



VIEWS AND REVIEWS

NO HOLDS BARRED

Margaret McCartney: Prescribing incentives feel grubby because they are

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Last week it emerged that Oxfordshire Clinical Commissioning Group has suggested that GPs should review patients in nursing homes and “rationalise” prescribing. If enough drugs are stopped or switched to meet the threshold, the GPs keep half the cash saved. Cue righteous outrage from the national press.¹ It feels grubby because it is.

There’s little doubt that incentive programmes, particularly the Quality and Outcomes Framework in general practice, have led to reflex prescribing and overprescribing. Doctors must satisfy their paymasters’ suspicions in justifying why they haven’t prescribed,² rather than why they have. Yet clear evidence shows that single disease guidelines for prescribing in multimorbidity aren’t fit for purpose.³

Financial incentives are rotten to the core. Money is used to make GPs prescribe, and then to make us not prescribe. This is, in essence, manipulation of the trusted relationships between doctors and patients by unseen puppeteers, who suppose that the desired outcomes will occur if just the right amount of pressure is correctly applied.

Self employed contractors, many wobbling financially, are in a bind. Not doing the work means loss of income. But doing the work is anti-professional. No one could argue that we should prescribe expensive varieties of drugs when cheaper and generic is better, and no one should support wasting money on poorly evidenced products. And overtreatment is a harmful waste of resources. Professionalism means doing the right thing, not the cheapest or easiest thing.

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The proposed Oxford scheme is just a continuation of the regressive path of general practice in England. Someone sees a chink of light in the black hole of finances and nimbly calculates that, with enough of a push, money can be saved.

Scotland, having thrown off the noose of the Quality and Outcomes Framework, still makes regular nods to prescribing incentives. We’re still given payments for medication switches

and for decreasing percentages of one drug compared with another. This is a process of diminishing returns. So we have a handful of people with difficult medical histories who are given, say, lignocaine patches and have tried managing without but would reasonably prefer these to gabapentin.

General practice is often practised at the edge of evidence, with constant compromise, persistent uncertainty, and fluctuating choices and priorities. Stopping one or two of those prescriptions means hitting a target, meaning payouts for practices—but what about the impact on patients? The conflict of interest is obvious and unnecessary: we don’t want overtreatment or undertreatment.

It would be possible to pay staff to do medication reviews for people at high risk of overtreatment, while making flat payments. Better would be to assume that this should be done anyway. For every payment by specific incentives, resources will be concentrated in one area, leaving less elsewhere. Why can’t we put the money in centrally and aim for basic, good quality care for everyone, using professionalism and transparent data—rather than financial targets—to help us?

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