

**Generic Drug Utilisation on the General Medical Services (GMS) Scheme
in 2001**

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Abstract

Expenditure on medicines under the Community Drug Schemes was €674.8 million in 2001, a 27% increase as compared with the year 2000. Prescribing less expensive generic drugs is one method of reducing costs whilst maintaining therapeutic efficacy. In this study the cost and quantity of generic drugs dispensed and the potential savings for GMS prescribing in 2001 that could be made by increasing utilisation of generic drugs was investigated. Twenty two per cent of prescription items were dispensed generically (branded generics (17%) and non-branded generics (5%)) in 2001. This represented approximately 13% of the total ingredient cost of drugs dispensed in that period. Eighteen per cent of prescription items were dispensed as proprietary preparations when a generic equivalent was available. Eleven of the top 30 drugs, of highest cost to the GMS scheme, had a generic equivalent which if substituted could produce savings in the region of €5.65 million. The results of this study highlight the potential for cost savings to be made by generic substitution, facilitating the most efficient use of the limited drugs budget.

Introduction

Expenditure on medicines in Ireland continues to increase significantly. The latest report from the General Medical Services (GMS) Payments Board reveals that total payments to pharmacies for medicines for the year 2001 was €674.8 million, a 27% increase in expenditure as compared with the year 2000[1]. Prescribing less expensive generic drugs reduces costs thereby enhancing cost effectiveness.

This study investigates the cost and quantity of generic drugs dispensed on the GMS scheme and potential savings that could be made by substituting the cheapest generic available for a range of drugs selected from the top 30 most expensive drugs for 2001.

Method

Extent of Generic Prescribing on the GMS

We determined the cost and volume of items dispensed generically on the GMS scheme for each healthboard area from December 2000 to November 2001 (data for December 2001 was unavailable at the time of the analysis) using the GMS database. The drugs were categorised into 4 classes: 1 – generic, 2 – branded generic, 3 – proprietary drug with a branded or generic equivalent, 4 – proprietary drug with no branded or generic equivalent.

Potential Savings from Generic Substitution

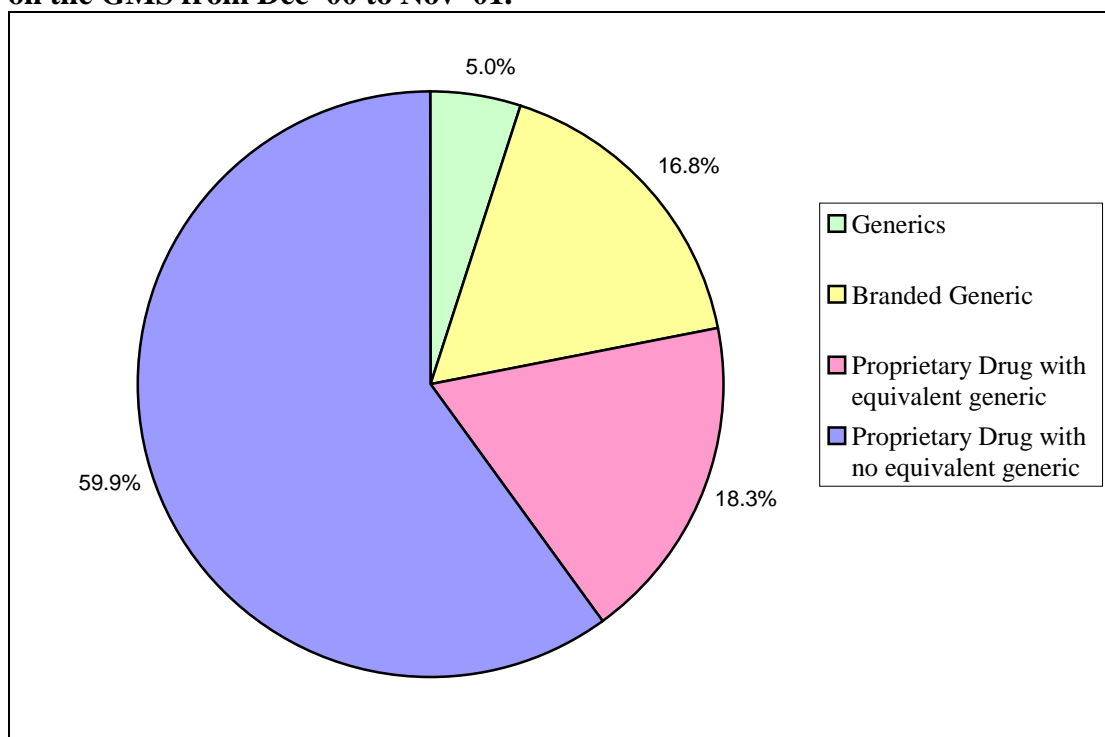
To determine potential savings that could be achieved by substituting cheaper generic drugs we selected the top 30 drugs by expenditure under the GMS scheme in the Eastern Regional Health Authority (ERHA). Eleven of the top thirty drugs had a generic equivalent available from the beginning of 2001 and were included in the analysis. The total ingredient cost and quantity for each of these drugs dispensed in the ERHA was determined. The percentage annual savings that could be achieved by substituting the least expensive generic preparation was then applied to the total ingredient cost of these drugs on the GMS for the whole country, using the data in the GMS Payments Board Report [2]. In order to validate the assumption that potential savings in the ERHA could be extrapolated to the whole country, an analysis of the savings that could be achieved in each healthboard was undertaken for one of the drugs (Nimesulide).

Results

Extent of Generic Prescribing on the GMS

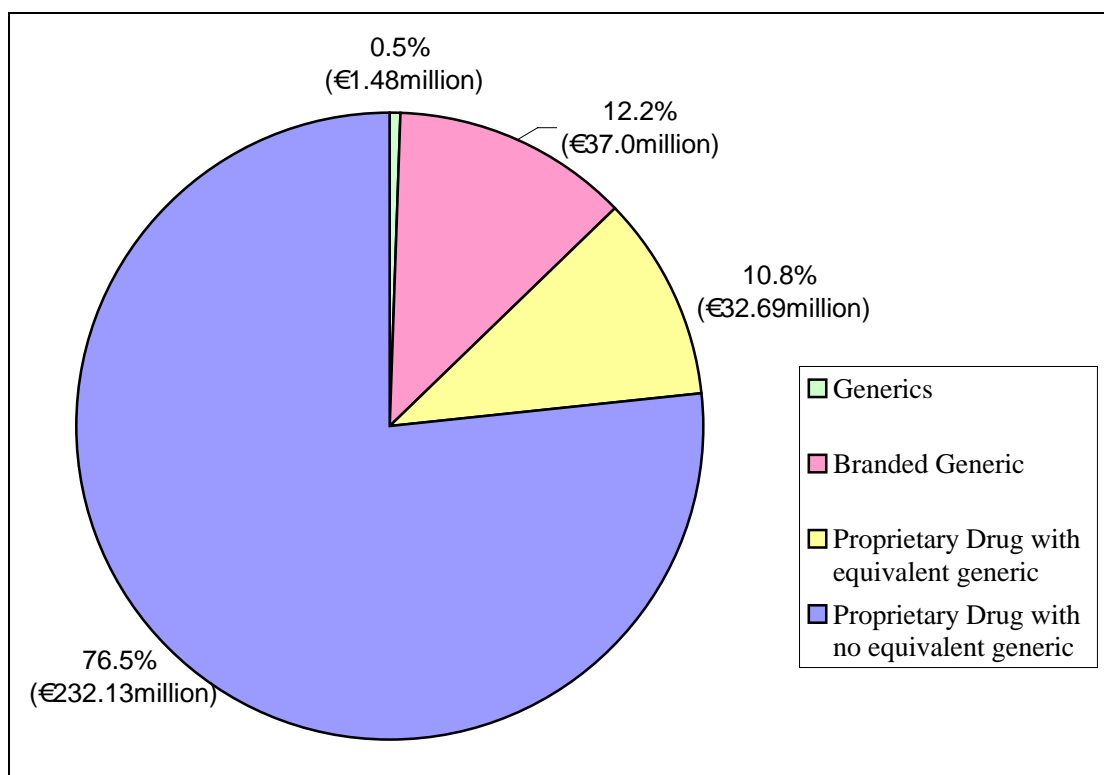
Sixty per cent of prescription items dispensed on the GMS were proprietary drugs which had no generic equivalent. Twenty two per cent of prescription items were written and dispensed generically (17% branded and 5% non-branded generics). The remaining 18% of prescription items dispensed were for proprietary drugs with a generic equivalent available (Figure 1). The extent of generic versus proprietary drug dispensing was similar for all healthboards.

Figure 1. The percentage of prescription items that were dispensed generically on the GMS from Dec '00 to Nov '01.



Eighty seven per cent (€264.82 million) of the total ingredient cost of medications for the GMS was spent on proprietary drugs. However, 10.8% (€32.69 million) of the total ingredient cost of medications was spent on proprietary drugs where there was an equivalent generic product available. Only 0.5% (€1.48 million) of the total ingredient cost of drugs on the GMS were spent on non-branded generic drugs (Figure 2).

Figure 2. The percentage of the ingredient cost spent on generic items on the GMS from Dec '00 to Nov'01.



Potential Savings from Generic Substitution

The annual savings from substituting the cheapest generic drug for 11 of the top 30 drugs of highest cost to the GMS, where a generic equivalent was available, was calculated at approximately €1.5 million (14.7% savings) in the ERHA alone (Table 1).

Table 1. Potential cost savings on the GMS scheme for the ERHA in 2001 by substitution of the cheapest generic drug.

	Cost to the GMS for 2001	Cheapest generic available*	Potential savings that could be made by dispensing the cheapest generic.	Potential savings as a % of the actual cost of these drugs to the GMS
Beclomethasone (metered dose inhalers)	€1,775,558	Beclazone [®] (50, 100, 250 mcg inhalers)	€76,194	4.3%
Diclofenac	€90,932	25 & 50mg: Diclo [®] , Diclofenac(Gerard labs), Diclofenac Sodium (Norton Waterford) 75 & 100mg: Diclac [®] , Diclomel [®]	€225,108	22.7%
Fluoxetine	€801,327	Norzac [®]	€108,505	13.5%
Co-amoxiclav	€83,269	Germentin [®] 625mg and Clavamel [®] 375mg	€108,658	12.3%
Nimesulide	€24,429	Mesulid [®]	€22,728	14.9%
Ranitidine	€1,056,494	Ranopine [®]	€297,996	28.2%
Isosorbide mononitrate	€41,048	Isotrate [®] 10mg, 20mg and 40mg. Sormon [®] or Cardox [®] SR 60mg	€158,202	16.8%
Captopril	€796,468	Actopril ^{®**}	€17,414	27.3%
Lisinopril	€730,206	Minor difference between Zestril [®] and Carace [®]	€6,178	0.9
Salbutamol (inhaled)	€41,747	Ventamol [®] MDI, Salamol [®] steri-nebs, Ventolin [®] and salamol [®] easibreathe	€129,791	15.4%
Atenolol	€20,013	Atenogen [®] , Atecor [®] , Antipressan [®] , New Formula Amolin [®]	€44,360	8.5%
Total	€10,161,490		€1,495,132	14.7%

* Based on prices from GMS database 2001.

** Actopril[®] is available as 12.5mg, 25mg and 50mg tablets. Captor[®] is available as 6.25mg and 100mg tablets.

It was determined that a saving of 15.9% could be made for the whole country if the least expensive formulation of Nimesulide was prescribed. This is 1% higher than the potential saving that could be achieved for this drug in the ERHA alone.

The eleven drugs analysed in this study account for 11.8% of the total ingredient cost of medications on the GMS for 2001[2]. Extrapolation of the percentage savings to the ingredient cost of these drugs for the whole country on the GMS would yield savings of approximately €5.65 million (Table 2).

Table 2. Potential cost savings on the GMS scheme for the whole country in 2001 by substitution of the cheapest generic drug.

	Cost to the GMS in 2001 for the whole country[2]	Potential savings if cheapest generic were dispensed
Beclomethasone (inhaled)	€6,018,262	€258,183
Diclofenac	€3,787,938	€860,620
Fluoxetine	€3,691,297	€498,325
Co-amoxiclav	€3,512,350	€432,019
Nimesulide	€3,359,683	€500,135
Ranitidine	€3,355,120	€946,144
Isosorbide mononitrate	€3,352,436	€563,545
Captopril	€3,285,967	€897,069
Lisinopril	€3,176,652	€27,002
Salbutamol (inhaled)	€2,983,805	€460,103
Atenolol	€2,431,701	€207,424
Total	€38,955,211	€5,650,568

Discussion

This study demonstrates that 22% of drugs dispensed on the GMS scheme were either pure or branded generics, representing 12.7% of the total ingredient cost in 2001. As 60% were proprietary drugs with no generic equivalent, there was a potential for 40% of drugs on the GMS to be dispensed generically. In England 52% of prescription items were dispensed generically in 2001 [3]. The term generic in the UK refers to a purely generic product whereas in Ireland branded generics are also classed as generic drugs [4]. In Ireland, if a drug is prescribed generically the pharmacist chooses which product to dispense and will be reimbursed for the cost of that particular brand. This differs from the situation in the UK, where the pharmacist is reimbursed at the tariff price thereby promoting generic prescribing [5].

This study shows that 18.3% of GMS prescription items were dispensed as proprietary preparations when a generic equivalent was available. It was estimated that approximately €5.65 million could be saved by prescribing the cheapest generic drug available for the 11 drugs with cheaper generic alternatives in the top 30 drugs by expenditure on the GMS. A report by the state auditors in 1997 estimated that potential savings of €1.65 million could be made by substituting generic drugs for more expensive proprietary products [6]. The 1997 report based its estimate on substitution of the average cost of the equivalent branded generic, whereas in our study the estimate was based on the cheapest generic available.

Policies adopted by European countries to promote generic prescribing include information feedback systems on prescribing, financial incentive schemes for prescribers and pharmacists and promotion of generic substitution. However, providing information on its own will not necessarily lead to substantial changes in practice [7]. The Indicative Drug Target Scheme (IDTS), introduced in Ireland in 1993, had a limited effect [8]. It was estimated that IR£13.5 million was saved in the first year of the scheme and a trend towards increased generic prescribing was reported [9]. However, the only year that the ingredient cost per item fell was 1993, the year the IDTS was introduced. Similarly in the UK, the relative reduction in costs (attributed to generic prescribing) for fundholders, compared to non-fundholders, disappeared after the third year [10].

Generic substitution has been national policy in Denmark since 1991. For products with generic versions the pharmacist must choose the cheapest equivalent based on the doctor's prescription and only in exceptional cases should the doctor write 'no substitution'. However, statistics show that in certain counties in Denmark up to 37% of doctors write 'no substitution' on their prescriptions [11]. In Sweden and Finland there are also plans to introduce generic substitution [12, 13]. In Australia, McManus et al demonstrated the success of the introduction of a minimum pricing policy involving generic substitution by pharmacists [14]. Patients may still receive a preferred brand name drug on payment of the cost differential [14, 15].

In Ireland, a report to the Minister for Health and Children in 1997 recommended that branded generic prescribing be discouraged and consideration given to a system of

drug tariffs where the state would reimburse at a set price for a given drug, regardless of the brand[9]. The introduction of such a policy would actively encourage generic prescribing. Our study highlights once again the potential for cost savings to be made by prescribing the cheapest generic formulation available.

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