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TECHNICAL REPORT

Prescribing in primary care

Understanding what shapes GPs' prescribing choices and how might these be changed

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Prepared for the National Audit Office

The research described in this report was prepared for the National Audit Office.

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Summary

1. The National Audit Office (NAO) commissioned RAND Europe to conduct a qualitative study into general practitioners' (GPs') prescribing behaviour. This qualitative study contributes to the NAO's larger investigation into prescribing in primary care in England, and more specifically how financial savings can be delivered by helping primary care prescribing to deliver better value for patients.
2. The study aims to understand what shapes GPs' prescribing decisions, and how the cost efficiency of prescribing might be improved in the future. The context is one in which it is recognized that there are considerable variations in the growth of GP prescribing costs nationally. Guidelines to encourage more consistently appropriate prescribing practices were produced by the Audit Commission as far back as 1994, and, more recently, National Institute of Health and Clinical Excellence (NICE) guidelines have provided detailed guidance for specific treatments. It was estimated in June 2006 that the use of generic statins alone, as part of an improved prescribing behaviour, could save in excess of £2 billion over five years.

Approach

3. The approach of the study consisted of five key tasks. The first task involved initial desk-based research and selection of two Primary Care Trusts (PCTs), each representing cases with relatively low and high adherence to NICE guidance on the prescribing of statins – a practice which was taken as a proxy for prescribing efficiency. The chosen trusts were Northumberland Care Trust (Northumberland PCT) and Greater Peterborough Primary Care Partnership (Peterborough PCT).
4. To identify preliminary prescribing issues, senior managers in each PCT were interviewed (Task 2). The purpose of the interviews was to elicit their views on GPs' prescribing practice, what they believe influence this, and how they believe prescribing behaviour might be encouraged to change in the future. The approach taken at the trust-level to monitor and influence prescribing practice was also considered. This stage helped identify specific measures taken by the PCT to incentivize GPs and to influence prescribing behaviour in general.
5. This step was followed by two GP focus groups within each PCT (Task 3). The purpose of the focus group was to elicit discussion about the GPs' current experiences of prescribing practice, how they appraise information from different sources, what influences their prescribing practices, and how they might be encouraged to change practices in the future. GPs were given the opportunity to comment on a range of

publicity material made available by drug companies and the PCT, and were asked about the feasibility, suitability and acceptability of different strategies to improve the cost efficiency of prescribing.

6. Subsequently, a workshop was held within each PCT involving PCT senior managers, GPs, and other knowledgeable individuals (such as pharmacists) to explore preliminary findings and to identify practical steps that might be taken to improve the cost efficiency of prescribing at the GP and PCT levels (Task 4).
7. The final task (Task 5) involved synthesizing and analyzing the findings from the interviews, focus groups and workshops, and also the wider literature. Initially, this task resulted in the identification of a set of factors which influence GPs' prescribing decisions.

Influences on GP prescribing decisions

8. GP prescribing behaviour is influenced by many factors, which operate at different levels in the health care system. At the national or international levels, clear evidence on treatments and drugs presented in authoritative journals was a significant influence. At the PCT level, influences included local guidelines, newsletters, site visits by prescribing advisers, personalized contacts, and recommendations from specialist or consultants in the secondary health care setting. At the practice level, the professional experience of the GP, the clinical needs of the patient, patient demand, peer networks, and drug company representatives may influence prescribing.

Improving cost efficiency of GP prescribing

9. During the interviews, focus groups and workshops, participants were also asked to identify ways to improve the cost efficiency of prescribing behaviour of GPs. In line with our brief, the majority of the discussions focused on initiatives which could be carried out at the PCT or practice level. A summary of participants' recommendations is presented in Table 1.

Table 1— Summary of Participants' Recommendations

		Structures		Processes	
Level \ Measure	Organizational	Rules	Information and Communication	Cooperation and Collaboration	
Macro	<ul style="list-style-type: none"> Create a national organization to identify and spread best practice. This should actively try to change behaviour.* 	<ul style="list-style-type: none"> Set national targets for prescribing in key areas to support the position of PCTs. Introduce national guidelines on which new drugs can and cannot be prescribed. Ban direct visits of drug reps. to GPs, instead channelling influence through national institutions (or a single national body). Introduce nationally a structured procedure (e.g. core competency frameworks) to support the prescribing process. Limit the availability of drugs in the NHS. 	<ul style="list-style-type: none"> Improve patient education through accessible information about drug evidence. Increase, through national campaigns, patient awareness of the limited possibilities of the NHS, the cost of treatments, and alternative treatments. Publish national benchmarks on PCTs' prescribing performance. Use national media as a tool to disseminate information. 		
Meso	<ul style="list-style-type: none"> Drug costs in acute care should be transferred into PCTs' responsibility. 	<ul style="list-style-type: none"> Create incentives for GPs to improve their prescribing. Tighten GMS contracts to create more formal means to enforce good prescribing. Align prescribing incentives between primary and secondary care. Introduce prescribing incentive schemes which: <ul style="list-style-type: none"> —consider and allow substitutes to prescribing, e.g. counselling, prevention, and alternative therapies —provide additional finance for work required to change prescribing behaviour —allocate more resources towards public health prevention. 	<ul style="list-style-type: none"> Communicate PCT policies to the <i>whole</i> prescribing community. Organize regular meetings with key representatives of local prescribing stakeholders. PCTs provide supportive mechanisms for GPs, e.g. alternative sources of care for patients and alternative therapies, e.g. osteopathy or counselling. 	<ul style="list-style-type: none"> Improve cooperation with the wider local prescribing community through joint working groups, etc. Encourage collaborative working with pharmacy advisers, GPs, consultants, and specialists. Work closely with secondary care to understand the basis for their prescribing decisions. 	
Micro	<ul style="list-style-type: none"> Abolish dispensing practices. 			<ul style="list-style-type: none"> Support peer-group meetings and facilitate networking among them. Allow GPs to collaborate with pharmacists, e.g. GPs could decide on the dose and pharmacists could decide which drug is cost-effective. 	

* While this is similar to the role of the National Prescribing Centre (NPC), this was suggested by a GP. The NPC was not mentioned during interviews, focus groups or workshops.

10. After analyzing the 27 recommendations and taking into account the key observations and influences on GP prescribing, the recommendations may be clustered into six key themes, outlined below. Each theme generally encompasses more than one recommendation and had support from multiple stakeholders, including GPs, PCT managers, pharmacists, and prescribing advisers.

Improving communication to improve the cost efficiency of prescribing. Cutting through all three levels of the system, a targeted, systematic and coherent communication strategy creates knowledge, awareness and commitment among GPs, patients and other stakeholders. This could involve the dissemination of clear national and international evidence; the development of a clear, targeted communication and translation strategy by PCT for the whole prescribing community; and developing personalized communication channels at the practice level.

Getting the incentives right. The interdependence of primary and secondary care prescribing makes an alignment of the incentives of both systems an important aspect of prescribing. Possible measures could include, for example, revising the varying costs of drugs in primary and secondary health care, or revising incentives that may exist in dispensary practices to prescribe high-cost and high-profit-margin drugs.

Addressing the whole prescribing community. Any strategy, be it aligning incentives or improving communication has to reach beyond the narrow PCT–GP prescribing relationship. Involving the whole of the local prescribing community (including consultants, specialists, prescribing advisers, nurses, and pharmacists, etc.) offers great potential for reducing prescribing expenditures, as these originate partly outside of the PCTs' control. Strategies that include the whole prescribing community could involve the establishment of personalized communication links as well as organized meetings of key persons.

Promoting GP commitment to the whole primary health care system. Making the budgetary constraints of the PCT one factor in GPs' prescribing decisions should be the aim of PCT strategy. Communication efforts should stress that GPs are part of a wider system on whose resources they draw, indicating that there are trade-offs between the resources they need for prescribing and other benefits that could be provided to patients. As the formal means to hold GPs accountable for their prescribing are very limited, soft approaches aimed at engaging the GPs are of crucial importance. These approaches are mainly concerned with communication and includes site visits to GPs by prescribing advisers, and the communication and full explanation of the PCT policies to the GPs via letters and newsletters.

Facilitating cooperation and peer meetings. Cooperation between different practices and with the secondary and acute sector as well as peer meetings should be actively encouraged by the PCT. Peer contact, via formal and informal mechanisms, proved to be an important source of knowledge and an important method to curb excessive spending by some GPs.

Getting the message through to the patients. Communicating the limitations of the PCTs' resources, the cost of prescriptions, and the available evidence of alternative

lower-cost treatments to the patients should be an important aspect of any national and local communication strategy.

11. To improve the cost efficiency of prescribing behaviour of GPs overall, measures at only one level of the prescribing system are unlikely to succeed. Because of the interdependence of the relevant levels within the national health care system, a comprehensive approach comprising a set of measures at all levels of the system is likely to have a higher impact than isolated measures at each of them. Figure 1 illustrates this way of thinking, pointing out the most important measures for improving the cost efficiency of prescribing at the macro (national/international), meso (PCT) and micro (GP–patient interface) levels.

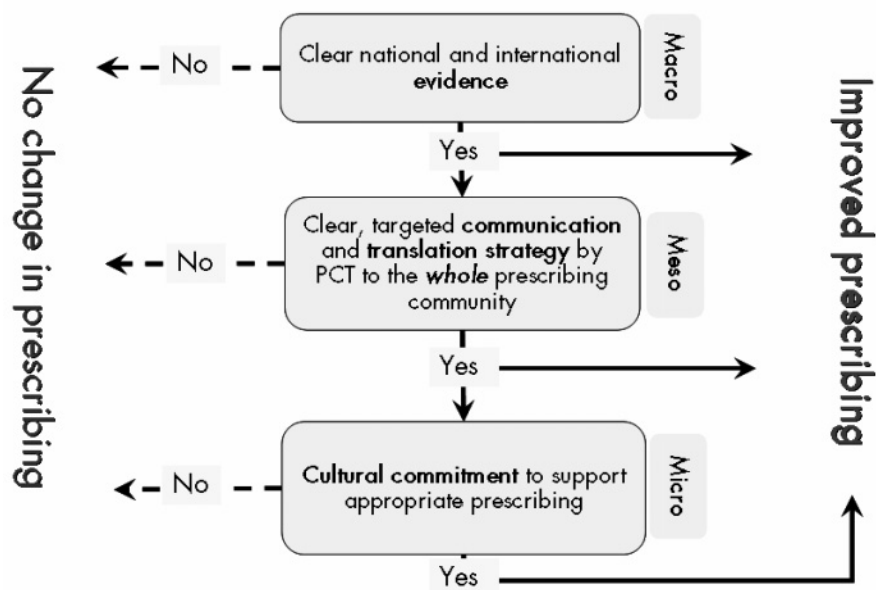


Figure 1 – Improving the Cost-efficiency of Prescribing Behaviour