

# We cannot afford to put cost before quality

By Tony Furber

Although it is widely acknowledged that United Kingdom farming and abattoir standards are as high as any in Europe — and better than most — “shortcuts” by farmers have been put forward as one reason for the rapid national spread of foot and mouth disease. The same was also said about bovine spongiform encephalitis. In both cases, it was said to be a reaction to downward pressure on food prices, by supermarket chains in particular, reflecting commercial competition and the public demand for low costs. Meeting high standards at low cost has been achieved by centralisation of abattoirs, which necessitates transport of animals over distances — a factor in the rapid spread of disease and the link between outbreaks in the different parts of the United Kingdom.

That is the world that we live in, and there are many examples where cost routinely takes precedence over quality. But how does this apply to the National Health Service and to pharmacy practice?

The recent public emphasis has been on quality. Much political “capital” has been made from clinical audit, from the Commission for Health Improvement as an independent monitor and instigator of action and from the National Institute of Clinical Excellence and related sources of guidance on good and effective practice.

What is equally strong, but receives less publicity, is the downward pressure on costs. Cost improvements have been an NHS management target for many years. Managers receive bonuses through performance related pay for achieving them. Often, these will be achieved from staff reductions, from centralising services and from contracting out services like catering and cleaning.

There is no doubt that 10 years ago there was considerable inefficiency to eliminate. Many would argue that there still is, with the Conservative party claiming that there is sufficient throughout the public service to fund major service improvements and tax reductions. I have no comment on that and see strengths and weaknesses in all the main political arguments, and more similarities than differences between the main parties.

From my personal experience, I am sure that some standards have slipped. As an inpatient on several occasions during the past year, I saw much higher medication error rates than were reported in the various studies from the early 1970s. In my view, these were largely due to pressure on the nursing staff which is not going to be instantly solved by throwing money into more pay or recruit-

ing nurses from abroad. I do not doubt the contribution made by ward and clinical pharmacists in the minimisation of drug interactions and the development of more rational prescribing.

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The Audit Commission recently criticised standards of hygiene and cleanliness in hospitals. Indeed, this also reflects my own experience, where routine cleaning was often cursory and “down to a price”. It was easy to identify potential sources of cross infection, such as patches of bare plaster where trolleys have repeatedly scraped along walls. I do not know how the cost savings on cleaning compare with the cost of treating any increased incidence of hospital acquired infection; probably no one does, but there is a cost.

All these examples have a disturbing similarity to the current and recent food chain problems: squaring the public emphasis on quality with the management need to achieve cost reductions.

Management targets in areas such as prescribing are still heavily biased towards cost reduction rather than evidence-based value. Incentive schemes usually remain cost-related and there is a management requirement and a performance target associated with the health authority remaining within NHS Executive allocation. The promised flexibility between prescribing, practice costs and hospital referral costs has never really materialised, and hospital referral costs are often overspent to meet waiting time targets.

Somehow, the NHS needs to move more quickly towards value for money and to have the flexibility to invest for longer-term health gain. Of course, there are examples where this is beginning to happen, through local health improvement programmes and, more particularly, through national service frameworks, but so far the strategy is more evident than practical action.

Is pharmacy any different? We are rightly placing a lot of emphasis on audit and quality and on developing the potential for improved patient care, but we must

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recognise that there is still a significant commercial element. Neither is there any doubt about the public interest in cost. The pressure for abandonment of resale price maintenance, fuelled by the media and the Consumers' Association, is good evidence for that. We must also recognise that there is cost competition between pharmacies, with the supermarket and chain pharmacies selling many items at lower cost than the small local pharmacy. That is what the public expects and demands, though we should also recognise that many of these pharmacies also provide a highly professional service including counselling and a range of supplementary services as well as convenience to the grocery shopper.

I fully recognise the professions efforts to educate the public on service and quality, but I am not sure just how successful we are yet in what is an essential public education role. Have we made progress in changing attitudes to quality when the commercial pressures are very much on cost?

I remember going to a Royal Pharmaceutical Society branch annual general meeting early in my career. The incoming chairman prefaced his remarks by observing that he was a businessman first and a pharmacist second. I never went to that branch again and I hope that this is not how we now see our role. We cannot afford to put commercial interests before quality.

So what do we need to learn from the foot and mouth and BSE crises?

First, quality is important and we must continue to do our best to change public attitudes to recognise this. There is a cost to quality, which represents good value in safety and is not always achieved by downward pressure on cost. Yet we must also demonstrate efficiency.

Second, over centralisation is potentially harmful to the quality of service. One of community pharmacy's major strengths is good local public access and accessibility, as indeed it is with general medical practice.

Third, we must have and be seen to have good standards and, most importantly, good control over their application to practice in order to safeguard the public.

Finally, we all have a practical commitment to ensuring the safety of the public.

There is no doubt that the foot and mouth and BSE crises have been a severe blow to many honest and hard working people in farming, transport and the food industry. But perhaps there is now an opportunity to press quality issues. I believe that all this is beginning to happen and deserves full recognition by the Department of Health, the National Health Service Executive and the Treasury.

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