The law of unintended consequences.

http://www.econlib.org/library/Enc/UnintendedConsequences.html

Actions taken in haste and regulation enacted without appropriate forethought is the breeding ground of unintended consequences.

As a non-political animal I have not followed the travesty that has been the process of negotiation then imposition of contractual changes in General Practice. I am, however, as a clinician but more importantly as a patient’s advocate, very aware of the unintended consequences of this process.

I would like to bring to your attention just one of these today.

As part of the imposed contractual changes there have been alterations to the “QOF” requirements. I do find it slightly odd that the QOF indicators receive so much attention as there is absolutely no evidence they have been of benefit to patients (see the recent review in the Journal of Public Health). However, that aside, the indicators have frequently been poorly evidenced and have sometimes had to be changed for this very reason (CKD indicators for instance). These poorly evidenced indicators are irritating, but generally no more than that.

For the first time an indicator has been put in place that actively encourages unethical behaviour. I can only assume this is an unintended consequence. It would be deeply disturbing should it have been deliberate.

The road to hell is paved with good intentions. I would add to this that the route is dictated by people with bad intentions and the workforce is people with poor understanding of evidence. The people with bad intentions would be the pharmaceutical industry and those with poor understanding of evidence would be rather too many clinicians and, I fear, most politicians.

The indicator in question is CVD-PP001. “Patients between 30 and 74 years with new Hypertension (excluding those with pre-existing conditions) with CVD risk >= 20% in the last 12 months, using statins (range 40 – 90%).” The plain English interpretation of this is that we will get paid on a sliding scale if at least 40% of our patients with a new diagnosis of Hypertension are prescribed statins if they have a 1 in 5 or greater chance of developing cardiovascular disease over the next 10 years (by the way this is rather a lot of people). I have no objection to earning money. I do, however, have an objection to earning money for bad medicine with no evidence and potential harm to patients.

There is absolutely no doubt that statins are powerful risk reducers in people with known Ischaemic Heart Disease. There is no evidence that statins reduce all-cause mortality in people who do not have pre-existing cardiovascular disease, i.e. in Primary Prevention. There are plenty of studies that show this. The most recent being “Statins and all-cause mortality in high risk primary prevention”. This meta-analysis of 65,000 people with 244,000 person years of follow-up is merely one more in a series of studies that show that using statins for Primary Prevention is a waste of time and resources. This being the case, demonstrably and repeatedly so, then we have the perverse situation where I am to be paid to do something we know will do no good and will probably harm a substantial proportion of the treated population (the true significant side effect rate with statins is probably around 20%). A truly appalling position where the only person who will certainly benefit from the activity being undertaken is the Doctor doing it. Congratulations.

Yours in despair.

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