

# Towards "intelligent" purchasing

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*Procurement of pharmaceuticals in secondary care has traditionally been undertaken by pharmacy staff. How well do they perform in changing NHS?*

**P**urchasing of pharmaceuticals in hospitals has been undertaken for many years by pharmacy staff. It is an activity that we are best placed to undertake efficiently and effectively. However, there are many changes occurring in the supply chain that require a more intelligent approach. Extensive use of modern technology and prudent use of limited resources are important to ensure that we continue to provide timely and cost effective medicines to patients.

This article sets out to identify these changing factors, and recommend ways in which pharmacy procurement can adapt to them.

## WHO SHOULD PROCURE?

There has been discussion in the profession about "giving up" the procurement function to allow concentration on clinical services.<sup>1</sup> The Government strategy "Pharmacy in the future" also gives us the challenge to re-engineer hospital pharmacy services, while remaining the focus for the efficient procurement and distribution of medicines.

Procurement is, and should continue to be seen as an integral part of the pharmacy supply function, essential to support a modern patient-focused pharmacy service. Pharmaceuticals are often niche products with specialised functions that do not fit easily into the more widely understood commodity-approached procurement process where alternatives are readily avail-

able for most items. The clinical requirements for these expensive goods need to be understood and defined locally. Trusts accommodate this with formulary management systems linked to drugs and therapeutics committees, clinical and medical audit, and by pharmaceutical input into the prescribing process.

By working closely with local clinical staff, the procurement function for drugs dovetails into this complex framework and reflects the variation in product demand created by the unpredictable case mix of an acute hospital, without over-investment or waste. At present, this can only be achieved by a procurement function based within the local pharmacy service. We need appropriately trained staff who understand the products and have developed specialised materials management techniques to address the variable and sometimes urgent clinical demands. We must ensure that the procurement process supports and influences, but does not dictate, effective clinical practice.

The distribution of medicines is monitored to ensure it is efficient, responsive and timely, but avoids excessive stockholding. This monitoring process has been formalised by the introduction of a controls assurance and medicines management framework.

## THE SYSTEM SO FAR

NHS hospitals in England have aggregated their purchasing requirements into regional, and since 1996, divisional contracts. Most of these contracts are administered by the Procurement and Supply Agency (PASA) previously called NHS Supplies. PASA has worked to consolidate and standardise its service.<sup>2</sup> An extensive review of the contracting system for pharmaceuticals was undertaken in April, 1998. The findings, reported in "A Generic Per-

spective",<sup>3</sup> facilitated the process. This report, which concentrated on generics, detailed a complex market with some market segments attracting high levels of competition whereas others had little. Government policy, and especially the Pharmaceutical Price Regulation Scheme, (PPRS) had an impact on the market. The separate contracting divisions worked independently of each other for the most part. They had separate working systems, legal terms and conditions, coding systems, and contracting cycles that were not co-ordinated. Decisions were made independently and usually in ignorance of the overall market picture. There were no national market overviews, and indeed, no mechanisms for undertaking them.

The secondary care market contains a relatively small number of customers, especially if trusts work together. This in turn means that purchasing decisions made by this handful of customers can have a large impact on the market overall. It is probably true to say that in most cases this fact is not appreciated by the trust staff involved.

## ISSUES ON THE HORIZON

Many of these problems have been identified elsewhere. The issues of standard terms and conditions and co-ordination are being addressed by PASA. They also now have the national PHATE (Pharmacy tendering evaluation) system, a method to undertake market analysis.

The contract terms and conditions state that adjudication will be made according to the quality of the product, the service levels from the supplier and the price. However, in practice there are some difficulties with these criteria, as detailed below.

**Quality of product** Generally, the quality of most pharmaceutical products is good

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Table 1: *Examples of changes to the supply chain*

Market sector	Change of practice	Impact on supply chain
Manufacturer	Multinational production	Reduction in number of sources of products, often down to a single worldwide production site.
Manufacturer	Larger batch sizes	Greater impact from single batch failure or recall
Manufacturer	Company mergers	Product rationalisation, often with loss of therapeutic equivalents
Manufacturer	Patient packs	Loss of alternative pack sizes, common packs for primary and secondary care
Distribution	Increased use of wholesalers	Reduction of stock held at manufacturers
Distribution	Reduction in number of wholesale depots	Reduction of stock held at wholesalers
Distribution	Automation of product handling	Reduction of stock held at wholesalers
Distribution	Computerisation of stock control and ordering	Reduction of stock held at wholesalers
Hospital	Computerisation of pharmacy stock control and ordering	Reduction of stock held in hospital pharmacies
Hospital	Improved stock control at ward level, eg, top-up schemes	Reduction of stock held on hospital wards
Hospital	Closure of pharmacy stores, direct supply to dispensaries	Reduction of stock held in hospital pharmacies
Hospital	Electronic prescribing	Reduction of stock held on hospital wards and pharmacies
Hospital	Direct ward delivery	Reduction of stock held in hospital pharmacies
All	Patient pack initiative	Smaller pack size may facilitate reduced stock holdings throughout the supply chain

since the licensing process ensures it. However, many products issued to wards could be labelled and packaged in a way that is more user-friendly. The many incidents that have been reported recently relating to similar looking packs<sup>4</sup> show that good labelling of products is essential for professional use and patient safety. The national specification for labelling and packaging of tablets is outdated, referring to ward packs of 50 which are still used on tenders. A new specification is urgently needed. It should reflect the trend towards using patient packs that will assist suppliers in meeting our needs and assist pharmacists with contract adjudication. Given that hospitals account for only a small percentage of the market for many products, unless agreement is reached nationally, there is unlikely to be any progress.

**Supplier performance** Supplier performance is increasingly inconsistent. This is unfortunate since the ability of customers to obtain products is critical. It is difficult to substantiate performance as no universally accepted performance indicators exist, although a number of local initiatives have been introduced at trust and supplier level. Manufacturers, wholesalers and distributors, and hospitals have reduced stockholding under financial pressures. This has led to a general reduction in stock held throughout the supply chain. This is illustrated in Table 1.

This reduction in stock held tends towards a "just in time" approach which has worked for many industries where demand is constant and regular. It cannot be applied to the pharmaceutical supply chain consist-

ing of a myriad of products, with wildly fluctuating demands, which are, in many cases, life saving. It is therefore important that all sectors of the market share the responsibility for maintaining the supply chain.

We must not act in splendid isolation and then blame others when problems arise. It is important to note that these effects have been seen globally, and are not limited to these shores.<sup>5</sup>

## The "just in time" approach cannot be applied to the pharmaceutical supply chain

**Price** The price of goods appears to be the main criterion used in adjudication. The continual use of this factor in isolation forces companies to adapt to the microclimate. Price reduction forces them to concentrate on low margins, requiring large demand and to give less emphasis to the other factors such as performance and labelling. This inevitably leads to fewer suppliers providing each product. Many products have only a single or dominant supplier, for example, diamorphine, heparin, prochlorperazine, and adrenaline. The small number of suppliers for each product introduces more fragility into the market-place; any difficulties in production lead to supply

problems when the other manufacturers are unable to make up the deficit. These effects have been noted by the government which is investigating the generics market through OXERA (Oxford Economic Research Associates), and advocating a greater UK generic manufacturing capacity with more suppliers providing a greater depth of product.<sup>6</sup>

Cyclical pricing can be seen in many markets as manufacturers develop a monopoly and can then increase prices.<sup>3</sup> This has been seen with etoposide capsules, diamorphine injection and bupivocaine. The PPRS allows companies freedom to balance their overall profits between the products in their portfolio. They can therefore cross-subsidise products to adversely affect competitors. This can allow monopolies to be introduced or maintained.

The massive number of pack changes that patient packs have forced has led to a revision of the portfolios of many companies. This has led to the discontinuation of packs, and even whole ranges, reducing competition. Companies can discontinue products with little notice, and do not always seem to understand the importance of the indications for the drug (for example, lorazepam and chlormethiazole injection). Notice of discontinuation of products should soon change; new guidelines were agreed this month between the Department of Health and the Association of the British Pharmaceutical Industry that should give pharmacists two month's notice of planned discontinuation of products.<sup>7,8</sup>

Trust staff will not always adhere to regional contracts and manufacturers may undermine commitment to contracts by

offering better prices. This reflects a lack of understanding by trust staff of the long-term effects of this behaviour to both their own trust and to the rest of the market. This lack of strategic knowledge is often caused by skill-mix initiatives; it is important that all trusts have access to appropriate expertise.

The introduction of unified budgets has increased the importance of, and the activity around the primary and secondary care interface. Historically, prescribing was initiated in secondary care. There were initial concerns about this since the primary care sector was increasingly aware that initiatives in primary care groups and primary care trusts could destabilise secondary care markets. These effects can only be rectified or avoided if knowledge and expertise are shared across the interface at an appropriate level.

As patents for drugs expire, the market becomes chaotic with huge variations in price over short periods of time. It is difficult for manufacturers and customers to manage these changes to their mutual advantage while taking into account the factors already mentioned.

Usage information used by trusts and PASA to inform the contracting process is not accurate. This can cause huge problems for companies trying to match production runs to an actual demand that bears little relationship to the prediction. Under-demand leaves them with unsold products, over-demand with claims for compensation, as trusts have to buy off-contract and claw back the difference.

## — THE INTELLIGENT APPROACH

The arrival of the PHATE system, which will allow nation-wide collection and comparison of contracting data by PASA, brings an intelligent approach to procurement. The system will provide trusts with a lot of data about their own contract via a CD-ROM and will eventually have the facility to update local pharmacy computer systems automatically.

There is a need to identify some "critical" products that require co-ordination of individual purchasing decisions to ensure continuity of supply, to maintain competition and to prevent the large price fluctuations we have seen. Where there is little competition, more suppliers could be encouraged to participate. Patent expiry dates should be co-ordinated, as well as product and pack discontinuations. All these functions require a co-operative inclusive approach. Although not yet published, The National Pharmaceutical Supplies Group (NPSG) has proposed a pharmaceutical market support group to undertake these activities.

This intelligent approach means that contracts are awarded for the best deal, not necessarily the lowest price. We have to

learn that it is not always beneficial to take the lowest price (to take the money and run), but that a longer-term view and a strategic approach is required. This may be difficult to accept, particularly as, if successful, few problems will be seen. It therefore requires that all trusts commit to this more sophisticated approach and that procurement staff, at all levels, are adequately trained.

## — OTHER REQUIREMENTS

For pharmacy procurement to adapt to these changes, there are other requirements that also need to be addressed.

**Support** Peer support is needed to help pharmacy system users to set up their systems and use them to best effect to maximise efficiency of stock holding systems

# The intelligent approach to procurement means that contracts are awarded for the best deal, not necessarily the lowest price

**Training** There should be more training of decision makers in trusts, and an increase in strategic advice. Specialist procurement pharmacists, at both regional and trust level, have a role to play here, as do purchasing consortia, in forming a network of pharmaceutical procurement expertise accessible to all trusts. The report "A Generic Perspective"<sup>3</sup> urges training of pharmacy purchasing managers "to ensure that they have the appropriate skills and knowledge to deal with strategic marketing issues".

**Performance** Universally accepted performance measures for suppliers are urgently needed. Ideally, these should be integrated into pharmacy computer systems to automatically collect the necessary data. This information would be used to inform the adjudication process and be fed back to suppliers.

**Auditing** The audit of pharmacy procurement functions initiated by the North West Region (and now taken up by the Guild of Healthcare Pharmacists) should be adopted as practice by trusts. More work will be needed as part of the Controls Assurance and Medicines Management agenda set by government.

**Contracts** Different types of contracting may be required for different market segments.<sup>3</sup> This needs consideration by local procurement groups.

**National objectives** It would be beneficial to all if NHS pharmaceutical purchasing in England, Wales, Scotland and Northern Ireland had common objectives and co-ordinated activity.

**Product packs** Agreement on the specification for product packs (especially those for the secondary care market alone) should be sought.

**Collection of information** A robust system for collecting usage information to inform the contracting process should be sought. This could be accomplished through the development of an interface between PHATE and pharmacy systems as proposed by the PHATE User Group (PUG) in correspondence to chief pharmacists and system suppliers.

## — CONCLUSION

An intelligent, strategic, long-term co-ordinated approach to procurement is needed if we are to avoid the market fragility experienced with critical products recently. There needs to be a recognition that local procurement decisions do matter and that increased levels of strategic support to local buyers will raise the level of decision making and turn it into an "intelligent" process. A dialogue between all participants in the medicines supply chain is required to agree joint action to build robustness into the system. Without this we will stumble from one supply shortage to another, letting down ourselves, our clinical colleagues and more importantly, the patients.

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