer movement had done a useful job. It was on the issue of their own particular industry that they tended to be critical of consumerism.

Smith or even nineteenth-century theorists like Karl Marx did not dream of.

But at the same time investment in new intellectual property has to be paid for, and knowledge of the continuously shifting range of high technology products rapidly diffused out to the public. Consumer leaders seem to make little allowance for these considerations. Despite the enormous gains innovation has generated they sometimes seem to yearn for an illusory 'golden age' associated with the type of simple 'perfect' market characteristic of a static rather than a technologically progressing economy. This tendency has perhaps been most obvious in the attitudes expressed towards promotional activities.

### Advertising and education

'You create demands, in many cases artificially, by conjuring up worlds of fantasy.' In this sentence Shirley Williams, speaking in 1974 as Secretary of State for Prices and Consumer Protection, summed up the feeling of disapproval and concern that some well meaning leaders of society feel about the work of men and women in advertising. Members of the consumer movement have, after Galbraith (1967), frequently expressed their fear that large companies manipulate demand for their own purposes, using advertising both to protect existing markets and/or to open out new ones even when there is little genuinely original to offer. These and other forms of promotional interventions have, it is argued, heavy social and economic costs (Medawar and Hodges 1973).

But such widely promoted claims are themselves sometimes questionable. For example, it is from a philosophical viewpoint<sup>4</sup> difficult to see what an artificial or 'false' demand is, other than one based on clearly untruthful claims. Provided that advertisers are honest and not excessively biased in their selection of information it may well be that the social costs of further restricting their freedom to stimulate desires for products could far outweigh any negative aspects of such liberty.

Furthermore, on the economic side, the advantages generated for both producers and consumers by promotion aimed at ensuring that sales levels are sufficient to achieve maximum economies of scale are often ignored, whilst the costs of practices like giving samples or offering bargain quantities of an item at times when demand is slack tend to be exaggerated. And the argument in favour of promotional spending is strengthened even more when it is realised that obviously useful goods and services can be surprisingly hard to sell. The Consumers' Association, for instance, finds it necessary to devote around a fifth of its total revenue to promotional activities in order to remain economically viable.

But this is not to deny that there are important problems related to the distribution of information in the market place, even in the UK where the work of the Advertising Standards Authority has now done much to satisfy the critics of promotion. Without widely available data on subjects like prices and performance and the skills needed to interpret them rational choices cannot be made. Hence no market can function efficiently. Few

people would suggest that advertising from manufacturers alone can fulfil this need. A range of sources is clearly required. Key questions relate to how communication between non-commercial information providers and the public can best be achieved.

The long-term answers relate to raising educational standards in general so that more people can make use of relatively sophisticated written as well as verbal information, and perhaps also introducing issues relating specifically to consumer decision making into school curricula. It may also be that some forms of adult education in this area are needed. The thinking in part underlying the establishment of the Consumers' Association's pioneer Advice Centre in Kentish Town in the late 1960s was that people with limited formal learning might be educated about general consumer issues via face to face contacts with staff made during the course of enquiries about specific difficulties.

The problems with the above relate to both cost and time scale. Person to person learning is a very expensive process; whilst improvements transmitted via the school system could take decades to influence significantly the market. In the face of such constraints some commentators argue that the mass media – radio, television, news papers and magazines – have an important short-term educational role to play. But this too is a questionable hypothesis. The type of complex information involved in consumer education is (unlike simple facts about, say, a product's name, price or functions) not easily or reliably transmitted via such channels. And the structural and economic characteristics of the major media organisations present further difficulties. Often they have neither staff able to present issues fully and objectively nor an economic motivation to do so. Newspapers, for example, are often purchased primarily for entertainment and amusement, not for serious enquiry into complex topics.

### State services – possibilities for change?

There is no better example of an area within the British economy in which the principle of consumer sovereignty is difficult to establish than that of the nationalised industries and allied sectors such as the National Health Service and local authority housing services. In the case of monopolistic enterprises such as electricity and gas supply (utilities) individual purchasers often have little opportunity to express preferences through straightforward action in the market place, despite the competition between the two industries.

Rather they have either to try to exercise influence via political representation at local or national level or to register complaints via the relatively little known system of Nationalised Industry Consumer Councils (NICCS). (See the appendix for a brief description of the relevant organisations and the similar bodies which exist in fields like air transport.)

A recent Department of Trade consultative document (1981) pointed out that the centrally funded NICCS currently cost about £4 million a year to run. They have some 3,000 mainly unpaid members, a third of whom are direct ministerial appointees. But despite the work of these individuals the document accepts that 'many users feel powerless in their dealings with nationalised industries, and may actually have more limited legal rights of redress than in their dealings with private firms'. This finding has

<sup>4</sup> In her 1974 speech Mrs Williams' objective may well have been political rather than philosophical. In January 1975 the financial base of the Advertising Standards Authority was completely restructured, and its independence strengthened.

been supported by research conducted by the National Consumer Council (NCC 1979, 1981).

Various possible reforms of the NCCs have been proposed by the Department. There were two structural options considered in the 1981 paper. One required that NCCs should be pruned in size by around 25 per cent. The second that they should be restructured into sector wide bodies, one for utilities, one for rail and bus transport, and one for posts and telecommunications. However, it may be argued that neither involves any genuinely significant proposal for strengthening consumer power in the state sector. Ministerial decisions on this question are, at the time of this paper's preparation (December 1982), being awaited with interest.

There are also a number of broader possibilities for reform in the nationalised sector. Parliament might, it has been suggested, wish to introduce stricter statutory controls over the activities of some state monopolies. It may be pointed out that in the United States, for instance, monopoly utilities are in some respects more tightly controlled than is so here. In certain cases the reintroduction of a plurality of supply could strengthen consumer powers. The government argues that the Transport Act of 1980 did this by exposing British Rail to fuller competition from bus services. And in others privatisation may alter the pressures on and interests of certain organisations, and so make them more consumer conscious. This could perhaps prove to be the case in relation to telecommunications services.

It would be beyond the scope of this document to attempt any detailed examination of any of these postulates here. Rather, it is perhaps useful to stress once again in this section that the problems of redress and representation throughout the public sector appear particularly deep rooted. This in the past may not have been fully recognised, possibly because of confusing political rhetoric which suggests that somehow state control automatically obviates conflicts of interests between producers and consumers. Despite the considerable effort that the NCC in particular has put into this field there remain many unresolved issues, which are touched on below in the particular context of health.

# Health care – the anatomy of a special case

Figure 3 indicates that there is a spectrum of consumer goods and services which ranges from 'ordinary', simple purchases which most consumers are equipped to make with little outside help through 'intermediate' items like, say, washing machines or garage services to 'special' goods and services. The consumer often needs professional guidance in relation to obtaining the latter, whilst the intermediate sector is that which consumer-good testing organisations have traditionally tended to focus their attention on.

Figure 4a outlines a model of the ordinary case producer-consumer relationship whilst Figure 4b illustrates the complex of factors which modify this relationship in the instance of health care, an archetypal special area. As the diagrams partly indicate, there are at least four sets of factors which make market conditions in the health sphere very different from those associated with ordinary economic activity.

First, the widespread utilisation of third party payment schemes – whether state/tax or insurance company/premium based – may radically affect the consumer's experience of payment. It can completely disassociate service uptake from the act of spending. In such circumstances phenomena like waste, poor service and/or excessive consumption may all be tolerated by the consumer to a disturbing degree, particularly if the third party payment system imposes no penalties on the consumer for unusually high rates of utilisation. (In economic jargon, there is 'moral hazard').

Second the 'agency' relationship in health care often transcends the normal producer/consumer one. That is to say professionals like doctors and pharmacists often take on a dual role as both service suppliers and proxy consumers. This is because few people believe that they possess the knowledge needed to decide what care they require when ill. They therefore appoint the doctor or pharmacist as their agent, and will follow his or her advice relatively uncritically.

Third, following on from the above, the emotional response of a sick person to those providing care is likely to be very different from that of a customer buying an ordinary service from a tradesman. Even informed individuals may need, when severely distressed, to suspend their critical feelings, trusting others to a perhaps irrational degree. And in the recovery period the reverse may occur. As subjects reassert themselves and return to

an active social role they may forcefully reject the people or the treatments which supported them through a period of dependence. This, together with other behavioural characteristics of producer/consumer relationships in the health context, will of course be influenced by the overall pattern of beliefs and expectations associated with sickness in a society.

Finally, the fourth set of intervening forces which make the health care consumption process an atypical one is the unique set of laws and professional and voluntary codes which affects its delivery. The existence of regulatory systems covering matters ranging from the safety of medicines to standards of professional conduct means that, in the developed world at least, the medical market place is a long way removed from the type of simple free market where consumer sovereignty alone acts as a major guiding force.

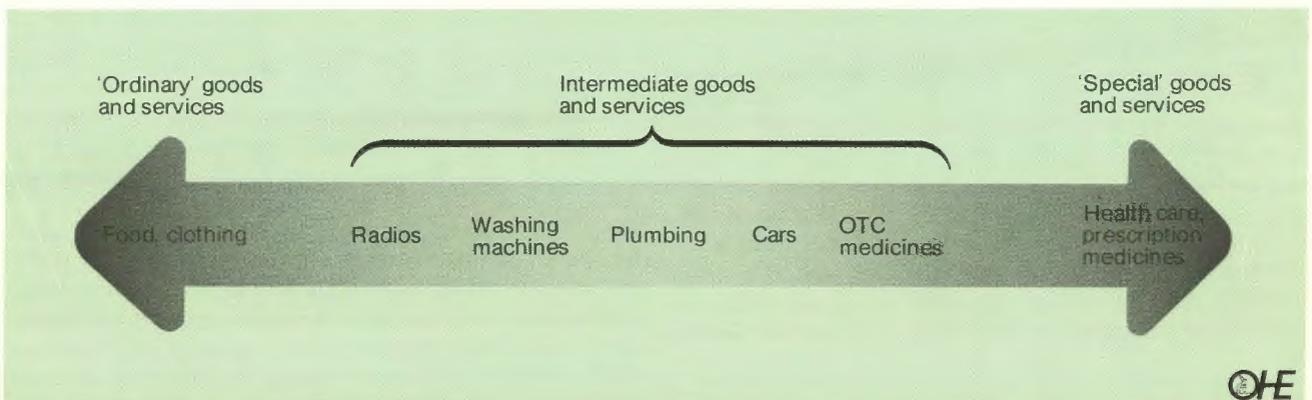
## Influencing the NHS

In the United States recently there has been some debate on the possibility of circumventing barriers to the market control of health care of the types described above by focusing consumer decision making on the act of insurance purchase rather than that of care uptake. However, this initiative has run into considerable political difficulties and even if practical would not in any case be applicable to the main British system of health care funding, which is based on general taxation.

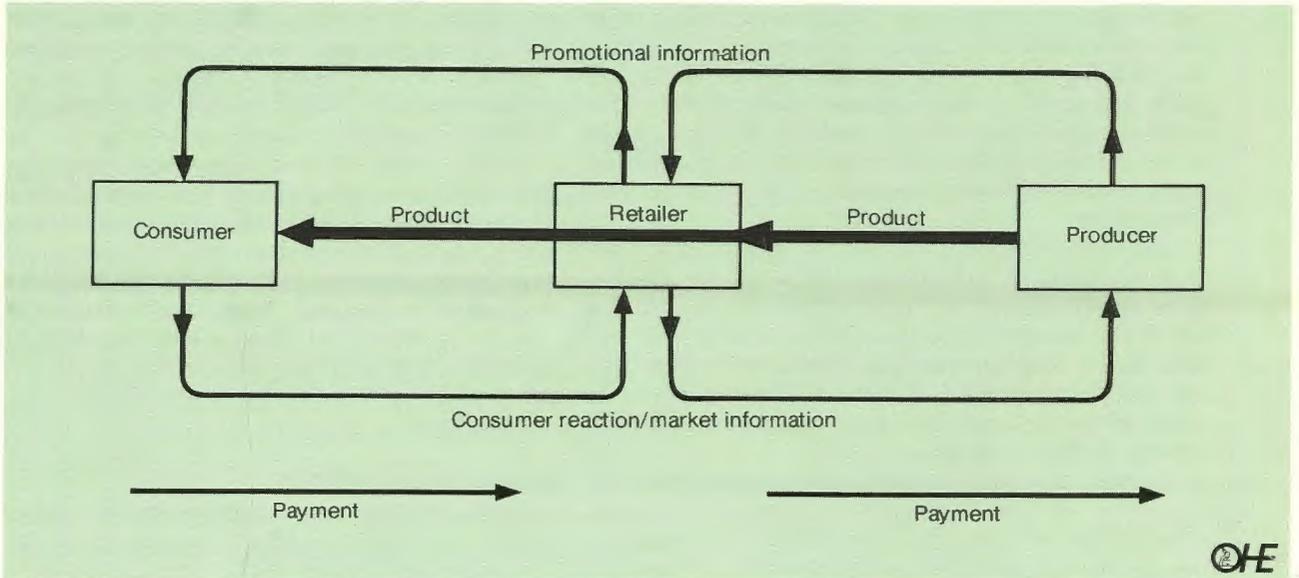
Despite the growth of private insurance in the UK there seems little likelihood that there will be any fundamental change in NHS financing in the foreseeable future, or that an increased range of private health care options would necessarily strengthen the consumer voice in the NHS. On the contrary, the latter might possibly be weakened by the removal of better-off patients from the state sector. A perhaps more desirable alternative would be in some way to institute more competition between alternative NHS care suppliers, whether at the general practice or the hospital level. However, there appear to be significant administrative problems in achieving this goal and it would not, in any case, avoid many of the market imperfections touched on above.

Attention has therefore tended to concentrate on the establishment of non-market means of consumer representation and redress within the NHS. In addition to the possibilities for legal action in cases of negligence (which

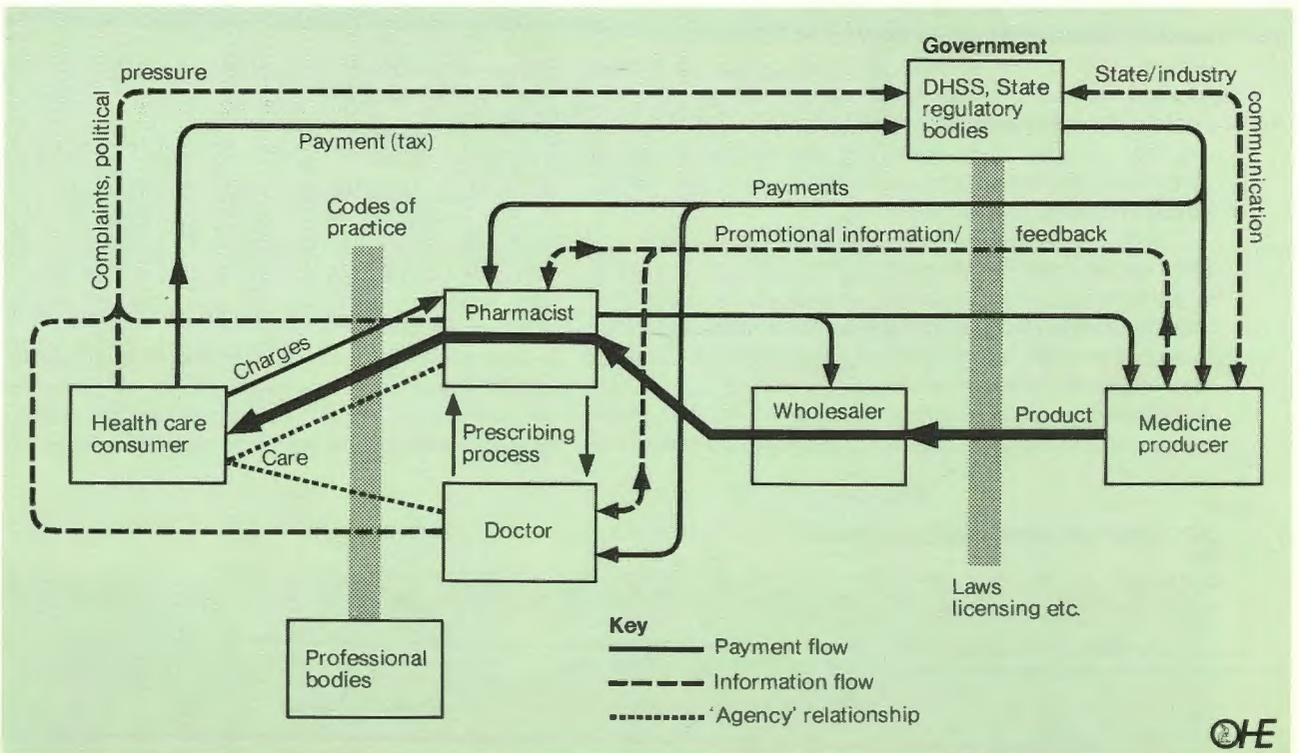
## 3 The consumer goods spectrum



**4a** The 'ordinary case' producer/consumer relationship



**4b** A 'special case' producer/consumer relationship – health care and prescription medicines in the NHS



exist despite the fact that NHS patients do not have direct contractual rights against any individual NHS contractors) these today include the complaints systems outlined in Box II together with the options for self expression offered both by the general political arena and the activities of bodies like the Community Health Councils, general practice patients' committees, the Patients Association and charities like MIND and the Spastics Society. These are described in the appendix to this paper.

There can be no question that collectively the systems referred to above provide consumers with a wide range of opportunities for indicating grievances. But it may still be thought inadequate in a number of areas. For example, some commentators are currently concerned that the Family Practitioner Committee system of enquiry into patient complaints is to a considerable degree in the hands of the professionals who administer the service. And questions of clinical judgement are excluded from FPC investigations. Despite the changes in the status of FPCs expected in the near future such problems are likely to remain significant.

Although in the case of the hospitals there is now a system for enquiring into 'clinical' complaints some consumerists feel that the BMA proposed arrangements involved still permit too much medical and too little lay participation (Ackroyd 1981). They are said to fall short of the original proposals put forward by the Davies Committee in 1973 and the DHSS in 1976 (see Farrell 1980). Yet, on balance, a basic peer review system does seem to have been set up.

Concern in the area of medical accidents has recently been further stimulated by the refusal (on the advice of their defence societies) of doctors involved in an incident in Hereford to take part in a health authority enquiry. Although Ministers are expected soon to issue new instructions on this matter it led to anger on the part of patients' representatives. Many believe that the threat of legal action which surrounds inquiries into medical accidents should be in part lifted by the introduction of a 'no-fault' scheme of compensation (Kennedy 1980, *CHC News* 1982). This would not leave negligent doctors free of the possibility of legal (or indeed professional) nemesis. But it would offer the victims of medical accidents a more certain and humane route to compensation than that available by the courts.

Turning to the opportunities open for more positive feed-backs between consumers and the health service the main bodies available for this are the Community Health Councils (CHCs). Set up after the 1974 reorganisation these now involve in each district individuals from local authorities and voluntary bodies and others appointed by the Regional Health Authorities. They can assist patients with complaints but perhaps the main role of CHCs is to provide a consumer feed-in to management and planning at the local level. They may thus be thought somewhat similar to the NICCS.

CHC representatives can mount an impressive case for their continued existence (Gerrard 1980, Fruin 1980). There is no doubt that in the last few years they have put more pressure on health authorities than was ever the case in the pre-1974 structure. And they have conducted a number of interesting research projects. But at the same time the BMA and the government have criticised their attitudes and the latter is not committed to their long-

## BOX II Complaining in the NHS

*General Practitioner services* Patients wishing to complain about GP care should write to their local Family Practitioner Committee (FPC) within eight weeks of the event causing concern. If the FPC thinks the doctor has acted in a way which violates his or her contract with the NHS it may deal with the complaint by an informal or a formal investigation. The latter involves setting up a seven person Medical Service Committee. People wishing to complain may contact their Community Health Councils for advice and support at the Committee hearing.

*Hospital services* Complaints in hospital should at first be made to the person(s) directly involved. Only if they cannot satisfactorily settle the matter should it be made formal. This can be done within a year either verbally to a member of staff who will write it down or by letter to the Hospital or District Administrator.

*Hospital treatment* Since 1981 a system for handling complaints about clinical judgement has been on trial in NHS hospitals. This involves, first, complaining direct to the consultant involved. Second, informing the Regional Medical Officer. Third, the establishment of a two man independent professional review.

*Unethical behaviour of doctors* If a patient or other individual believes that a doctor has behaved unethically or unprofessionally he or she can report the matter to the General Medical Council in London. The sanctions available to this body include striking a doctor's name from the medical register. Issues dealt with by the GMC include neglecting patients, charging for free services, excessive drinking or other health problems amongst doctors, misuse of drugs and sexual misconduct.

*The Health Ombudsman* The Health Service Commissioner(s) can investigate complaints about any aspect of NHS care management except those relating to clinical judgement, provided that future legal action is not planned. Complaints should be made within a year of the incident involved, and should first have been made to the authority concerned.

*Note:* The National Consumer Council has recently produced a booklet called 'Patient's Rights' (NCC 1982). It examines all the areas above and other relevant issues in detail, and provides instructions on how to complain, addresses and other useful information.

term perpetuation.<sup>5</sup> Even though the cost of the CHCs is limited (under £5 million a year) some commentators believe their functions could be more efficiently carried out by bodies like the Citizen's Advice Bureaux and a strengthened health advisory service (Klein 1980).

Like other consumer organisations, the CHCs have been criticised for being unrepresentative of the public as a whole. They are 'middle aged and middle class' (OHE 1975, Klein and Lewis 1976). As has been suggested earlier, this is to a degree inevitable. But for those genuinely interested in strengthening the degree of consumer sovereignty in health care such comments raise the worrying point that better educated, articulate people cannot (or do not) always fully represent the interests of the less able, less advantaged.

To place power directly in the hands of the latter is difficult in any type of system, market based or bureaucratically organised. The only real solutions lie in transmitting information and skills directly to the general

<sup>5</sup> Already their budgets have been frozen and the grant to their publication *CHC News* was removed at the start of the current financial year.

public, and encouraging individuals to participate in health care as it affects them in their daily lives. This allows not only personal action in the direct consumer/producer relationship. It augments the efficient working of all the complaints and representation systems touched on above.

The NHS was formed principally to protect sick people from injustices and catastrophes in the medical market, particularly in the financial context. It was highly successful in this. But the NHS cannot relieve individuals from all responsibility for maintaining their own physical and mental wellbeing or for using the services available as well as possible. This fact may have been obscured during the 1950s and 1960s, but with today's emphasis on primary prevention and disability alleviation it is becoming more apparent. State paternalism is no substitute for support aimed at enabling consumers to gain maximum independence.

### Towards greater self-care

One main channel by which people hear about health related topics is the media – radio, newspapers, magazines and television. In terms of setting an 'agenda' for public discussion such communication channels are very important, even though they may sometimes show bias in the selection of events they choose to cover and the manner in which they report (Best *et al* 1977). It could be argued, for instance, that the NHS has had an unduly bad press since the mid 1970s.

However, the underlying cause of this may well not be incompetence or malintent on the part of journalists. Rather it could in large part be simply a function of public demand for stories involving a degree of conflict coupled with variations in the number of and degree of competence with which positive as opposed to negative stories are put forward to the press.

What is perhaps more important from the viewpoint of those anxious to increase the public's underlying knowledge of health issues is that there is little reason to suppose that any of the media channels are particularly good at transmitting complex educational material to unsophisticated audiences. Of course, very simple messages can be 'targetted' to any group in the population, just like advertising. But 'health propaganda' should not be confused with genuine education. The foundations of the abilities needed for informed choice in the health sphere often require, like basic consumer education in other fields, methods of teaching which involve direct personal contact and support.

Of the options available those utilising the skills and time of professionals already active in the health service are amongst the most attractive. In addition to health education in schools (which should not, perhaps, be isolated as a subject distinct from others on the curriculum like biology, cooking and sport)<sup>6</sup> workers like health visitors,

general practitioners and pharmacists can all add to the stock of consumer knowledge about health issues during their daily contacts with the public (Anderson *et al* 1980).

However, here again too much should not be expected from conventional techniques. They will probably promote only a gradual shift in the degree to which patients feel able to participate actively in their care and to which they and well individuals regard themselves as primarily responsible for their future health.

It is tempting, therefore, to consider briefly two other possibilities for stimulating constructive, individual level consumer participation in health care in the 1980s. The first involves the new computer technologies for information retrieval, processing and presentation. The second relates to the further encouragement of self-help groups comprised of people who share an illness or disability.

It is fitting to note after what has been officially dubbed 'Information Technology Year' (1982) that in the coming decade the impact of micro-computers with sophisticated software programmes will revolutionise the public's access to medical data and self diagnostic techniques. As such machines become easier to use – they may even as early as 1990 be voice responsive and able to reproduce speech – so will they add new dimensions to the doctor/pharmacist/patient interface. Those receiving poor or unusual care will be better placed to ask for explanations or to take action of their own.

The latter could involve joining self-help groups. For people with chronic physical or psychiatric complaints like arthritis or depression these may have much to offer in terms of promoting self-knowledge, alleviating some forms of symptomatic distress (through communication and mutual counselling) and organising practical help at times of crisis (Brown 1981).

They may of course draw on expert advice and help. Indeed, it could well take positive professional intervention to establish such groups in many instances. But at the same time the health care consumers who join them are likely to become both more assertive and more realistic in their demands as patients. Although a few commentators will probably greet such developments with dismay there can be little serious doubt that they should ultimately strengthen consumer sovereignty in the health care market.

6 The verbal and allied skills necessary for health maintenance – such as self-knowledge, ability to perceive other family members' distress and ability to transmit accurate information based on the above to selected health professionals – do not fit in particularly well to an academic, written work oriented syllabus. Making health education a 'subject' could well destroy its usefulness to many people. This is not least because such a move might 'wall off' the information learnt in health education classes from the day to day, practical activities of life. Rather, health relevant knowledge needs to be built in to all formal and informal school activities.

# Medicines and the consumer

In the last few decades the products of the pharmaceutical industry have done much to preserve, and improve the quality of, life. In both rich and poor countries many millions of consumers have benefited from products like antibiotics and vaccines, tranquilisers and anti-depressants, heart medicines and anti-rheumatic drugs. The list of therapeutically successful medicines is long and still growing. Recently, for example, effective anti-viral and anti-cancer preparations have started to enter the market place.

But against the immense benefits that pharmaceutical producers offer the public there are inevitable economic, social and personal costs associated with medicine usage. The consumer movement throughout the world has from time to time expressed concern about a wide variety of topics related to modern drugs. Although these in fact largely reflect consumer leaders' broad worries about most commercial enterprises, they are sometimes particularly intensely felt in the pharmaceutical sector. In a recent review Tootell (1980) has itemised six major areas of criticism regarding medicine manufacturers' activities in countries like Britain. They are:

That there is over-promotion of medicines.

That there is consequent over-consumption.

That prices are excessive.

That there is unfair partitioning of (ie, differential charging between) markets.

That there is too much 'me too' innovation.

That medicines lack safety.

In addition he argued that there are a variety of sub-issues which are inextricably linked with the work of pharmaceutical companies. These include questions relating to animal experimentation, product liability and social changes mediated by the availability of products like contraceptives and psycho-active substances. And perhaps most important of all, there are also a whole set of problems related specifically to the supply of medicines to the third world, where chronic poverty and the acute lack of health care infrastructures creates conditions quite unlike those of the rich nations – see Box III.

It would be beyond the scope of this paper to attempt to discuss all these areas in detail. For example, it does not investigate the question of animal experimentation, even though this raises very strong feelings amongst many people.<sup>7</sup>

7 Unfortunately, there are at present no viable and/or legal alternatives to many forms of animal experimentation in relation to medicines. Provided the subject creatures are not treated cruelly most people appear to accept the need to protect human life by animal experiments.

## BOX III The consumer movement, medicines and the less developed countries.

The supply of existing medicines to and the development of new ones for the countries of the third world involves many complex problems (OHE 1982). In a situation of profound poverty and lack of organised health services, where currently some 70 per cent of many rural populations have little access to even basic medicines or other forms of public health care, there are unlikely to be any easy solutions.

However, a recently formed, loose association of groups known as Health Action International (see the appendix) has begun advocating a programme which suggests that if medicine advertising could be strictly limited or eliminated and the supply of pharmaceuticals throughout less developed countries reduced to only the 200 or so drugs on the WHO 'essential' list then substantial progress could easily be made.

There are a number of cogent reasons to doubt the validity of such claims. Not least is the fact that HAI's goal of eliminating or severely limiting private pharmaceutical markets in the third world would in itself do nothing to improve the lot of the poor there, and might undermine the economic position of the medicine manufacturers otherwise capable of making useful drug innovations and supplying much needed basic pharmaceuticals in large bulk and at low cost.

Nevertheless HAI (which involves British organisations like Oxfam, War on Want and Social Audit) may mount a formidable public campaign against the pharmaceutical industry by utilising techniques like those employed in the very different context of the protest against 'baby milk' marketing in the poor world. The latter area involved many difficult questions. But the members of IBFAN (International Baby Food Action Network) managed to reduce their campaign to basic, very simple points. Associated bodies claimed that '10 million babies a year' died because of artificial baby milk marketing.

Such figures are ludicrous distortions of the truth. But

through a programme involving intensive lobbying of key 'targets' and repeated propaganda statements from apparently independent sources coupled with a planned approach to controlling the main media gateways, public opinion was swung very strongly against major baby food manufacturers. Although in medicines the primary need is for more rather than less consumption of many products, HAI has a similar programme in the pharmaceuticals sector. It has already publicised many criticisms of the international industry, backed by incomplete information on events such as recent moves by the Bangladesh government to alter the balance of its pharmaceutical market.

It would be wrong to suggest that the behaviour of multinational pharmaceutical companies in the third world cannot be criticised. In some areas there have been clear examples of malpractice. But at the same time it would be unfortunate if the activities of consumer bodies like HAI in association with respected charities like Oxfam led the public to believe that British medicine manufacturers have no useful role to play in the context of the poor nations, or that they do more harm than good.

The pharmaceutical industry has recently initiated a number of moves aimed at improving promotional standards and third world medicine supply. These include the publication of an international code of marketing practice by the International Federation of Pharmaceutical Manufacturers Associations and co-operation with the World Health Organisation in regard to areas like its Tropical Disease Research and Training Programme, its Essential Drugs Programme and its Programme for the Control of Diarrhoeal Disease. The latter remains a major problem in all poor areas, as it has been throughout history. Such measures, together with the industry's existing record of research and local production in the third world (Worlock 1982) already go several steps towards answering criticisms made by informed observers.

Rather, the remainder of this section confines its attention to just the major questions of pricing, promotion and safety, illustrating where possible the arguments put forward with ABPI/OHE research findings on public and medical attitudes. It also examines some aspects of the difficulties inherent in improving communication between prescription medicine manufacturers and the ultimate consumers of their products, the general public.

### The costs of pharmaceuticals

In 1982 the NHS paid, in manufacturers' price terms, some £1,200 million for medicines. Although UK *per capita* pharmaceutical outlays are modest compared to those of countries like the United States, Germany, and Switzerland this is a considerable sum, and consumers are right to demand that it should be well spent. However, some debate on this topic has been ill-informed.

For instance, statements by politicians that cuts in the 'drug bill' of sums ranging from £30 to £200 million could be easily and painlessly made through, say, generic prescribing, are often based on little or no factual data. Critics of industry sometimes make no attempt to calculate the costs to the British economy of weakening the pharmaceutical sector. They imply instead that cash savings on NHS medicines could automatically be channelled to other ends, like paying nurses a more satisfactory wage. Such suggestions are not only fallacious in themselves, they may also create widespread misconceptions about pharmaceutical spending. This last suggestion was borne out by an ABPI/OHE survey of 400 members of the general public and 100 doctors conducted recently (ABPI 1980).

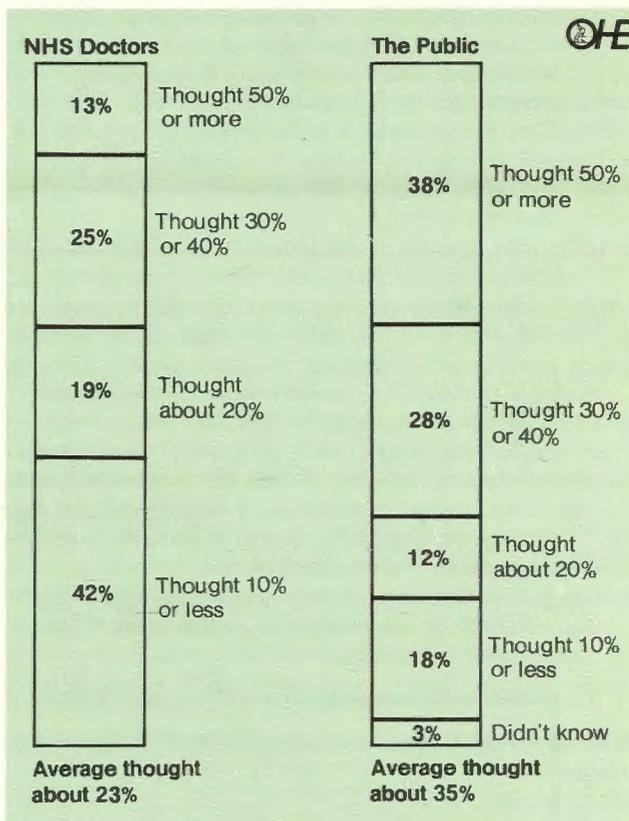
The results of this inquiry showed that both groups considerably over-estimated the proportion of NHS money devoted to medicines, as is illustrated in Figure 5. Only one person in five (and two physicians in five) knew that pharmaceuticals account for less than 10 per cent of the total NHS budget. The average member of the general public in 1980 believed that the figure was actually 35 per cent.

Both groups questioned also showed little knowledge of the government's Pharmaceutical Price Regulation Scheme (PPRS). This keeps items like pharmaceutical industry profits and (incidentally) advertising spending within state defined limits. And nor did more than a small minority of even the medical profession realise that Britain is one of the world's leading exporters of medicines. Its positive balance of trade in this field is over £500 million per annum.

Such widespread ignorance of even the basic facts about Britain's spending on and interests in pharmaceutical trade must considerably distort consumers' view. This is a situation for which industry must accept some blame. Yet it is difficult to introduce the sort of complex material needed for a genuine understanding of the area into the political, much less the public, arena. And any industry with high 'sunk' research spending and fixed capital and related costs of production (but relatively small variable costs of production) is going to experience difficulty in explaining its pricing policies to a naive audience.

Conceptual limitations have also tended to undermine the consumer movement's understanding of international issues like 'third world' drug costs and the variations in medicine prices which exist even between the countries

## 5 Perceptions of NHS medicine costs as a percentage of all NHS spending (1980)



Note The actual figure, in 1980 manufacturers price terms, was under 10 per cent. Compared with 1964, when OHE last conducted such a survey, both doctors and the public have very considerably increased their estimates of NHS drug outlay in proportional terms. The true position has stayed almost static.

Source ABPI 1980

of Western Europe. Organisations like BEUC have condemned the latter (BEUC 1978) whilst 'transfer pricing' has been a special target of groups claiming to represent consumers in the poor world. The entire area is complicated by factors like variations in national social security and drug price control schemes; currency fluctuations and related problems; and differences in competitive environments such as the lack of adequate patent protection in some markets.

However, for the purposes of this brief overview two points are perhaps worth drawing out. The first relates to the fact that, in some instances, even when all the above factors have been accounted for, medicine prices are not uniform across the various countries of the European Community. Is such discrimination defensible? Organisations committed to pan-European harmony might argue that it is not. But on an equity basis it could be suggested that richer communities should carry a greater proportion of the costs of vitally required goods than poorer ones. This is certainly the view of those third world oriented consumerists who argue that multinational companies should supply medicines to poor nations at only the marginal production cost, or give their technological 'know-how' free of charge. On a similar basis, it has been suggested that price discrimination within domestic markets has a legitimate role (Reekie 1975).

The second, related, point is that even if it were

accepted that price harmonisation for pharmaceuticals is a desirable and possible goal in Europe, the consumer should not necessarily expect a price fall as a result. The public interest might demand a levelling up, not down. Recent OECD research has emphasised that if national incomes are to be maintained Europe must remain active in, and thus invest adequately in, high technology areas like pharmaceuticals (Burstall *et al* 1981). The example of Japan's high price for medicines (Reekie 1981) clearly indicates the policy which would be adopted by any country intending to become or remain a leader in the world pharmaceutical trade in the 1980s and 1990s.

### Promotion

A second area which frequently stimulates the expression of consumer concern is that of pharmaceutical promotion. Its critics allege that it is a wasteful, excessively costly activity;<sup>8</sup> that the medical profession does not value it and resents the time 'wasted' by representatives; and that it helps to cause excessive prescribing and a proliferation of unwanted products.

Industry, on the other hand, regards advertising as essential to the competitive process driving innovation. Companies believe that they would not be able to recover their investments in new products, much less gain a reward for creating intellectual property, within the patent protection period without the help of promotion.<sup>9</sup> They believe that most doctors are cautious in accepting even the most useful medicines and that they genuinely value representative visits and kindred interventions, like the advertising which supports medical newspapers and magazines. Those wishing to defend pharmaceutical promotion might also add that the current brand name system may actually reduce rather than increase product proliferation.

In fact the proportional cost of pharmaceutical promotion does appear to be rather higher than that incurred by the majority of industries. The possible reasons include restraints which necessitate the establishment of special channels of communication between prescription medicine makers and their immediate contacts in the producer/consumer chain, the doctors and pharmacists. Commercial channels open to the public which permit cost sharing are not used for prescription medicines. Also the pharmaceutical industry has to transmit highly technical data about a wide range of products to many tens of thousands of potential prescribers and stockists. This is rather different from the task confronting a manufacturer who has only to communicate simple brand-name related information, or from that facing high technology industries which need to inform only a limited number of purchasers.

Regarding the quality of UK promotional activities and their acceptability to doctors the pharmaceutical industry may point to the existence of the comprehensive ABPI code of practice. This provides the basis of a self-imposed

monitoring and disciplinary system. And survey work on doctors' attitudes towards promotion carried out by ABPI/OHE in the 1960s and the 1970s also provides information on this issue.

The latest major study in this last context was conducted in 1975 (Taylor 1975). Amongst its findings it showed that over three-quarters of general practitioners (in a sample of some 500) positively desired representatives to call, and that 86 per cent felt at that time that representatives were adequately trained. Only 1 per cent complained that the representative they had most recently seen had given distorted information. Statistics like these, particularly when coupled with the high readership rates of medical newspapers supported by advertising, make it impossible to support suggestions that pharmaceutical promotion is regarded as unnecessary or unwelcome by most members of the medical profession.

As to the possibility that promotion is a prime cause of excessive drug usage, this too seems unlikely. The professional audience being addressed in Britain today is a highly educated one. It has nothing to gain economically from high volume drug usage. And there are many other counterbalancing sources of information.

One interesting result from the 1975 survey quoted above was that although older doctors, particularly those in single practice, were the individuals most likely to be very approving in their attitudes towards representatives these were not the physicians most likely to be innovative in their prescribing. Younger, more critical (but also more adaptable) doctors in larger practices proved more likely to be influenced by information about new therapies. Such findings support the contention that the medical market place is not easily distorted by promotional activities.

However, it is likely that members of the consumer movement will remain suspicious of pharmaceutical advertising and other forms of promotion. This is in part, maybe, because of doubts about all advertising's value, and in part because of uncertainties about the role of medicines and the value of therapeutic innovations. The latter can arise because of the special nature of the producer/consumer relationship in prescribed pharmaceuticals, where the manufacturer promotes not to the ultimate consumer but to his or her agents, the doctor's and pharmacists, and is paid via the NHS and the Treasury.

The exclusion of the consumer from this process of information transfer can obviously have destructive results. This is especially so in circumstances where doctors or pharmacists are not completely trusted or do not subsequently communicate competently with their patient/customers. The latter may easily come to fear that their interests are being ignored. The emotions so generated may be subsequently exploited or manipulated. For instance, both major political parties have during the economic crisis of the 1970s used slogans like 'there is not a pill for every ill' to try to damp down demand for health care generally.

In the case of the media and publishing the apparent 'saleability' of anxiety inducing 'copy' makes drug advertising and safety 'scandals' popular subjects, although other factors may also play a part in generating bias. Because prescription medicine advertising is one of the few fields where newspapers and television cannot directly profit, journalists may be free to express doubts that in

8 Currently, promotion related to prescription medicines is running at around 10-11 per cent of manufacturers' NHS revenue, that is some £120 million. This compares to a UK research spend of well over £300 million.

9 Extension of the patent life of medicines could decrease the urgency of marketing in some instances. However, the industry already realises that excessively aggressive marketing may prove damaging (ABPI 1982).

other contexts, like, say, those of alcohol and tobacco advertising, they have to voice more modestly.

### The safety of medicines and medicine-takers

Any pharmacologically active substance may cause unwanted side-effects. No effective medicine can be used without some degree of risk. The possible costs have to be balanced against the likely benefits as rationally as possible, because complete safety is unattainable. This point is particularly valid in the case of medicines because often the reason for an unwanted outcome is not a defect in the product but an abnormality in the consumer. (See Box IV.)

Determining correct policies thus requires disciplined, scientific investigation of both the physical effects and the social and economic role of any given medicine, not emotional or politically expedient reaction based on simplistic assumptions. It is unfortunate that some commentators do not seem to recognise this truth, although despite occasional alarmist statements the general public seems comparatively sanguine in its attitude towards drug safety. Despite the many stories about medicine risks which have appeared since the thalidomide tragedy in the early 1960s (which include some well-funded concerns and a great number of very dubious, sensationalised stories on topics like vaccination, contraception and the use of minor tranquillisers) Figure 6 indicates that four people in every five questioned in the 1980 ABPI/OHE survey were generally confident about the safety of medicines.

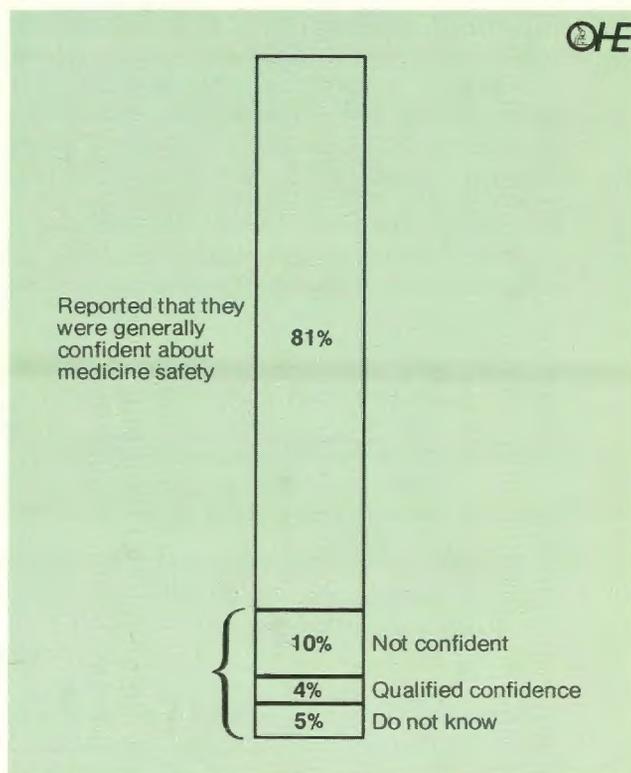
#### BOX IV Product liability in the pharmaceutical sector

Many consumer groups (see, for instance, the Consumers in the European Community Group 1980) have pledged their support for an EEC proposal which would make producers liable for any injury caused by a medicine, whether they were negligent or not in the product's manufacture and testing. This has been the subject of considerable controversy and the British government has itself questioned such an approach. The British pharmaceutical industry, amongst others, has explored the possibility of a central scheme to provide compensation in those cases where a patient suffers a serious unexpected adverse effect from a medicine; the patient would not be troubled with proving negligence. Rather, it would be up to the scheme's administrators to recoup their costs from a manufacturer where negligence existed.

In fact there may be significant problems related to funding even this type of arrangement equitably. But perhaps the most important point is that in many cases consumers are hurt by 'acts of God' not attributable to any clearly identifiable cause. Whatever the law on product liability in the context of cases like, say, vaccine damage, many people will be left unprotected and uncompensated because their handicaps are nobody's 'fault' or identifiable responsibility.

This is so even in countries like New Zealand and Sweden, which have widely discussed 'no-fault' compensation schemes (Bywater 1981, Smith 1982). Public debate has too often avoided this point. Hence attention has been drawn away from the need for adequate care and support for all who need it rather than just the few who have been injured in circumstances where a specific organisation like a pharmaceutical company can, however indirectly, be held responsible.

## 6 Public attitudes towards medicine safety (1980)



*Note* In OHE's 1964 survey 89 per cent were 'generally confident'. Despite the thalidomide tragedy of just two years before, only 4 per cent were positively not confident.

*Source* ABPI 1980

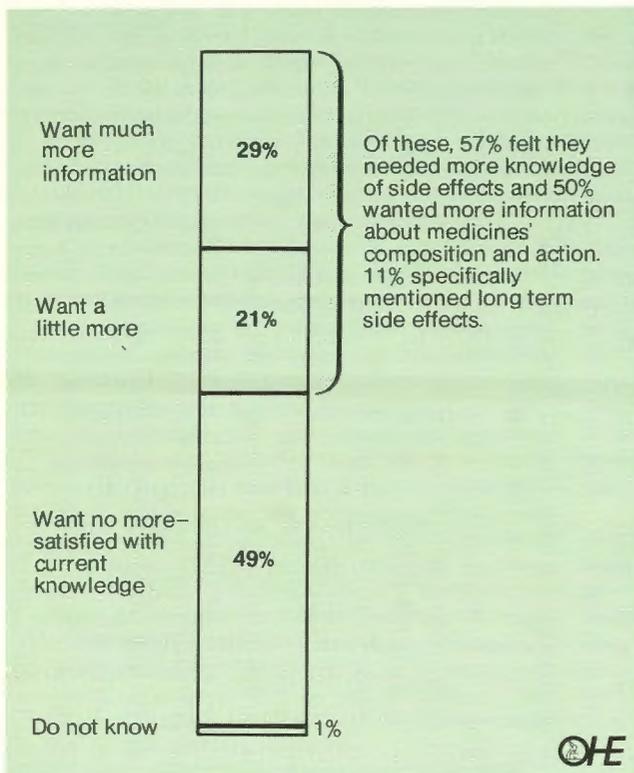
However, only a small minority of the public had any detailed knowledge of the work of bodies like the Committee on the Safety of Medicines and the extensive regulatory procedures introduced via the 1968 Medicines Act. The possible meaning of this data, therefore, is that many people may simply be complacent, not rationally secure. If this is so it may explain the irrational response sometimes illicit by drug accidents or side-effects when they unfortunately occur.

Another notable finding was that, as Figure 7 shows, only about a third of all respondents in the stratified sample concerned felt that they would like much more information about the medicines they take. Roughly a half were satisfied with their current knowledge of side-effects and the way in which drugs work. It was the more educated individuals who seemed to have the greatest desire for more consumer information.

These results suggest a number of possible conclusions, of which perhaps the most important is that those patients who might be thought most at risk of suffering poor treatment are probably those least likely to be represented by the more active consumerists. Desirably or otherwise, older, sicker and less-educated people probably want to be able to put their trust in their doctors and avoid being confronted with too many difficult choices related to their treatments.

This is not to say, of course, that in the long term greater patient education and participation in treatment processes is undesirable. Indeed, from the viewpoint of all parties active in health care intelligent and informed con-

## 7 Public attitudes towards information about prescribed medicines (1980)



sumer involvement is much to be desired. But the above remarks serve to cast some light on the current needs of particular consumer sub-groups, and may lead to some questioning of recent consumer movement statements relating to topics like the organisation of clinical trials.

In the last instance, for example, bodies such as the Patients Association have stressed the need for all patients to give their informed consent to their involvement in any trial or 'experimental' therapy. Few sensible people would doubt the general reasonableness of such a call, which can normally be complied with without undermining the scientific usefulness of such activities. But at the same time practising physicians may perhaps question the value of such consent in certain cases. This is not simply because many people may not be able to grasp the issues involved in their care fully; rather, some might be actively distressed if they are called upon to do so. And not all have interested relatives to advise them.

Aged, less intellectually trained people with what are at present painful, disabling and or ultimately terminal illnesses have very different requirements to young, or middle aged, middle class individuals with curable complaints. The point to draw is that no one policy is ever in practice the universal answer to problems like those relating to clinical trial participation.

### Meeting consumers' information needs – the role for industry

The above discussion points to a number of areas where consumers of medicines may experience a need for, or could gain more objective attitudes from, improved information about pharmaceutical products and their producers. One such field relates to the general public's understanding of the costs of medicines and the economics of

their manufacture. Here the pharmaceutical industry has a clear role to play in continuing to distribute objective information to the press and other groups involved in leading debate.

The latter include consumer bodies like the Community Health Councils and women's organisations. Industry leaders who are not prepared to enter into dialogue with such bodies have little right to claim that consumer groups views are needlessly biased or ill-informed. People working in what they experience as an information vacuum are very likely to turn against those who they see as depriving them of key data.

Much the same can be said in relation to the drug safety question. Few people have any idea of the elaborate and costly safeguards now existing in the field of new medicine development. Nor are they usually helped to balance in their minds factors like the pain and distress of the diseases which have long afflicted mankind against the risks of existing treatments and the possibilities for new cures in the future. In as much as the pharmaceutical industry has as its prime function the generation of increased human and animal welfare through pharmaceutical innovation it has a clear duty to counter inaccurate claims or groundless fears which could undermine or stop the process of medicine discovery (Box V).

But in this context government, too, has some responsibility. In America, the Food and Drug Administration publishes a journal, the *FDA Consumer*, which helps to explain the work of that body to interested parties. Perhaps the United Kingdom drug regulatory authorities should consider a similar publication, aimed both at highlighting genuine risks to the public's wellbeing and balancing distorted reports which may emanate from ill-informed or opportunistic sources.

A third, more controversial, area relates to the supply to consumers of information about particular medicines they may be prescribed. A traditional view of this area is that it is exclusively the role of doctors and pharmacists to decide how much knowledge patients should be given (see Box VI), and in what manner. Partly because of fears of alarming such groups and the possibility of legal pitfalls the prescription medicine industry has tended to avoid involvement in this field. Yet in recent years pressure for a more active policy has increased. It may be argued that more measures should be taken to break down the barriers between industry and its ultimate clients and provide the latter with sources of knowledge alternative to those offered by the established professions on the one hand and media and other popular commentators on the other.

The areas open for innovation include:

Supply of additional material about medicines to the media, possibly supported by advertising.  
Supply of written material with medicine packs. Such inserts could be,

- a) specific to each individual product.
- b) relevant to broad groups of products.

Increased supply of educational aids to doctors and allied professionals, who may employ them in the course of their daily contacts with their patients.

Additional support to voluntary bodies involved with self-help and associated care activities in fields where subjects are likely to be medicine users.

Establishment within companies of consumer advocates

## BOX V Pharmaceutical research – the economics

The British pharmaceutical industry spent about £320 million on research and development in the UK in 1981 – two and a half times its outlay on promotion. There can be little doubt that such expenditure has, to date, been successful in keeping Britain at the forefront of medicine innovation. But at the same time there have been criticisms of certain aspects of the UK research record. These relate to topics like the development of treatments for the poor world (see OHE 1982), imitative innovation and the balance between fundamental and applied or development work. Regarding 'me-too' products, for instance, it is sometimes alleged that the industry spends too much of its time and money looking at areas where therapies already exist and producing only minor variants of existing medicines. Critics urge that more money should be devoted to rare, 'Cinderella', diseases.

The key problems underlying such issues are economic. Figure v.1 provides a basic framework for understanding them. It shows that innovation and competition in the modern pharmaceutical industry can be divided into three areas. The first is 'true' innovative activity. This creates fundamentally new products which may either render existing technology obsolete or open up entirely new fields of therapy. It is the area in which 'creative destruction' and 'workable competition', often between oligopolistic or even monopolistic concerns, is concentrated – see text page 12.

The second is imitative or price plus product competition. Here variables like price, presentation and product support through information services are coupled to relatively minor improvements in an existing medicine's pattern of action. And the third is commodity competition. In this, the last stage of a major drug's life cycle, the price is forced down to the lowest economic level by the market. So here incentive is focused on creating savings from large scale production and/or from new, more cost effective, production techniques.

Few people do not see the value of innovative competition in the pharmaceutical sector, although many may sometimes fail to fully recognise it. This is because the time span of modern pharmaceutical research can be forgotten. In innovative competition the arrival on the market of a novel drug stems from a process which began a decade or two decades previously. Many companies try to enter a given area, and a few succeed. A strong case can be made for allowing the 'runners up' in such a race to market their alternatives to the medicine which first reaches the consumer.

The latter rests on a) the desirability of extending the armoury open to physicians which may benefit smaller groups of patients with atypical needs or reactions b) the

possibility that the analysis and exploration of minor differences between products may eventually lead to major innovations (ie, small-step and chance discovery processes) and c) the need to distribute income between companies in order to maintain a balanced industry structure.

Such considerations are also relevant to cases of pure imitative competition/innovation, that is of the type in which a new product is from the start of its development intended only to reproduce, and possibly to improve upon, the action of an existing medicine. Such research may seem of doubtful value, but it is often essential from a corporate economic viewpoint and can bring the consumer benefits. This is not least because it is the herald of commodity competition.

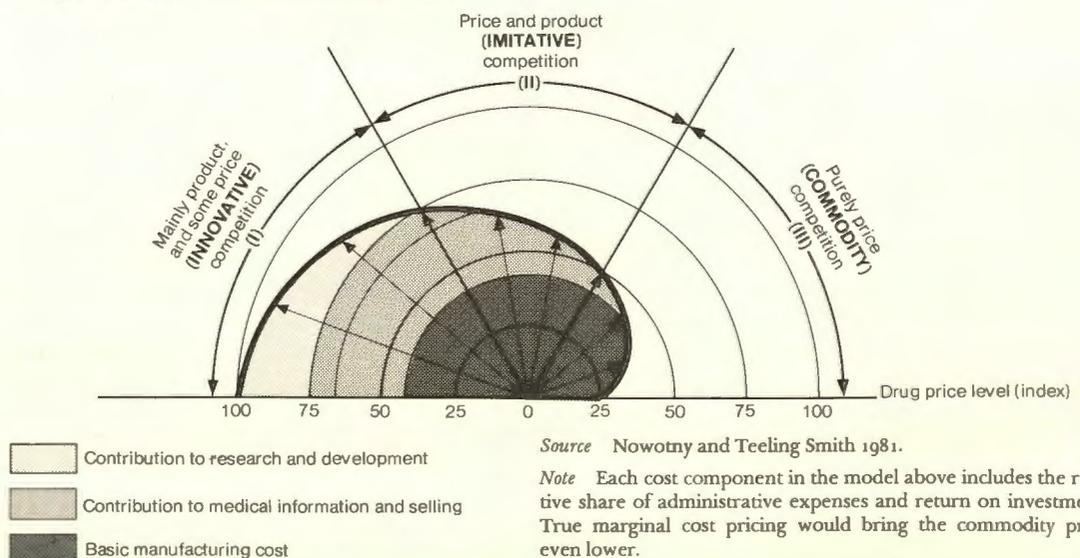
The quite separate issue of 'Cinderella' problems relates to the fact that where very small numbers of potential consumers are involved the unit costs of any treatment to emerge will be correspondingly high. Provided that third party funding organisations (the government in the case of the NHS) are prepared to meet the costs involved there is no difficulty inherent in testing and marketing such medicines. But in tightly regulated markets where planners are primarily concerned with the wellbeing of majority groups some opportunities could be passed over.

Similarly, economic pressures may result in progress in the tropical disease field not being as fast as concerned observers wish it to be. Poor communities which can only purchase adequate volumes of pharmaceuticals at basic (or marginal) manufacturing cost (that is, a commodity price) do not generate income for research activity. Nor do they offer the prospect of future financial rewards even for successful producers of highly beneficial new drugs. Such 'market failures' are only likely to be minimised by close government/industry/international agency co-operation.

Finally, the proportion of industry research budgets devoted to 'fundamental' investigations is relatively low – typically around 10 per cent, depending on the precise definitions employed. It may be argued that this is because industry's main expertise is in applying theoretical concepts to specific problem areas and developing employable therapies as a result.

Market competition is an appropriate way of promoting incentives for funding the latter. Academic enquiry into basic issues is often better organised through peer-review and related controls such as those used by the MRC. Even so, it should not be forgotten that on fundamental research alone UK pharmaceutical industry spending is equivalent to about a third of the global MRC outlay.

### V.1 The types of pharmaceutical competition



### BOX VI Consumers' questions about their medicines

Dr Andrew Herxheimer, the Editor of *CA's Drug and Therapeutics Bulletin* and chairman of the IOCU Medical Committee, has long been an advocate of the supply of more information about medicines to their users. The questions below point to the range of basic knowledge he and his colleagues feel fundamentally necessary for anyone to take prescribed medicines properly. They should be asked by the consumer him or her self or, in the case of children or other dependent individuals, by those responsible for their day to day care.

#### *What for and how?*

What kind of tablets are they and in what way do you expect them to help?

How should I take them? How many, how often?

Will I be able to tell whether they are working?

How do I keep them?

#### *How important?*

How important is it for me to take these tablets?

What is likely to happen if I do not take them?

#### *Any side-effects?*

Do the tablets have any other effects that

I should look out for?

Do they ever cause any trouble?

Is it alright to drive while I'm taking them?

Are they alright to take with other medicines I may need?

Will alcohol interfere with them?

What should be done if someone takes too many?

#### *How long for?*

How long will I need to continue with these tablets?

What should I do with any that are left over?

When will I need to see you again?

What will you want to know at that time?

See Hermann *et al* 1978, *Drug and Therapeutics Bulletin* 1981.

or non-executive directors with special contributions to offer in the consumer field (Adamson 1982). This latter type of initiative may be aimed primarily at increasing industry's sensitivity towards an understanding of consumer concerns.

There are objections and difficulties surrounding all the above possibilities. For instance, increased attempts at consumer education via the first channel might be seen as simply a route for promotion. Also the difficulties surrounding the transmission of complex information in this way are considerable. Not only did three-quarters of doctors questioned in the 1980 ABPI survey feel that mass media coverage of medical topics tends to be inaccurate. Many educationalists doubt the value of written materials and other indirect information sources to less advantaged subjects. They emphasise instead the value of, and the need to teach, verbal communication skills in the health context.

Similar queries relate to the value of patient package inserts (PPIs) supplied with medicines. In fact, research by organisations such as the Rand Organisation in America indicates that inserts are quite frequently read and that drug knowledge is improved by them. They are attractive in as much as their distribution could be seen to be a step towards meeting the demands of consumer leaders for more medicine information. And they might indeed be highly appropriate in the context of therapies used by

younger, educated and relatively healthy people. Oral contraception is an example where PPIs are already available.

But across the broad range of the population there is little reason to suppose that PPIs change patient behaviour in any significant manner. Also those who value them could well be able to use alternative published information sources. Practical difficulties surround their use in contexts where there is not original pack dispensing. The cost effectiveness of PPIs must therefore be questioned, particularly as in the near future new information technology could easily revolutionise this field.

From both a political and economic viewpoint the option of providing doctors, pharmacists and perhaps other health workers with aids to patient communication looks rather more attractive. Indeed, it is already existing practice. Health staff can distribute written material about particular categories of medicine to those requiring it, whilst selectively helping those likely to respond only to verbal or other direct information.

However, the difficulty here from the viewpoint of some consumers is that this option leaves control of information release firmly in the hands of groups like the doctors. It does not involve the free access to data and modification of professional authority central to some models of participative health care. Additional, rather than alternative, measures to meet this criticism could involve the fourth option listed above, support for, and the supply of medicine related information directly to, self-help groups.

This may be seen as an undesirable move by some although, once again, it is already the existing practice of many companies to fund appropriate voluntary bodies. In as much as medicines can only be used appropriately within the context of intelligent user behaviour and complementary social support for distressed or disabled individuals, increased activity in the self-help/community care area seems particularly desirable. Yet the success of any of the steps towards better communication touched on above will hinge on manufacturers having a clear and sympathetic understanding of consumer needs and goals. Thus initiatives in the final category, aimed at providing companies with receptive social 'eyes and ears', may well prove to be of ultimate importance.

# Conclusions

The genesis of the consumer movement in the democratic societies of the North West lay in the increasing complexity of the twentieth-century market place. Confronted with a wide range of unfamiliar, highly sophisticated and fast-changing goods, consumers began to demand sources of information additional to manufacturers' advertising and retailer and word-of-mouth recommendation. Their leaders also called for increased legal protection against commercial malpractices and associated phenomena, protection of a type which had perhaps not been needed in the simpler, less anonymous conditions of early centuries.

The increased wealth which was both the motor and the product of the above changes gave Western society the capacity to support bodies which could supply independent consumer advice and information. It has also permitted governments to intervene, often after prompting by consumer organisations, to protect the public against hazardous goods, inadequate services and undesirable trading practices. Industry, in parts of the private sector at least, has in response organised itself better to ensure that public needs are fulfilled.

The analysis presented in this paper suggests that these developments represent a desirable evolution of the Western economic tradition of market freedom within the law. Few commentators deny that the consumer movement can claim a significant degree of the credit for reforms relevant to the positive progress outlined in earlier sections of this paper.

However, consumerists are not without their faults. Some seem excessively hostile towards industry. Although such attitudes are normally confined to the more extreme fringes of the movement it is possible that even well-established individuals who spend much time attempting to correct defects and injustices in the relatively free Western nations can occasionally be blinded to the great strengths of societies like Britain. They may also tend to take rather a one-sided view of the producer/consumer relationship, and so stimulate needless conflicts between the two 'halves' of the economic system.

More seriously, it can be argued that the consumer movement has failed to convince many people in government, industry and the population as a whole of its importance in a modern market economy. Consumerists presumably believe that if more than lip service is to be paid to the concept of consumer sovereignty in complex industrialised communities then organised representation of and support for consumers is a vital element in creating effective competition. Yet the status of consumerism appears to be such that it is widely considered to be of only peripheral significance.

Turning to the area of health care there are in this context clearly special factors involved which make direct consumer sovereignty difficult, not to say impossible, to achieve. What is wanted is 'workable' consumer power. In the longer term health education and possible modifications to the structure of the NHS should allow the consumer a more positive role to play in his or her own care decisions. Such a possibility is to be welcomed. But there is no radical alternative which will suddenly open the way to avoiding the health related consumer problems touched on in this paper. At present the most urgent need is for a more satisfactory balance between professional excellence and authority on the one hand and effective systems of complaint and redress on the other, coupled by

as much goodwill as possible in the relations between care providers and consumers.

Much the same points apply specifically to the use of medicines. OHE has elsewhere (OHE 1976) described how, in a manner analogous to the overall development described above, the proliferation of new medicinal products generated in the first therapeutic revolution of the 1940s and 1950s led to an information vacuum. This was at first filled by producers through advertising and other promotional material. Then the medical profession and the public demanded new, counterbalancing sources of information and, partly in reaction to the thalidomide tragedy, new controls on the pharmaceutical market designed to reduce hazards, control costs and stop unfair or misleading marketing. The regulatory forces needed came into being largely in the 1960s and the 1970s. In particular the 1968 Medicines Act provided for the establishment of the Medicines Commission and allied bodies like the Committee on the Safety of Medicines, whilst the Pharmaceutical Price Regulation Scheme ensures that NHS medicines provide value for money.

These arrangements are amongst the most comprehensive and efficient in the world. Although consumer leaders and other commentators have every right to continue to voice their concerns about topics like drug safety and medicine spending, it would be tragic if alarmist or otherwise misleading material undermined or destroyed the free enterprise UK pharmaceutical industry's ability to research and successfully sell new medicines. There is a real danger that such an outcome could occur, particularly if rich world anxieties are fuelled and amplified by distorted anti-industry propaganda relating to third world pharmaceutical supply problems. Those who advocate state control of the pharmaceutical industry in Britain or the 'de-commercialisation' of the world pharmaceutical market (Health Action International 1981) should examine in detail the probable consequences of such 'cure-alls' for consumers and consumer sovereignty. In fact, the philosophies underlying 'consumerism' on the one hand and 'nationalisation' on the other appear to clash at many points.

However, it is appropriate to conclude this document by emphasising that just as sections of the consumer movement do not always seem to act in the global public interest, so, too, is the independent pharmaceutical industry open to criticism. Indeed, much of the argument in favour of keeping drug research and manufacture in the private sector is that this encourages not only intra-sector competition but also the expression of healthy concerns by politicians and civil servants as well as journalists and consumer groups.

It may be that many individuals within the pharmaceutical industry fail to recognise the value of this, and that they show too little willingness to enter into an open dialogue with their critics. Medicine makers are, rightly or wrongly, widely believed by consumer leaders, elected representatives and journalists to be excessively defensive and secretive (Mitchell 1982). Yet the material assembled in this paper suggests that they have much to gain from trying to communicate more effectively the true facts of the pharmaceutical market and the place of medicines in health care to all consumers.

# Appendix: Organisations in the British Consumer Movement

The objective of this appendix is to provide a brief guide to the make up of the main consumer groups in this country, and of those abroad to which British organisations are linked. It pays particular attention to the health sphere, and is divided as follows:

'Mainstream' UK consumer organisations.

Consumer groups specifically concerned with health.

Charities and self-help groups involved with representing health care users.

Women's organisations active in consumer affairs.

The Nationalised Industry Consumer Councils and associated bodies.

Government agencies involved in the consumer area.

International consumer organisations.

Other bodies.

It does not claim to be a completely comprehensive catalogue of the bodies involved. But it should provide the reader with a general view of the size, funding and nature of the greater part of the British consumer movement.<sup>10</sup>

## MAINSTREAM CONSUMER ORGANISATIONS

### The Consumers' Association (CA)

This is by far the most important independently financed consumer body in the UK. Virtually the only other one to have claimed national status is the National Consumer Protection Council, which has produced relatively little significant work.

Formed in 1956, CA today has an income of over £12 million (1982), a staff of more than 400 and a membership in the order of 650,000. It offers a wide range of publications, the best known being *Which?* and associated journals like *Motoring Which?* and *Money Which?*

The CA is currently extending its interest in the health sphere. It already publishes the *Drug and Therapeutics Bulletin*. This is distributed free to all NHS doctors and hospital pharmacies via an agreement with the DHSS. The revenue of this publication is about £300,000 per annum. Its editor, Dr Andrew Herxheimer, is also chairman of the medical committee of IOCU – see below.

CA helped to establish bodies like the Research Institute for Consumer Affairs in 1963 and the Institute for Consumer Ergonomics in 1976. It also provided support to organisations like Consumer Advice Centres and has played a important role in shaping British consumer legislation in the past 25 years.

The Consumers' Association, 14 Buckingham Street, London WC2N 6DS 01-839 1222.

### The Consumers in the European Community Group (UK) (CECG)

The Consumers in the European Community Group is funded by the Department of Trade via the NCC (see below). Annual spending is now (1981/82) some £80,000, and there is a permanent staff of four. CECG was formed in 1978 by the principal bodies in the consumer movement to coordinate their activities in relation to EEC affairs. It thus formally took on the role of its progenitor, the EEC Consumers Coordinating Group, founded in 1972. CECG has published pamphlets on topics like common agricultural policy and product liability.

Consumers in the European Community Group, The Mary Sumner House, 24 Tufton Street, London SW1P 3RB 01-222 2662.

### The National Consumer Council (NCC)

The NCC was established by the Government in 1975. The Welsh, Scottish and Northern Irish Consumer Councils were also set up in that year. Each council has its own programme of work, although they vary greatly in scale. The Irish body employs only one person whereas the NCC has its own London offices, a staff of about 40 and a budget of close to £1 million per annum. The latter is met via Department of Trade grants. The remit of the NCC states that it should; a) have a special role in representing inarticulate and disadvantaged consumers; b) concern itself with overall public service provision issues and; c) encourage consumer representation whenever that is deemed appropriate.

In concentrating effort in such areas and avoiding activities such as comparative testing or the provision of individual advice the NCC's role is kept quite distinct from that of other bodies like the CA, local consumer advice services and the nationalised industries' consumer organisations. The type of destructive conflict which has sometimes taken place abroad between the government backed and independent consumer bodies does not, therefore, exist.

The members of the Consumer Councils are appointed by the Secretary of State for Trade, except in Ireland where the Secretary of State for Northern Ireland is responsible. NCC has a magazine entitled *Clapham Omnibus* and has produced numerous *ad hoc* studies of high quality. Recently it published *Patients' Rights*, a guide to patients rights in the NHS.

The National Consumer Council, 18 Queen Anne's Gate, London SW1H 9AA. 01-222 9501.

The Northern Ireland Consumer Council, 176 Newtownbreda Road, Belfast BT8 4QS 0232 647151.

The Scottish Consumer Council, 4 Somerset Place, Glasgow G3 041-332 8858.

The Welsh Consumer Council, Oxford House, Hills Street, Cardiff CF1 2DR 0222 396056.

### The National Federation of Consumer Groups (NFCG)

The National Federation of Consumer Groups was founded in 1963, following an initiative made in 1961 by CA intended to stimulate growth of local consumerism. This met with early success – there were 32 groups at the time of NFCG's formation – but subsequently there has been little expansion. Current NFCG group membership is 40. NFCG collates and transmits information about their activities, and helps form new consumer groups. Budget is in excess of £40,000 a year, including CA and Department of Trade grants, individual and group memberships and associations and fees from publications and survey work.

The National Federation of Consumer Groups, 70-76 Alcester Road, South Birmingham B14 7PT 021-444 690.

### Public Interest Research Centre Ltd and Social Audit Ltd

The Public Interest Research Centre is a registered charity; Social Audit is its non-profit making publishing arm. Both were formed in 1971.

Social Audit has a staff which has at times numbered up to seven individuals, although its full time 'hard-core' is more normally only two or three. Social Audit has received income from bodies like the Rowntree Trust, the Ford Foundation, CA, the Methodist Church and War on Want. On average it would seem to run at £25,000-£30,000 per annum.

Social Audit has published many once-off studies, including books such as Charles Medawar's *Insult or Injury?* (which touched on problems relating to prescribing information supplied in the third world) and the more recent book *Drug Diplomacy*. It is associated with the group Health Action International, and Social Audit has prepared and distributed HAI literature.

Social Audit Ltd is currently relocating. Temporary (December 1982) telephone 01-586 7771.

<sup>10</sup> Other useful introductions to this area include the Consumer Congress Directory, published in 1982 by the National Consumer Council, and chapter 22 of *Marketing and the Consumer Movement*, edited by J. Mitchell.

## HEALTH CONSUMER GROUPS

### Community Health Councils (England and Wales), Local Health Councils (Scotland) and District Health Committees (Northern Ireland)

The 1974 reorganisation of the NHS led to the formation throughout the UK of district level Councils outside the main management structure, the role of which is to 'represent the interests of the consumer in the health service'. In England and Wales alone there are over 200 CHC's which run at an annual cost of £4.5-£5 million. The great majority are members of the Association of Community Health Councils of England and Wales which publishes a monthly paper *CHC News*.

CHCS, LHCS and the DHCS have conducted many small scale research projects, act as 'patients friends' in assisting with health service complaints. They contribute both to health service management and planning and they provide general advisory support for the public.

The Association of Community Health Councils for England and Wales, 362 Euston Road, London NW1 01-388 4814.

The Association of Scottish Local Health Councils, 29 Castle Terrace, Edinburgh. 031-229 5782.

The Association of District Health Committees of the Health and Personal Social Services (Northern Ireland), 27 Adelaide Street, Belfast BT2 8FH 0232 24431.

### The National Association for Patient Participation in General Practice

Throughout Britain a number of general medical practices have established participation groups designed to improve consumer/provider communication. The Association exists to encourage the spread of such groups and to facilitate their work, via conferences and other methods of information exchange. It currently has around 50 members.

The National Association for Patient Participation in General Practice, 28 Heol y Deryn, Glyncoirwg, Port Talbot, West Glamorgan 0639 850604.

### The Patients Association (PA)

PA is the only national consumer group exclusively interested in health service affairs. It has around 1,000 subscribing members and a total budget (including a DHSS grant) of around £10,000 per annum. PA publishes a magazine called *Patient's Voice* and has taken considerable interest in topics like the NHS complaints systems and the testing and safety of medicines.

The Patients Association, 11 Dartmouth Street, London SW1 01-222 4992.

## CHARITIES AND SELF-HELP GROUPS

The United Kingdom enjoys a unique system of charitable and voluntary bodies active in the health sphere. They range from relatively large organisations with incomes in the order of £20 million per annum to very small local groups; and from research oriented organisations to bodies concerned exclusively with providing care to the sick and disabled. Some like the Spastics Society and Age Concern, have been actively involved in pressing for better standards of NHS care whilst others, like Oxfam and War on Want, are particularly concerned with third world health issues.

In some instances government is involved in partly funding voluntary organisations. This is so at a national level, for instance, in the cases of MIND, RADAR and ASH. However, in a system involving the outlay of several hundred million pounds annually, total direct state support is only in the order of £10 million.

It would be beyond the scope of this brief appendix to attempt even to list all the bodies active in this category. But useful guides to the range of self-help groups and health charities include:

Self-Help and the Patient (8th edition, 1982), available from the Patients Association.

The *Sunday Times* Self Help Directory (2nd edition, 1982).

Voluntary Organisations (1982), available from the National Council for Voluntary Organisations.

Help! I Need Somebody (3rd edition, 1970), written by Sally Knight and published by H Kimpton.

Get Help (1981), by Primrose Halliburton and Kate Quelch, Published by Tavistock Publications.

Health Help (1981), produced by Thames Television and the Merton, Sutton and Wandsworth Health Education Unit.

Guide to Self Help Groups (1981), by Share Community Ltd.

The Directory for the Disabled (3rd edition, 1981), from RADAR.

The Charities Digest (1982), from the Family Welfare Association.

The Directory of Community Health Initiatives (1982), available from the National Council for Voluntary Organisations.

Such publications may be seen in the libraries of organisations like the NCVO and the King's Fund, which is updating its own Directory of Organisations for Patients and Disabled People. An idea of the work of the research charities may be obtained from the Handbook of the Association of Medical Research Charities (1982), obtainable via the British Heart Foundation.

## WOMENS' ORGANISATIONS

Many of the major women's organisations take an active interest in consumer affairs. They include the following bodies:

**The Co-operative Women's Guild** (342 Hoe Street, London E17 9PX). This was founded in 1883, and currently has a membership in England and Wales of around 15,000. The Scottish and Irish Guilds bring the total to over 20,000. Spending last year, in which a conference took place, was some £80,000. The Guild is currently working on health issues alongside the RUC and the Labour Party.

**The National Association of Women's Clubs** (5 Vernon Rise, Kings Cross Road, London WC1X 9EP) is an educational charity financed both by DES grant and membership payments. The Association has 700 clubs and some 40,000 members. Central income is around £50,000 per annum. Health issues are frequently discussed at Association meetings.

**The National Council of Women** (36 Lower Sloane Street, London SW1W 8BP) is affiliated to the International Council of Women. The latter was formed in the 1880s, the British body in the 1890s. It has some 5,000 branch members and 80 affiliated societies. There are committees on both health and consumer affairs.

**The National Federation of Women's Institutes** (39 Eccleston Street, London SW1W 9NT) was formed in 1917, two years after the first Women's Institute in England. This is by far the largest group of women's organisations with a total membership in England, Wales and the Isle of Man and the Channel Islands of 380,000. The NFWI's central income is some £500,000 (including DES grants as it is a registered educational charity) in addition to which the 63 Island and County federations and the several thousand individual Institutes have their own budgets. NFWI has taken a major interest in health topics, on matters ranging from drug abuse to rural health services.

**The National Housewives Association Ltd** (112 Durnford Street, Stonehouse, Plymouth, Devon) was formed in 1972. Figures are not available on membership and income, but the organisation has been active on topics like the use of animals in cosmetic testing and is a member of the CEEG.

**The National Union of Townswomen's Guilds** (2 Cromwell Place, London SW7 2JG) was founded in 1929. There are today

some 2,500 Guilds in the UK, organised into 112 federations. Total membership is around 164,000. Like the NFWI and the NAWC it is an educational charity, and has a DES grant. Central NUTG income is around £400,000 per annum.

**The Scottish Women's Rural Institutes** (42 Heriot Row, Edinburgh, EH3 6EU) is the Scottish sister organisation of NFWI. It has a total central income of approaching £30,000 per annum and the number of Institute members in Scotland is 50,000. The organisation takes an active interest in health topics, and many LHCS in Scotland have Institute representation.

## THE NATIONALISED INDUSTRY CONSUMER COUNCILS AND COMMITTEES (NICCs) as of December 1982

The 44 currently constituted NICCs cover the gas, electricity, coal, rail and ferry transport, and posts and telecommunications industries. All except the Electricity Consumers' Council (ECC) are statutory bodies, working within a framework set by the nationalisation legislation of 1945-50. They involve almost 1,000 direct Ministerial appointments. (The Regional gas and electricity NICCs in addition make some 2,200 appointments to their local committees, which formally are not NICCs). The NICCs are serviced by a permanent staff of about 240. Their total cost was £3.7 million in 1980-81 (Department of Trade 1981).

The major bodies so classified include:

**The Central Transport Consultative Committee** and 11 **Area Transport Users Committees** covering Great Britain. The address of the CTCC is 3-4 Great Marlborough Street, London W1V 2EA.

**The Domestic Coal Consumers Council** established under the Coal Industry Nationalisation Act of 1946. There is no regional structure in this sector. The DCCC, Gaurelle House, 2 Bunhill Row, London EC1V 8LL.

**The Electricity Consumers Council** for England and Wales is a non-statutory body established in 1977. There are also 14 **Electricity Consultative Councils (ECCs)** of much longer standing, one ECC matching the area of each Electricity Board in England, Wales and Scotland. Across Britain there are 78 local committees (1981 figures) linked to the ECCs. The address of the national Electricity Consumers Council is Brook House, 2-16 Torrington Place, London WC1E 7LL.

**The National Gas Consumers' Council** was formed under the Gas Act of 1972, whereas the 12 **Regional Gas Consumers' Councils** date back to the 1948 Act. There are also 63 local committees (1981) associated with the latter. The NGCC, Estate House, 130 Jermyn Street, London SW1V 4UJ.

**The Post Office Users National Council** was established as an independent statutory body in 1969. The address of POUNC is Waterloo Bridge House, Waterloo Road, London SE1 8UA.

Other bodies analogous to the NICCs proper include the **Airport Consultative Committees** one of which has been established for each of the British Airports Authority's seven main facilities. ACCs also exist for some large local authority airports. The **Air Transport Users Committee (AUC)** was established in 1973 and became more independent in 1978. It can be contacted at Space House, 43-59 Kingsway, London WC2B 6TE.

## GOVERNMENT AGENCIES

**The Department of Trade**, at which Lord Cockfield is currently Secretary of State and President of the Board of Trade and Dr

Gerard Vaughan is Minister of State for Consumer Affairs, is the main government department involved in consumer matters. Its Consumer Affairs Division, which has approaching 120 staff, deals with the matters relating to topics like the Consumer Credit Act, the NICCs, the advertising industry and the Fair Trading Act. It also has responsibility for the National Weights and Measures Laboratory.

The Competition Policy and Service Industries Division, with about 80 staff, has functions relating to items like mergers, restrictive trade practices and consumer safety. Finally branch 5 of the International Trade Policy Division, with just under 20 staff, is concerned with standards and quality assurance, including international work in such areas.

The main address of the Department of Trade is 1, Victoria Street, London SW1H 0ET.

**The Office of Fair Trading** was created by the 1973 Fair Trading Act. The Director-General is neither a civil servant nor a politician, although he or she is appointed by the Secretary of State for Trade. The OFT costs approaching £5 million a year to run.

Through legislation such as the Consumer Credit Act of 1974, the Restrictive Trade Practices Act (1976) and the 1980 Competition Act OFT has responsibilities in three main areas: consumer affairs, consumer credit and monopolies and mergers and restrictive trade practices.

In the context of the first of these the Director-General collects information about all complaints to bodies like Citizen's Advice Bureaux, encourages trade associations to produce codes of practice and takes action against traders who fail the public. He or she may ask the **Consumer Protection Advisory Committee (CPAC)** to consider undesirable trade practices, although in recent years the CPAC has not been active.

Regarding consumer credit one of the OFT's main functions is to license agencies which lend money or hire goods, or are concerned with ancillary activities. In the case of monopolies the Director-General may amongst other things advise as to whether or not a referral should be made to the Monopolies and Mergers Commission. In 1981 he considered 164 mergers involving £43,000 million.

The OFT also produces a wide range of literature relating to consumer affairs. Information about this and other aspects of the Office's work is obtainable from the OFT at Field House, Bream's Buildings, London EC4A 1PR.

## INTERNATIONAL CONSUMER ORGANISATIONS

### Bureau European des Unions de Consommateurs (BEUC)

BEUC was originally funded in 1962 and since 1973 has had a permanent office in Brussels. It now has 14 member associations and 5 correspondent members. They include from Britain the CA and the NCC in the former group and the NFGC and the British Standards Institution's Consumer Standards Advisory Committee in the latter. CA is the largest single contributor in economic terms, although BEUC also receives a sum roughly equivalent to its total membership subscriptions from the EEC's Consumer Protection Directorate for research projects. Total budget would seem to be around £160,000.

In addition to its research and information functions BEUC plays an important role on the Consumers Consultative Committee - see below. BEUC studies in recent years include investigations on topics like pharmaceutical pricing and the use of antibiotics and hormones in animal husbandry. It has an ongoing interest in such areas. BEUC, Boite, 3, 29 Rue Royale, Brussels 1000.

**The Consumers Consultative Committee (CCC)** has consultation rights with the Consumer Protection Directorate, its funding body. Established in its current form in 1973, it has since mid 1980 had 33 members. BEUC, COFACE (a European grouping of family

organisations) EUROCOOP (a similar association of the cooperative movement) and European Unions Confederation CES (also referred to as ETUC) each have six representatives. Nine places are for individuals chosen by the Commission for individuals viewed as having special expertise in consumer affairs. This relatively new, enlarged membership is felt by some commentators to have balanced out past 'excessive' trade union representation on the CCC.

The CCC has produced opinions on a number of topics relevant to health, including medicine prices. Its main influence seems to have been related to a gradual process of education and attitudinal change towards consumers in Brussels.

**International Organisation of Consumer Unions (IOCU)** was established in 1960 by five 'rich world' consumer organisations, including the CA. It now has well over 120 member bodies, many from the third world countries where 'consumer protest' is sometimes one of the few tolerated forms of public dissent from the economic and associated policies of ruling groups. The total budget of IOCU, raised from members, is in the order of £200,000. The organisation has relatively close links with the UN and has a centre in Malaysia which specialises in third world affairs. It has a number of publications, including the annual *International Consumer*.

In the 1970s IOCU was involved in the infant feeding controversy and the work of IBFAN, the Infant Baby Food Action Network. Recently, three other action networks – Health Action International (HAI), The Pesticides Action Network (PAN) and the Appropriate Products Research and Action Network (APRAN) – have been formed with IOCU support.

HAI is a loose-knit association of some 50 organisations which appears to have no clear legal status. Even the full membership is not easily obtainable. Nor is precise information on funding published, although bodies such as the Dutch government and a Scandinavian church are believed to have donated resources for work in the area of third world health. HAI has focused its attention particularly on topics like medicine promotion standards, in part through the research of British participants like Oxfam, War on Want and Social Audit. A former member of the latter's staff, Virginia Beardshaw, is now HAI's only full time worker in The Hague.

IOCU, 9 Emmastraat, The Hague, Netherlands.

## OTHER BODIES ACTIVE IN BRITISH-CONSUMER AFFAIRS

### The Advertising Standards Authority Ltd (ASA)

Founded in 1962 by the Advertising Association, the ASA is an independent limited company which exists primarily to enforce the British Code of Advertising Practice. The ASA, Brook House, Torrington Place, London WC1E 7HN.

### The British Standards Institution (BSI)

The BSI, at the outbreak of the 1939–45 war, was invited by the Retail Standards Association to co-operate in establishing more effective consumer standards. Subsequently it was involved in the wartime utility schemes, and in the post-war period became increasingly seen as a 'consumer champion' via the work of its Women's Advisory Committee (set up in 1951) and its Consumer Advisory Council (originally formed in 1953). Today the BSI's Consumer Standards Advisory Committee advises its Executive Board on matters relating to consumer interests. The BSI, 2 Park Street, London W1A 2BS.

### Centre for Consumer Education and Research in Scotland (CERES)

Created in 1976 to develop research projects related to consumer education. Part of the School of Consumer Studies. CERES, Queen Margaret College, Clerwood Terrace, Edinburgh EH12 8TS.

### The Citizen's Advice Bureaux (CABx)

This service also began with the 1939 war, and is today the nation's most extensive independent advice and support system. It involves some 12,000 largely voluntary workers and approaching 800 bureaux. In 1973 a National Association was formed, which has a central policy-making role. A special Scottish body was formed in 1975.

Total central government funding to the central CABx organisation is nearly £6 million, of which almost £1 million is earmarked for services which compensate for the government withdrawal of Consumer Advice Centre grants. In addition local government gives perhaps as much again to individual Bureaux. The Association's figures indicate that in 1981/82 the CABx helped with 4.5 million enquiries, 790,000 of which related to consumer affairs. The National Association of Citizen's Advice Bureaux, 110 Drury Lane, London WC2B 5SW and the Scottish Association of Citizen's Advice Bureaux, 82 Nicolson Street, Edinburgh EH8 9EW.

### The Co-operative Union

The central organisation of the co-operative movement, which serves the functions of a trade association. There are around 150 Co-operative Societies in the UK with a turnover of over £4,000 million, making 'the Co-op' the nation's largest retailer. The Union was founded in 1869 and produces consumer oriented literature, as well as serving the societies. It has an annual budget of some £2 million. The Co-operative Union, Holyoak House, Hanover Street, Manchester M60 0AS.

### The Good Housekeeping Institute

Owned and financed by the National Magazine Company, the Good Housekeeping Institute was founded in 1924. The Good Housekeeping Institute, National Magazine House, 72 Broadwick Street, London W1V 2BP.

### The Institute of Consumer Advisers (ICA)

Founded in 1974, the ICA assists in the education of and provision of information to people involved professionally in advising consumers. It publishes a bi-monthly newsletter, *Help and Advice*.

### The Institute of Trading Standards Administration (ITSA)

Dates back to the 1894 Incorporated Society of Inspectors of Weights and Measures – the name was changed in 1972. Largely concerned with professional affairs, although does take part in direct consumer education exercises. The official journal is the *Monthly Review*.

### National Council for Voluntary Organisations (NCVO)

Formerly the National Council for Social Service, the NCVO has over 300 member organisations. Total spending in 1981 was over £1.7 million. The Council acts as a focus for the UK voluntary movement, holding meetings, publishing literature and information, conducting projects, establishing new bodies and representing members views to government. The Youth Hostels Association, the National Childrens Bureau, Age Concern and the National Association of Citizen's Advice Bureaux all grew out of NCVO work, the organisation itself being founded in 1919. The NCVO frequently acts in concert with the Councils for Wales, Scotland and Northern Ireland.

CSSW, Llys Ifor, Crescent Road, Caerphilly, Mid Glamorgan CF8 1XL.

NCVO, 26 Bedford Square, London WC1B.

NCSS, 2 Annadale Avenue, Belfast BT7 3JH.

SCSS, 18–19 Claremont Crescent, Edinburgh EH7 4QP.

### Trading Standards/Consumer Protection Departments

Previously the Weights and Measures Departments of Local Authorities, these bodies enforce at 'grass roots' level much consumer legislation. They also provide direct consumer information and support and recently have taken over the functions of many of the local authority **Consumer Advice Centres** which developed in the 1970s.

**The Scottish Federation of Independent Advice Centres**

This represents some 50 independent centres, providing information and promoting their interests at all levels. The SFIAC, Citizen's Rights Office, 132 Lauriston Place, Edinburgh 3.

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