HSR-2018-080 - Impact of hospital prescribing on GPs low cost drugs prescriptions

The proposal originally sent by GRAS (Groupe Researche Action Santé) and discussed in 2018 was considered relevant and feasable and was consequently, approved to be included in KCE’s working programme of 2019. However, after some preliminary work performed to better scope the work, and careful consideration, a number of important points raised questions regarding the appropriateness and value of carrying out this reseach within the KCE.

This document captures these important points:

## 1. No data on (clinical) appropriateness of prescribing

The fact that hospital prescriptions have an influence on GP prescriptions and that pharmaceutical companies may grant hospitals large discounts for their brand products, to be listed in their therapeutic formulary and ultimately, benefit from the influence of hospital precribing on GP prescriptions has already been studied and documented. A study published in 2013, Volger et al. looked at prices of 12 medicines in 25 hospitals in European countries (Austria, the Netherlands, Norway, Portugal and Slovakia), and found that high price reductions tended to be granted for medicines whose treatment was likely to continue in primary care, after hospital discharge.

A further study from 2016 by Pruckner and Schober made use of administrative data from Austria, to show that patients with prior hospitalisation had a significantly lower probability to receive a generic drug in the outpatient sector.

Therefore, in order to be able to add to the available literature and draft relevant recommendations in this field, the extent to which these practices are done in the absence of any justified clinical benefit would need to be measured. This was indeed, included in the original proposal. However, data on appropriateness of prescribing is currently not available.

The research team suggested to still go ahead and carry out the study in the absence of these data, but supplement the data analysis results with a qualitative survey, to highlight points raised by specialists and GPs regarding the appropriateness of these switches from generic (pre-hospitalisation) to brand (post-hospitalisation hospitalisation). The lack of relevant quantitative data on the clinical justification of the product being prescribed would nevertheless, continue being an important weakness of the study and should be recognised as such.

## 2. Further limitations in the scope of the project

Discussions with the RIZIV/INAMI (held on Friday the 17th of January 2020) revealed further points that make this topic less interesting for KCE to research. Thus, our discussion highlighted that chronic medication taken by patients (which should be the main focus of this research), prior to a short hospitalisation, is not changed during hospitalisation, with patients most often being asked to bring in their (chronic) medication.

In this context, the main study focus would need to be limited to chronic medication started during a hospitalisation (chronic diseases diagnosed at the hospital). This would narrow down the research significantly, reducing its value and would also place the emphasis on GPs and the renewal of hospital prescriptions as such in the community as opposed to a wider focus on both specialists and gp prescribing habits.

Such study would not require a complicated analysis and thus, may not be an ideal subject for a full KCE report (given the procedures required to validate and publish KCE reports).

## 3. Possible recommendations

A discussion around possible recommendations that could come out from such a report was also held, with the INAMI/RIZIV and internally, to ensure the relevancy of the research.

Discussions with the RIZIV/INAMI revealed that the current quotas for “cheap products” in place for different prescribers (GPs and specialists in ambulatory care), are only aimed at offering feedback, and that increasing these quotas, appears to have a limited direct influence on prescriber’s choices. Commonly prescribed brands coming off patent (e.g. statins), or an indirect influence of quotas, via manufacturers lowering the price of their brands to fit within the “cheap product” description, appear to have more weight on the volumes of cheap products prescribed nowadays in Belgium. Therefore, any recommendations surrounding changes to these quotas are unlikely to have a significant effect on prescribing habits. Moreover, there latest increase of these quotas dates from 2018, so any further changes over those may still be premature.

A further possible recommendation would be to make INN prescribing mandatory. However, this specific recommendation has already been made in past projects (e.g. KCE Report 126[[1]](#footnote-1)) and considering such measure, would not require completing further projects, such as the one here discussed.

Recommendations regarding the need for including more “generic/cheap” products in the formularies of the hospitals are also difficult recommendations to make given the active role of hospitals in managing their own finances and the attractiveness of the discounts they are offered to include some expensive products in their formularies. Also, the necessary data to push for such policy is easily available at the INAMI and would not require complex data analysis, so once more, answering such research question would not require a full KCE report.

## Conclusion

For all of these reasons we believe the above presented research should not be pursued as a KCE project and the resource hereby freed should instead be used in other, more informative and valuable research topics.

**References:**

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1. <https://kce.fgov.be/sites/default/files/atoms/files/d20101027318.pdf#page=13> [↑](#footnote-ref-1)