Generic Prescribing

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Synonym: non-proprietary prescribing

What is generic prescribing?

The term ‘generic prescribing’ describes the use in prescribing of a non-proprietary title for a pharmaceutical preparation. The non-proprietary titles in the British National Formulary (BNF) are often titles from the European Pharmacopoeia, British Pharmacopoeia or British Pharmaceutical Codex 1973. In this way we know that the preparations prescribed by non-proprietary title must comply with the standard of the particular publication as required by Section 65 of the Medicines Act.

In March 2004 it was announced by the Chief Medical Officer that the names of medicines would be simplified with the aim of reducing the risk of error in the prescribing and dispensing of medicines. The simplification referred to the change from the ‘British Approved Names’ (BANs) to the international system of ‘recommended International Non-proprietary Names’ (rINNs). For example, bendrofluazide (BAN) becomes bendroflumethiazide (rINN). A full list of names affected can be found on the Medicines and Healthcare products Regulatory Agency (MHRA) website.

What are the benefits of generic prescribing?

Generic prescribing allows for any suitable drug, rather than a particular brand of drug, to be dispensed. This can lead to cost savings because cheaper alternatives can be prescribed. It may avoid delay because the chemist can dispense a wider range of alternative preparations, rather than being limited to one which may not be stocked. Many practices may achieve 80% generic prescribing but a higher rate is not thought to be advantageous and may carry risks. Primary care trusts (PCTs) have used prescribing incentive schemes to improve the quality and cost of prescribing. The most frequently monitored prescribing indicator was generic prescribing used by 88% of PCTs. However, specific advice is needed to maintain quality and make financial savings. In 2007 the National Audit Office published a report indicating that PCTs could save up to £200 million by encouraging all PCTs to prescribe as efficiently as the top performing 25%. The specific improvements relating to generic prescribing were:

- Generic prescribing of simvastatin.
- Generic prescribing of proton pump inhibitors.

A study in Lancashire found that such initiatives resulted in significant cost savings but it did not evaluate the clinical impact of the changes.

It is widely appreciated that rates of generic prescribing need careful interpretation when passing judgement on the quality of prescribing. A Somerset study suggested that a high rate of low-cost statin prescribing did indeed result in poorer achievement in cholesterol quality markers.

Recently, the emphasis has shifted to cost-effective prescribing using Better Care Better Value (BCBV) indicators. The three current BCBV indicators are:
• Increasing low-cost prescribing of drugs for lipid modification.
• Increasing low-cost proton pump inhibitor prescribing.
• Increasing low-cost prescribing for drugs affecting the renin-angiotensin system.

PCTs have been advised by the Department of Health that the aim is to increase cost-effective prescribing tailored to the needs of patients, not to strive for targets which could damage patient care.\(^\text{[8]}\)

The BCBV indicators are reflected in the Quality and Productivity prescribing indicators of the GP contract for 2011/12. The Quality and Productivity indicator QP1 states: \(^\text{[9]}\)

"The practice conducts an internal review of their prescribing to assess whether it is clinically appropriate and cost effective, agrees with the PCO three areas for improvement and produces a draft plan for each area no later than 30 June 2011, which reward practices for reviewing their prescribing performance and implementing plans to improve clinical appropriateness and cost-effectiveness."

No doubt, for many practices, their level of generic prescribing will form one of their QP1 areas of improvement.

**When should proprietary titles be used on prescriptions?**

Broadly speaking, brand names, or proprietary titles, should be used where it is clear that prescribing generically will create problems with bioavailability or lead to confusion for the dispensing chemist or the patient. It is not always possible to prescribe generically because a non-proprietary title does not always exist. One study found that generic substitution of anti-epileptic drugs was associated with increased morbidity and greater use of healthcare resources.\(^\text{[10]}\)

Examples are:

- **Where there is a particularly narrow therapeutic index**, for example:
  - Lithium carbonate
  - Ciclosporin

- **With modified-release preparations** such as:
  - Theophylline
  - Diltiazem
  - Isosorbide mononitrate
  - Nifedipine

- **With compound preparations**, for example:
  - Oilatum® emollient

- **With certain combined preparations**, for example:
  - Hormone replacement therapy
  - Oral contraceptives

- **When the same drug is used for different and separately branded indications**, for example:
  - Indoramin used as Doralese® (20 mg od or bd) for urinary incontinence.

- **When the same drug is formulated to give different potency**, for example:
  - Qvar®, CFC-free inhalers. A 100 microgram dose of Qvar® is equivalent in potency to 200-250 micrograms of beclometasone by CFC-containing inhaler.

**Further points**

• Generic prescribing rates are much higher in the UK than in many other countries. Efforts in other countries are being made to increase rates of generic prescribing, often as part of efforts to improve the quality and efficacy of prescribing.\(^\text{[11]}\)
• Patients' concerns about generic prescriptions are very common and often centre on the perception that cheaper drugs may be inferior. One German study found that generic substitution may be associated with a nocebo effect (nonspecific side-effects which cannot be substantiated by pharmacological factors). A Spanish study suggested that interventions to modify the attitudes of primary care doctors towards generic drugs should be implemented. The authors infer that better informed patients, longer doctor appointment times and more varied dosage forms of generic drugs would also improve generic prescribing rates.

• Confusion over brand names is also an issue and education by prescribing doctors, dispensing pharmacists and manufacturers is important.

• The scope for cost saving is greatest in countries with low rates of generic prescribing. In the UK the scope for big cost savings is correspondingly much smaller. Incentives to prescribing physicians are suggested in countries with low rates of generic prescribing and have certainly been used in the UK.

• Concerns over the therapeutic equivalence of branded products and generics are common amongst physicians too. This is true in areas of prescribing where equivalence is critical, such as with anticonvulsants and anticoagulants.

• More savings might be made with generic prescribing with improved management of the purchasing of generic drugs by the NHS.

• In 2010, the Department of Health consulted on the possible introduction of automatic generic substitution. This scheme would involve pharmacists substituting selected branded drugs with their generic substitutes. After considering the responses, however, it was decided not to progress with the initiative.

Maintaining a high rate of generic prescribing

This can be achieved by:

• Education of doctors and pharmacists.
• Education and information for patients.
• Good quality control and regulation to maintain therapeutic equivalence*.
• Incentives to encourage generic prescribing.
• Careful selection of brand names.

*The Medicines and Healthcare products Regulatory Agency (MHRA) was formed in April 2003 from the merger of the Medicines Control Agency (MCA) and the Medical Devices Agency (MDA). It has regulatory duties and supervises production of the British Pharmacopoeia. When patents expire on drugs then generic drugs can be produced according to standards regulated by the MHRA.

Further reading & references

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