

Commercial and political pressures raise polypharmacy, so patients suffer

By Chris Brewer, medicines information pharmacist for North Cumbria Acute Hospitals NHS Trust

A 15-item prescription carries 105 possibilities for a drug–drug interaction. That, I think, partly explains the feeling of dysphoria that descends while I leaf through a three-page hospital discharge sheet. I am not alone in my dislike of polypharmacy: I know of no hospital doctor who enjoys writing these long prescriptions or nurse who enjoys the tedious drug rounds. So, given that we all hate polypharmacy, it should be easy enough to reduce excessive tablet burdens if we all work together, should it not?

Unfortunately, hospital practitioners only need to take a step out of their secondary-care comfort zone to see that they are in fact rather isolated in this respect. Not all interested parties have the same aversion to drug histories that are longer than a Rugby League team sheet.

First — and most obviously — pharmaceutical companies are probably not going to help us in any quest to reduce the nation's tablet burden. Without them of course, we would have no new drugs. However, whenever a novel treatment is launched, the pharmaceutical companies would like us to prescribe it for each and every patient who may benefit from it. This needs to happen if they are to stand any chance at all of making back the £100m or so spent bringing the drug to market in the first place.

Moving on to community pharmacy, it is certainly true that the reimbursement system in the UK is heavily dependent upon the number of items dispensed. This produces a clear disincentive for a proprietor to inform a GP that a repeat prescription could be radically rationalised. Any community pharmacy business that takes it upon itself to tackle polypharmacy may not be around for too long — such is the nature of the free market. The introduction of medicines use reviews is certainly a step in the right direction for the pharmacy profession. But you do not have to be a great mathematician to see that the £25 fee will be quickly negated if an MUR results in the discontinuation of repeat items.

I am sure that no GP would stand up in support of polypharmacy, but there are in fact several factors that push GPs towards increasing tablet burdens rather than reducing them. First, there is still the unfortunate cultural expectation among patients that a consultation should result in a prescription. A typical patient will consider it a complete waste of time to walk away from the surgery empty-handed — despite the fact that the GP may have offered completely appropriate lifestyle advice. Secondly, by rewarding practices for achiev-



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ing surrogate markers such as blood pressure targets, the general medical services contract distorts the perception of what is in each individual patient's best interests. For example, an elderly patient with diabetes who is having difficulty achieving blood glucose control may not be best served by being given four antihypertensives as well. Blood pressure reduction is undoubtedly important, but we see far too many patients for whom the tablet burden is simply too high.

Finally, the Department of Health positively loves polypharmacy. Why do I say that? Does the phrase "the NHS is treating more patients than ever before" sound familiar? Fine words. But remember that these extra treatments may just be low cost prescriptions based on a high number-needed-to-treat.

Imagine the conversations in the corridors of power:

"So you are saying that these new drugs cut the risk of heart attack by 40 per cent."

"That's correct, minister."

"Then once we get everyone on these statin thingies, we can close 40 per cent of the coronary care units. Imagine the savings!"

"I'm not sure it's quite as simple as that, minister."

"It seems simple enough to me. Get the Chancellor on the telephone!"

These commercial and political pressures are unfortunate because it is the patient who may ultimately suffer. Polypharmacy is a disease in its own right and an insidiously progressive one at that. Each time an adverse drug reaction is mistaken for a new symptom, the vicious circle is completed once again, and the disease advances. All practitioners would do well to remember the truism that a new symptom is only rarely due to a new disease. It is much more likely to be due to a disease we already know about — or an adverse reaction to a drug the patient is already taking.

So what else can be done? In secondary care, we can (and do) encourage prescribers to use a hospital admission as an opportunity for a medication review free from any commercial pressures. As for the wider health care system, here are just two suggestions:

GPs have recently shown how good they are at fulfilling the terms of their new contract while keeping costs down in their practices. If FP10 expenditure were to come off the balance sheet of each GP practice, that would certainly concentrate minds when it came to rational prescribing. Historically, this was an aspect of GP fundholding, but now that FP10 expenditure is sucked into a primary care trust "black hole", there is inevitably less accountability. An obvious objection to this idea would be that extremely high cost drugs could skew the equation. However, this can be dealt with through a drug exclusion list, as is already the case in secondary care commissioning.

Secondly, why not get rid of the dispensing fee paid to pharmacies per item and instead reimburse with a global sum based on the number of patients registered. Just think! Pharmacists would then have a vested interest in reducing polypharmacy and delivering health education, as it would result in less work and increased profitability. A community full of well people would equal a profitable pharmacy. What better motivation could there be for a health professional?