How did we get to the point where £22m is spent on prescribing drugs—*every day*? In the first of a four-part special, Jerome Burne launches our campaign to tackle

Drugged-Up Britain

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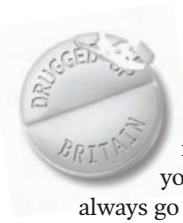
When 54-year-old John arrived at a nutritional clinic in south London, he was in a bad way. Overweight, with chronic hip pain due to osteoarthritis, he also suffered from migraines, heartburn and severe mood swings. For the last six months, he'd been taking five or six different drugs a day—mostly painkillers, but also one for migraine and another to reduce acid in his stomach.

"Sometimes it was really hard to get up the energy to go to work," he says. "All the pills made me feel woozy. They obviously weren't going to cure me; they just dulled the pain. The doctor said I should lose some weight, but eating was about the only pleasure I had left."

Aspects of John's situation will be familiar to many of us. You've got backache or your guts are upset; maybe ▶

LOGO BY STEVE CAPLIN



you feel constantly tired or you're depressed. So you go to the doctor and get a pill for one or more of your ailments. But while it might make you feel a bit better, the underlying problem doesn't always go away. And then there are the side effects—muscle pains, dry mouth, a loss of libido...

This situation is set to get worse. Every year we consume around £11bn pounds' worth of drugs in the UK, a spend of around £183 per head. Another way of looking at it is to say that an average of 16 prescriptions is written each year for every single person in England, at a cost of £22m a day. (The figures don't quite match up because you have to add in the rest of the UK to the second set of figures.) In England and Wales, the number of prescriptions went up from 500 million to 700 million between 1996 and 2003.

Or take a look at America, where the drug consumption is even higher. According to the sociologist Professor Donald Light, "Four-fifths of all Americans—including half of all children—take a prescription drug each week." And wherever the US leads, the UK is rarely far behind.

The overall picture is clear. We've created a system that encourages us to consume ever-larger quantities of expensive drugs at a time when deep cuts are being made in public services. Even worse, the number of us over 65 is set to soar. Next year sees the arrival of the Silver Tsunami, when the first of the baby boomers hit 65. By 2030, the number of people over 65 will be five million more than today, and about half of those over 65 are already taking five or more prescription drugs, according to the Royal Pharmaceutical Society. Welcome to Drugged-Up Britain.

But there's something we can do about it. Quite apart from the question of whether we can afford an ever-rising drugs bill, the experiences of people like John suggest that reaching for the prescription pad is not always the best way to handle many chronic health problems.

Of course, drugs can be lifesavers. If you've got a serious

KILL RATHER THAN CURE?

There were worries about the diabetes drug Avandia increasing your risk of a heart attack instead of cutting it even in 2000, when it was first licensed by the European Medicines Agency (EMA). In response, the EMA asked Avandia's manufacturers GlaxoSmithKline to set up a separate clinical trial, which eventually concluded that the drug was safe. But a later investigation into the trial by the FDA, America's drug watchdog, queried these results. Avandia was eventually pulled from all countries in Europe last year.

Reaching for the prescription pad is not always the best way to handle many chronic health problems

infection, you need antibiotics; getting the right treatment after a stroke can be the difference between recovery and life in a wheelchair, or worse. Modern medicine is brilliant in emergencies. But if you have conditions such as pain or heartburn, or you want to cut the risk of a heart attack, drugs may not be the best place to start. Just as you'd shop around if you were buying a washing machine or life insurance, so it pays to be a canny consumer about healthcare.

Looking for the most effective and safest deal is what's sending John and thousands like him in search of treatment that offers a more personalised approach. What we all want to know is why we've fallen ill in the first place—and what we can do to get healthy again.

Over the coming months, *Reader's Digest* will be suggesting ways to make your search more effective. If you're looking after an elderly parent or relative, for example, it's useful to know about some of the ways their needs and risks can be different from somebody younger. Knowing about the remarkable benefits of getting enough vitamin D, for example—and not enough of us do—could help cut your risk of all sorts of chronic diseases in the future. And we'll be talking to GPs whose practices combine the best of the drugs approach with one that's more patient-centred.

A friend recommended that John try the south London clinic of nutritionist Lara Just. "The drugs weren't helping John to function well, so the first step was to find out what nutrients he was missing," says Lara. "Checking the amount of vitamin D in his blood was an obvious move, because weak bones have long been linked to low vitamin D. Recent research suggests much higher levels are linked with less inflammation and better mood as well. I also tested how well his guts were absorbing nutrients, and how much of the anti-inflammatory omega-3 fatty acids he was getting."

It's an approach that many find more satisfying than that of a conventional doctor. "Treating bone or joint pain with aspirin-like painkillers is standard with doctors," says ▶

STATINS: THE REAL EFFECTS

If you're taking daily cholesterol-lowering statins to cut your risk of a fatal heart attack, you need to know what long odds you're betting on (assuming you haven't yet had an attack). In 2009, an authoritative study of over 60,000 patients found that, out of 10,000 taking the drug for four years, seven would avoid a deadly attack. The reduction was so small it could have happened by chance. The Cochrane Collaboration, which reviews all the data, found that statins' effect on the risk of dying from a heart attack if you hadn't had one was small—about 1,000:1. Statins also come with side effects, so the risk of a bad reaction may be bigger than your chance of benefiting.

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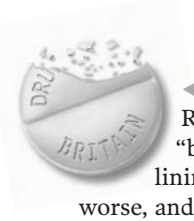


◀ Professor George Lewith of the Primary Care Research Unit at the University of Southampton, "but it raises the risk of irritating the stomach lining. That can make something like heartburn worse, and may affect how well nutrients are absorbed." Another painkiller—codeine—can also make your guts less efficient by causing constipation.

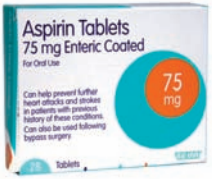
John was treated with vitamin D for his bone pain, along with omega-3 and -6 fatty acids to reduce inflammation, and probiotics to help his gut function. "My tummy is in a much better state than it has been for years," he says. "I get hardly any migraines, and the unbearable pain in my hip joint is manageable with just the occasional painkiller."

"It's remarkable how resistant John's doctor was," says Lara. "He ignored my request to do vitamin D and a couple of other tests. When we got it done by a respectable private lab in Harley Street, he refused to accept the result and sent John off for another test at a hospital—which also found that he was badly deficient. Then the doctor did give John a vitamin D supplement, but the amount was small (400IU) and it came with calcium in a form that was poorly absorbed." It was only after Lara put John on a supplement of 2,000IU a day that the improvement began.

Individualised treatments are common to many non-drug approaches, but they've come under attack because they're not backed up by the large-scale randomised trials that drugs have to go through. Critics say the benefits come from the placebo effect. Professor Lewith replies that many conditions—such as irritable bowel or premenstrual tension—are treated by GPs with drugs that have pretty poor evidence behind them, and a high placebo element.

But there's a bigger problem with exclusively relying on randomised controlled trials. They can tell you about what happens *on average* to people who get a treatment, but they aren't useful for testing individualised treatments.

If you have a sympathetic GP, however, you can always ▶



A U-TURN ON LOW-DOSE ASPIRIN?

For years, over-50s have been advised to take low-dose aspirin to help cut their risk of a heart attack (it makes the blood less likely to clot). But in the last 18 months, at least six big studies have found that the chance of avoiding a heart attack (350:1) is about the same as the aspirin causing serious internal bleeding (400:1). The British Heart Foundation no longer recommends low-dose aspirin for "people who don't have symptomatic or diagnosed artery or heart disease", but it clearly hasn't had much effect. Before the reports, doctors wrote 34 million prescriptions for low-dose aspirin—afterwards, it only fell to 32 million.

Two non-drug treatments are supported with mountains of evidence—a healthy diet and exercise. Every doctor recommends them

What Can You Do?

Try asking these questions next time you're given a prescription

Is this a drug that's only been licensed recently? If so, has your doctor received a lot of pharmaceutical promotion about it? When you start on a new drug you're effectively a guinea pig, because it will only have been tried on a few hundred people. Some drugs are heavily promoted, and it's worth knowing if this is one of them.

Is it a replacement for one that's just run out of patent? In which case, it's likely to be very similar but may have new side effects.

Is this being prescribed "off label", or has it been specifically licensed for your condition? Often drugs are licensed for one condition such as pain, but then drug marketing encourages doctors to use it for something else, which may lack scientific support.

Have there been any trials of the drug not financed by the manufacturers? Trials run by the manufacturers are four times more likely to be favourable.

Was the drug tested on the same sort of people as those most likely to use it? If older people are the likely users, was it tested on them or younger people?

Has the drug been tested against any drugs already in use, and how did it perform? New drugs often turn out to be no better than older ones. And issues with older ones are better understood.

Are there any non-drug treatments that are more effective than drugs for this condition? Cognitive-behaviour therapy, for instance, can be superior to drugs for both depression and insomnia.

Have all the trials that have been done on the drug been registered anywhere, so we know what the results were? Did any trials show no effect or signs of problems? Results that aren't favourable might have been kept under wraps.

Does your doctor think that it's worth filling in Yellow Cards, the system for reporting side effects to the drug watchdog? Did they fill in cards for any patients taking the antidepressant Seroxat, or the anti-inflammatory drug Vioxx, or for any other drug removed from the market because its side effects were too dangerous? If a doctor does fill in cards, they're probably more careful about side effects.

Is this drug likely to cause any vitamin or mineral deficiencies? Doctors usually don't know about this. At least, yours should know that statins lower levels of a very important antioxidant called coQ10, and that the diabetes drug Metformin may block the absorption of vitamin B12.

HUNTSTOCK/PHOTOLIBRARY.COM

run your own trial. Professor Lewith explains: "Drugs are tested against biomarkers. Trials ask: do they bring down cholesterol, reduce hypertension, or improve blood-sugar control? If you're following a non-drug approach, it makes sense to have such tests to see if the [alternative] treatment is working."

Two non-drug treatments are supported with mountains of evidence—a healthy diet and exercise. Every doctor recommends them. Unfortunately, getting people to change their lifestyle is hard, which is why most people with heart disease or diabetes find themselves on the pills. Realising they're not trained as lifestyle coaches, a few pioneering doctors are calling on the skills of people who are.

"Once we've diagnosed a chronic disorder, we're not really needed for treatment," say Dr Michael Dixon, Devon GP and chair of the NHS Alliance. "What patients need then is people who can tell them about diet, about new ways of cooking, really encourage them to do exercise, and so on. The results can be remarkable—and long-lasting." ■

LES CUNLIFFE/AGE FOTOSTOCK/PHOTOLIBRARY.COM

We want to hear about *your* experiences of Drugged-Up Britain. Please email us at readersletters@readersdigest.co.uk

Next month: the special problems of prescribing drugs for elderly people

BUDDING AUTHORS, TAKE A BOW!

This tale of thwarted ambition is another of the many 100-word stories submitted in our recent competition that we thought deserved a wider audience, even though it missed out on the main prizes.

Turning point

Today. Today's the day. Today, I'm going to be all that I can be, do all I can do. I'll answer every question, earn every grade, live every moment. A hero among teenagers. Today, students will admire me; teachers will seek me out for advice. Today's the turning point: the first day of the rest of my life.

My shrill alarm interrupts me. Jumping out of bed, I pull the curtains aside to reveal the blanket of snow that has settled on the icy ground. It's snowing. School's closed. I go back to bed. Oh well. Maybe tomorrow's the day.

Submitted by Stephanie D'Costa, 15, Dartford, Kent

Stephanie says: *When I heard about the competition, I wanted to write something that everyone can relate to and find funny: an optimistic, get-up-and-go approach, quickly followed by a resigned attitude when things don't go right. I've written a few stories before, and I hope this one was interesting and entertaining to read.*

Stephanie will receive a cheque for £70.
Read a new 100-word story every day at readersdigest.co.uk/magazine