IMPROVING PHYSICIAN PRESCRIBING PRACTICES: BRIDGE OVER TROUBLED WATERS

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Abstract • Résumé

The amelioration of drug prescribing practices holds out the prospect of improving health outcomes without increasing health care spending or the demands on hospital and ambulatory services. The challenge is to permit prescribers to assert their leadership as patient advocates while addressing the need for greater support in therapeutic decision making. Best practice includes the optimal use of drug and nondrug therapies and must be supported by research and the timely dissemination of information. The individualization of drug therapy will remain critical to quality prescribing and will depend on the appropriate preparation of prescribers for clinical decision making. The principal issues in improving prescribing practices were addressed at a workshop held by the CMA in Ottawa in October 1995, documents from which will be published in *CMAJ*, beginning with this issue (see pages 635 to 640). These issues deserve consideration by everyone with a stake in both cost-effectiveness and quality of care.

L'amélioration des pratiques d'ordonnance des médicaments pourrait améliorer les résultats sur la santé sans accroître les dépenses consacrées aux soins de santé ni alourdir le fardeau des services hospitaliers et ambulatoires. Le défi consiste à permettre aux prescripteurs d'affirmer leur leadership comme défenseurs des patients tout en répondant au besoin d'appuyer davantage la prise de décisions thérapeutiques. Les meilleures pratiques comprennent l'utilisation optimale des pharmacothérapies et des autres traitements et elles doivent s'appuyer sur la recherche et la diffusion rapide d'information. La personnalisation de la pharmacothérapie demeurera cruciale pour l'établissement d'ordonnances de qualité et dépendra de la bonne préparation des prescripteurs à la prise de décisions cliniques. Les principaux enjeux de l'amélioration des pratiques d'ordonnance ont été abordés au cours d'un atelier que l'AMC a tenu à Ottawa en octobre 1995. Des documents de l'atelier paraîtront dans le *JAMC* à compter du présent numéro (voir pages 635 à 640). Ces questions méritent l'attention de tous ceux qui ont un enjeu à la fois dans la rentabilité et la qualité des soins de santé.

It is an axiom of modern business practice that one should always pick the low-hanging fruit. As physicians strive to assert their role as patient advocates the amelioration of drug prescribing practices is such an opportunity ready to be seized. No reasonable argument can be made that current prescribing patterns are optimal; examples of overprescribing and underprescribing abound. As the main prescribers in Canada, physicians are well positioned to spearhead a campaign for quality assurance that will serve the interests of their patients and build on the strengths of the Canadian health care system. This challenge was the focus of a workshop held in Ottawa in October 1995 by the CMA. Background papers and recommendations from that workshop will appear in *CMAJ*, beginning in this issue with the article by Dr. Aslam H. Anis and associates (see pages 635 to 640).

Improving prescribing practices is crucial: it represents the clearest available opportunity to improve disease management without putting additional pressure on hospital or ambulatory services. Although we have been led to see prescribing issues mainly from the perspective of cost containment, the question of quality assurance is equally important. There is every reason to believe that the optimal use of medications will result in lower or unchanged health care spending, but this does not necessarily mean that total *drug* costs will be reduced. We have been persuaded by governments and, to some extent, private insurers to regard drug prescribing as a drain on health care resources — without due regard to

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the curative and preventive benefits of drug therapy and the sometimes pressing need for more, not less, pharmacologic treatment. Physicians should rally to the cause of improved drug prescribing, not because of potential savings but because of the essential improvements to be made in patient care and health outcomes. Furthermore, the reallocation of resources toward quality in drug prescribing would foster a chain reaction of education and research initiatives, the benefits of which would be felt throughout the profession. It is important that the goal of improved care not be obscured by an obsession with cost containment that ignores equally important health goals.

Canadians have been bombarded with reports of strategies to improve the use of prescription drugs and streamline regulation, reimbursement and the dissemination of prescribing information.[1] The result has been a classic case of paralysis by analysis, culminating in the ill-fated National Pharmaceutical Strategy, which was discussed during the past 3 years. This initiative was finally brought to a standstill in 1995 by the apparent lack of interest on the part of provincial deputy health ministers in nonfiscal aspects of drug prescribing.

Although public servants who steer provincial drug plans agree that physicians require more information in order to improve prescribing, they have not recognized the need to invest in research and education to assure the timely delivery of such information. The issues addressed in the National Pharmaceutical Strategy were the same as those taken up at the CMA workshop, but the need for the provision of information to support optimal prescribing has in the interim become more pressing. Provincial governments are now withdrawing from their programs that support the provision of therapeutic drugs because of their unwillingness to maintain previous levels of payment. The federal government has never been credible in this area because drug therapy is not covered by the terms of the Canada Health Act. The federal influence on drug prescribing has been restricted to drug regulation, an area in which the government has found it difficult to please all stakeholders. In this leadership vacuum the field remains open to physicians who, acting in accord with the highest standards of professionalism, have the opportunity to develop a framework to assure optimal prescribing practices that rest on a foundation of sound information and continuing education.

Physicians have been accused of failing to rely on evidence in the application of diagnostic and therapeutic techniques. Although this premise is debatable, the recognition that choices based on evidence are to be preferred has given rise to a new movement in practice[2] and now has journals devoted to it such as *Evidence-Based Medicine*.[3] However, controversy remains on the extent of the problem.[4,5] An optimistic view is that physicians are already adept at applying evidence in therapeutics, once that evidence has been amassed and effectively communicated. None the less, there are clearly areas of significant underprescribing, as in the treatment of hypertension, myocardial infarction and depression. Significant overprescribing probably occurs in the treatment of disorders such as anxiety, insomnia, viral infection and lassitude. The variability in drug prescribing that Anis and associates discuss in this issue speaks to a lack of consensus in the management of many common conditions. Of course, such shortcomings can be corrected, although total homogeneity in prescribing is neither desirable nor achievable. Improved access to evidence to support clinical decision making and the electronic dissemination of information as part of "just-in-time education" will go a long way to improving prescribing practices.[1,6]

Other strategies adopted elsewhere have had a mixed impact. In the United Kingdom direct feedback to practitioners about their prescribing profiles drove patterns toward the norm;[7] this is generally recognized as an improvement in overall drug use. In Germany insurers allotted fixed amounts to cover the cost of prescriptions. Any overspending on drugs was to be taken out of the funds available as compensation for physician services. Practitioners responded by altering their prescribing practices; by June 1993, 6 months after the new policy was implemented, drug expenditures were 16.2% below the June 1992 level.[8] This dramatic change may seem desirable, but it is worrisome in contexts where underprescribing is common. In the United States Medicare and Medicaid plans have used the expedient of delisting drug benefits in some states, but results have proved unpredictable and the savings illusory.[9] The conclusion is inescapable that the policy knife as wielded to date is not a very fine instrument, although this fact is not fully appreciated by policymakers. Several examples of the eviceration of drug plans with blunt instruments are now apparent in Canada:

- In British Columbia reference-based pricing will force substitution within drug classes without an open process for the identification of reference products. Can full therapeutic substitution be far behind?
- In Saskatchewan high deductibles have essentially reduced the public drug program to a form of catastrophe insurance.
- In Ontario user fees are being introduced despite repeated warnings that they represent a tax on illness that will have inevitable consequences for health, especially among disadvantaged people.
- Restrictive formulary listing practices in several provinces have greatly limited the availability of new chemical entities to beneficiaries of provincial insurance plans. In Ontario only 31% of recently approved new chemical entities have been listed, even

though current economic pressures have discouraged most pharmaceutical companies from the development of any but the most important new agents.

Patients will soon need to choose between public policy and fully informed professional judgement as the main arbiter of drug rationing. There is no doubt that public interest will be best served by an autonomous profession highly committed to the ideals of optimal therapy and insistent on the timely receipt of research data and ancillary drug information. Central to the improvement of drug prescribing will be the development of a national network committed to research and education.[1] This may sound disturbingly like the National Pharmaceutical Strategy or its stillborn child, the Canadian Agency for Pharmaceutical Information Assessment, but it is in accord with a genuine need. Provincial boundaries are irrelevant to drug information and initiatives to optimize prescribing. The profession will be best served by an interprovincial effort to provide timely evidence-based guidelines for prescribing. In the future such guidelines will probably be disseminated electronically, although not exclusively so. It will then be the responsibility of individual prescribers to promote the highest quality of drug and nondrug therapy and to serve as advocates for their patients with both public and private insurers.

The low-hanging fruit is poised tantalizingly near. It can be seized by physicians acting alone, but it would be preferable for prescribers to take the lead in a multisectoral effort that recognizes the interests of insurers, employers and, above all, patients.[10] Furthermore, the partnership of drug manufacturers should be seen as an essential asset rather than an obstacle to progress. The CMA deserves commendation for organizing a workshop on physician prescribing practices that has led to the publication of seminal papers. This is a good beginning, but the next steps require and deserve the support of the entire profession.

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