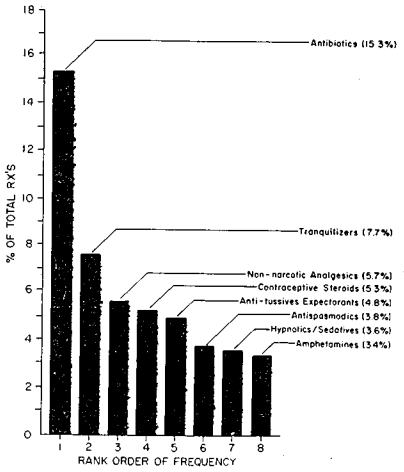

Figure 1. The eight most frequently dispensed classes of drugs in a mid-Atlantic state county (population, 112 000) in 1968.

OVERALL PHYSICIANS' PRESCRIBING PROFILE

The mean number of *different* drugs prescribed in 1968 by the primary care physicians (general practitioners and general internists) monitored was 270. Some doctors managed their practices with only about 100 different drugs, whereas others prescribed almost 500. These findings may be compared with the size of the New York Hospital Formulary (3), in which less than 500 different drugs are considered sufficient for a hospital practice (which includes inpatient and ambulatory care patients). The physicians in the area issued an average of more than 2000 prescriptions (including refills) during 1968, and some issued more than 5000 prescriptions that year: the practice size also varied greatly.

SELECTED PATIENT CHARACTERISTICS AND DRUG USE

The age of the patients receiving prescriptions was recorded in a special study, and it was found that the elderly (especially older *women*) accounted for a disproportionate amount of drug use. One woman patient's profile showed that she had consulted nine different physicians and received 181 prescriptions at a total cost of $586 during a 1-year period.

Patients who received free drugs under the State Public Assistance Program were usually issued prescriptions of larger quantities than private, paying patients; these quantities were often close to the maximum allowed under the program, illustrating the effect of payment mechanisms on prescription practices.

Summary and Conclusions

In 1968, the American public received more than one billion prescriptions, dispensed from some 54 000 community pharmacies, at a total consumer expenditure of more than $3.5 billion (4).

When this expenditure is analyzed for a single county, as was done in this study, the pattern of drug consumption, prescribing, and expenditure become more obvious and interpretable.

It is clear that a substantial proportion of the community drug expenditure was for psychotropic drugs that either sedate or stimulate. It is equally apparent that a large amount of drug prescribing and drug costs are for common, benign, and self-limiting illnesses (for example, the uncomplicated common cold). United States national marketing research data also indicate that most physicians (about 95%) will issue one or more prescriptions to a patient whom they diagnose as having the "common cold," and almost 60% of these prescriptions will be for antibiotics. Data are not available to determine what proportion represent bacterial complications of an illness that was originally viral (5).

The study of the most frequently prescribed drugs in the community shows the vast amount spent on currently popular drugs to treat conditions for which older drugs with similar actions are available (for example, Darvon Compound versus codeine, Librium versus phenobarbital). The insignificant amount of generic prescribing in this community points to the deeply ingrained practice of prescribing by proprietary name that has been encouraged successfully by the promotional activities of the drug industry. For this reason it is unlikely that drug costs will be controlled if the sole or central cost-control measure employed is an attempt to get physicians to switch to generic prescribing.

Although there are over 22 000 drugs and drug products marketed, most primary care physicians manage to practice medicine with only several hundred. But the confusing U.S. nomenclature, which allows multiple proprietary names for the same generic ingredient, results in a large number of drugs with identical modes of action being dispensed in any community.

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