I n February 2008, Lord Darzi visited the of- fices of the Royal Pharmaceutical Society as part of a Society “Darzi Day”. Frustratingly, he omitted to mention com- munity pharmacy during his presentation when describing the need to reduce the complexity of patient pathways as part of the drive towards improving the quality of healthcare across the NHS.

Another presenter that day was Gary Belfield, NHS director of commissioning. As part of his presentation he described how primary care profession- ers should look beyond the confines of the NHS when searching for new and imagi-native commissioning solutions. He went on to describe how, in the days of “domination and dictation” before digital cameras changed everything, Fuji was desperately competing with Kodak for market share. Apparently Kodak was the clear brand leader with Fuji in second place. Mr Belfield described how Fuji’s mis-sion statement was “Kill Kodak” and how this competitive approach should be adopted by NHS commissioners.

During questions I challenged Mr Belfield’s thinking. I asked him if “Kill Kodak” was really the right ethos for primary care commissioning. If what we really want is patient-centred, multidisciplinary care, is a “Kill Kodak” approach going to bring that about? Are health professionals from different disciplines really going to work together in a competitive “Kill Kodak” environment? Are GPs really likely to work with community pharmacists, as I believe they should, if we are seen as Fuji and they as Kodak? Let us face it. All are divided commissioning “trumps” have been handed to GPs. Does “Kill Kodak” go some way to explain the effective exclusion of pharmacy from so-called practice-based commissioning?

The reality is that PBC has been more about provision by GPs (who are obviously conflicted and have a vested interest) than true commissioning, a scenario I often de-scribe as practice-based commissioning!

I asked the “collaboration versus competi-tion” question again during the closing ple-nary session at last year’s NHS Alliance Conference. (The NHS alliance is a network of senior NHS managers, doctors and prac-tice managers, nurses, pharmacists and allied health professionals, along with board chair-men and members. It has no political affilia-tion and works in partnership with the NHS with the aim of supporting the modernisation of the NHS, freed from the traditional tribalism of single interest groups.)

We need to influence the healthcare environment itself, and we can achieve this through a strong and effective professional body

Another presenter, Paul Corrigan, a former health adviser to the then Labour Government (and an architect of the com-petitive environment) demurred, and even then only in part. His view was that primary care trusts had to encourage collaboration between providers but, at times, seed collabora-tion as well. A mixture of both approaches was inevitable.

As I have suggested before (PJ, 31 October 2009, p443, and 31 October 2009, p483), the current community pharmacy contractual framework is not fit for purpose. Like many other aspects of the NHS internal market and contracting arrangements, it is full of perverse incentives and fails to reward the promise of the White Paper “Pharmacy in England — building on strengths, delivering the future”. This, and the level of resources, must change fundamentally and soon. But changing the pharmacy contract alone will not be enough.

If the NHS really wants multidisciplinary, patient-centred care then it must reflect that in its commissioning strategy and incentivise inter- and intra-professional collaboration ac-cordingly. As far as encouraging collaboration goes, the current pharmacy and GP contracts fall equally short. Both are full of perverse in-centives which promote competition, not collaboration.

There is now a new team at the Department of Health (soon to have a new system architecture and, it is suggested, re-named the Department of Public Health). It needs to decide what it wants from pharmacy and it is crucial that the profession influences thinking at the highest level. With an increas-ingly challenging financial climate, it is at last being recognised that the excess capacity needed to drive a traditional competition model may not be sustainable or even appro-priate. Competition breeds secrecy, the with-holding rather than sharing of information and mutal distrust rather than co-opera-tion. This is fundamentally wrong in a health-care environment.

The lack of political acuity in pharmacy has been one of my long-term themes. By tra-dition, pharmacists are proudly non-political and we disengage from the political process. This is professional as well as political suicide because ultimately it is politicians who take the key strategic decisions about the NHS and our roles within it. The political playing field may be uneven, but often as not we are not even on it. This is a tragedy, because when we do engage we can be effective lobbyists. One need look no further than the influential All-Party Pharmacy Group in Parliament to see what we can achieve when we try.

Recently I have been delighted to see all three major national pharmacy organisations getting much more political. This can only be a good thing — but too often they seem more intent on competing against one an-other for the limelight than on collaborating, when they should be working together to get the best result for the profession. We still do not have that much-promised “clear strong voice” — but the potential is there.

We must convince the Government that we are crucial to delivering its health and well-being objectives for the NHS. Pharmacy, working in partnership (not competition) with other health professions, could do so much more to accelerate earlier diagnosis of long-term conditions, improve public health (especially in addressing the health inequali-ties agenda) and to optimise medicines manage-ment.

This could save lives in their thousands and save pounds in their millions. Given the Reframe relationships

In a compelling recent Agenda article (PJ, 3 June 2010, p53), Gooi proposed a European per-spective and following the recent change of government, GPs will be more in the commissioning driving-seat than ever. She suggests: “As with all major changes, what we need to do first is reframe our relationships and conversations — especially with GPs.”
Current cost-constrained, evidence-based NHS environment, we have a compelling argument to put forward.

I recently attended a regional meeting of National Association of Primary Care — an organisation that spans the whole of primary care. My “competition versus collaboration” arguments were well received. All the talk was of the need to remove tribalism and to work together in patients’ interests. Encouragingly the term “clinical commissioning” is increasingly replacing practice-based commissioning.

More encouragingly still, the next meeting is being held in London, hosted by the Royal Pharmaceutical Society. We have the positive prospect of a debate on clinical leadership within the NHS, and how pharmacy can contribute, with an audience comprised of senior NHS personnel and clinical leaders from several other health professions. The NAPC offers real hope of partnership working and increasing pharmacy influence. I would encourage as many colleagues as possible to get involved.

Our new professional body is just around the corner now. However, it will only be credible and viable if the overwhelming majority of pharmacists join it and engage with it. So we must set our doubts aside and help shape it.

Conclusion
Returning to my premise: competition between pharmacists and GPs, far from improving the quality of patient care is actually having the reverse effect. Competition is preventing GPs and pharmacists from collaborating to deliver the integrated, high-quality primary care that is needed. Competition is obstructing the delivery of people-centred, prevention-focused services. If we are to gain the necessary momentum to position our profession where it needs to be, ie, central to healthcare delivery and public health, then we need to look beyond the confines of the failing pharmacy contract to the wider aspects of how healthcare is to be delivered and paid for in the future.

We need to influence the healthcare environment itself, and we can achieve this through a strong and effective professional body. We owe it to our profession, to our patients, and to the public to do so.

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