ANNA DONALD

ON TURNING COGS IN A BLANCHE MANGE

Last month's surprisingly absorbing three-part BBC series on management at Rotherham foundation trust revealed a lot about what is right and wrong in the NHS.

Everyone was trying to do the right thing — the NHS ethos is still working its magic — yet was stymied by small obstacles in a depressing environment of 'no can do', in which staff felt like 'cogs in a blanche-mange', as one of my medical friends puts it.

In Can Gerry Robinson Fix the NHS?, staff implied that a key problem is that hospitals are run by two interdependent yet isolated groups — the consultants and the chief executive. If anyone doubts there are two cultures, read the discussions about the programme at www.open2.net/forum, particularly the doctor versus manager debates. Ouch!

Doctors and managers clearly need one another to make things happen, yet neither knew how to talk to each other, much less tell each other what to do. Where authority was unclear, committees — the algal bloom of bureaucracy — thrived.

The scenes reminded me of incidents in my early medical career, to which my absurd confidence and lack of managerial training contributed. One was arriving at my first house job at Glasgow Royal Infirmary to find that there was no desk for doctors to write notes on.

Junior doctors were practised in the art of creating towers of medical records and writing notes on the uppermost record. But every day the towers collapsed, causing records and test results to spill across the polished floor. I remember crawling under patient trolleys to retrieve a particularly critical X-ray.

In a fit of frustration and naivety, I telephoned a supply unit to ask for a desk. (I didn't know that managers existed. We knew nothing of them from medical school.) When the man asked for my authority to buy the desk, I said I was a doctor. He promptly sent a new desk wrapped in bubble wrap. The look on the ward sister's face remains in my memory. I have no idea who got the invoice. This didn't matter to me, since I didn't know what an invoice was.

This experience illustrates part of the problem. Doctors are not stupid people. Their preferences, decisions and non-decisions profoundly affect many things for which chief executives are responsible: waiting times, equipment, cost of procedures, number of ancillary staff, admissions policies and length of stay, to name a few.

Yet, with few exceptions, doctors have no training in management, finance, conflict resolution, price negotiation, working with trade unions, organisational analysis, employment, administrative or EU law, or any other skill set you need to get things to happen in large organisations.

To learn these things you virtually have to quit medicine. There is no training stream or specialty that leads you from medical school to chief executive.

And hospitals do not work like single-partner practices. Just as medical treatments now require specialised skills and co-ordinated teamwork, management isn't like it used to be, when matron and doctor could apparently run the Brompton, or the Crimea for that matter.

What factors are there? If only it were as simple as in Bob the Builder. No doubt Sir Gerry is right to suggest that the chief executive should get out and talk to the clinical teams, of which he appeared terrified but admirably determined to do. And it still seems to make a difference. But, as Brian James has himself suggested on www.jamesxalk, it will take more than 'walking the floor' to transform the two cultures and turn the blanche-mange into a well-oiled machine.

Having trained as a doctor then run a company for seven years, I believe that one major obstacle is the profoundly different way in which doctors and managers are trained to view the places in which they work. Chief executives have years of training and experience in thinking about hospitals in terms of organisational systems. For doctors, William Oster, the 19th century physician who virtually prohibited thinking beyond the patient in bed, remains our patron saint.

Most doctors would struggle to conceive of a hospital in anything other than descriptive terms, rather than analysing it as an organisation. Non-medical chief executives would have the same problem with diseases.

In short, neither party really knows what the other worries about, yet both wield a lot of authority that profoundly affects the other. I am not trying to argue that consultants should become chief executives or vice versa, but that a real understanding of what the other does might improve communication and, ultimately, leadership. It is bad enough having two head chefs in the kitchen, let alone two chefs who view it in completely different ways.

There are several tools for sharing, enlarging and transforming ways of seeing. One is McKinsey's 7S framework. 7S describes the factors that leaders need to consider for organisational coherence. It can reveal differences in how groups see their roles and others' in organisations.

It would be interesting to see what Sir Gerry might make of the ways in which managers and doctors would understand the elements of 7S: structure (how people are co-ordinated, including reporting lines and accountabilities, task division and integration); systems (procedures that govern activity); strategy (the goals and actions they believe will lead to success); style (leadership approach and cultural style); staff (in terms of organisational groupings); shared values (principles upon which a hospital is built and things that influence people to work towards common aims); and skills (distinctive capabilities and competences).

Transforming all this — 'ways of seeing' is a big task but perhaps not insurmountable, given how much NHS professionals want to make things work. Maybe we need Bob the Builder, to rally things along:

Can we fix it? Yes we can.

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Doctors, you would think, have never had it as good as under this government. There are more consultants than ever before, a third more funding for the NHS, and significant pay rises for most.

And the devolution of funds to primary care trusts has given GPs unprecedented ability to control their own destiny (not to mention the destiny of their hospital-based colleagues).

Yet it would seem that within the doctor camp, morale is at an all-time low. According to a doctors.net poll of more than 3,000 doctors last month, only one in 10 thought the extra money given to the NHS had been well spent. Less than a third thought there had been any improvement in the NHS since 2002. And only a third envisaged working to normal retirement age within the NHS.

So what is the matter? Is this just another case of doctors being curmudgeonly? Or is it something more profound that the government would be foolish to ignore?

Jon Katzenbach, a management specialist who has spent his working life studying what motivates people in the workplace, would almost certainly argue the latter. The Doctors.net survey is only the latest in a series of pieces reflecting the prevailing level of medical nascency, a mood that will lead to much greater trouble in future if leaders do not wise up.

The issue is not pay (some doctors privately think they are now paid too much), but doctors' raison d'être, what they are here for.

In his book Peak Performance, Katzenbach argues that different kinds of occupational groups are motivated by different things and need different management paths. He identifies five groups.

The first is motivated by mission, values and pride. People in this group typically work in highly engaged teams, like marines. They are less motivated by money for its own sake and by meeting external targets than by a strong sense of purpose and value-driven leadership. While they are rarely individual risk-takers, they are often willing to sacrifice themselves for the team and the group's mission.

The second group is motivated by process and measurable outcomes. These people can be found in workplaces where consistent quality is paramount, such as manufacturing industries.

They delight in meeting numeric targets and goals. They do not necessarily mind that they did not set these goals themselves. These are people who are genuinely excited by the idea of payment by results.

The third group is entrepreneurial. They love high-risk, high-reward work and care about ownership of what they do. They include market traders and leaders of high-risk industries.

They don't need social recognition as much as a sense of personal risk-taking and material reward. They are often willing to lose everything to follow their personal dream. These people are rarely found working in the health service.

The fourth group cherishes individual achievement. Those in it need to be able to see opportunities and incentives to give them a sense of personal achievement and progression. Many professionals, who rarely endure years spent qualifying for the sense of achievement it gives them, fall into this group.

The fifth group cares most about social recognition and celebration. People in this group don't like taking risk, they are not as bothered about pay unless it slips beneath a decent minimum, but they do care that their special effort is acknowledged by the group. They tend to work as employees in large organisations that rely on consistent customer service and relatively low-paid staff, such as fast-food chains and retail banks.

While you might take issue with Katzenbach's groupings, the main point is his observation that different people get out of bed and retreat to their duvets for profoundly different reasons. This is what is at make for NHS doctors.

Using Katzenbach's framework, I think doctors mostly fall into groups one and four. We are taught to remain loyal to our colleagues and to sacrifice a lot - our youth, our sleep, the other paths we might have taken - for our profession and our patients.

To become a doctor, you also need a strong sense of individual achievement to endure nearly 20 years of grinding tests of individual knowledge and skill. By contrast, doctors are definitely not from groups two, three, and five. Doctors are rarely personal risk-takers; they would be offended by the term 'doctor of the month' signs on the ward, and nothing seems more idiotic to them than some externally imposed measure that they cannot make personally meaningful, either within their team or their individual career path.

So what to do? So much of the rhetoric of reform is couched in terms of externally imposed political and financial targets that leave most doctors flat.

That's not to say that such targets are not important, but they are not the way to motivate most doctors. Large, abstract goals set by others, which might rally people in groups two or five ('let's reduce waiting times by 20 per cent!') seem vacuous for groups one and four, unless they are personally engaged in setting and meeting them for themselves, their teams or their patients.

The NHS needs doctors firing on all cylinders, not retreating to their duvets. Like marines or directors of professional law firms, doctors are intelligent, big people capable of doing great good. And they can create great havoc if their needs for achievement and meaning are not met.

In a recent editorial in the Journal of the Royal Society of Medicine, Dr Kamran Abbasi asked what role the world would like doctors to adopt. It is a question that I think health leaders would do well to ask themselves, before the current malaise among doctors takes a more destructive form.

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Four years ago, I had breast cancer. Since writing my last column, it has come back.

Because this has given me plenty of time to observe the NHS 360 degrees from the hospital bed, I hope you will tolerate my writing from this perspective this month.

Lying in hospital, it is obvious that quality of care from a patient perspective relates to three things. The first is quality of relationship. The second is systems. The third is technical skill and equipment.

This is because you need to feel cared for, that things are in control, and that the right things are being done to you.

It is also clear that quality of relationship underpins the other two, because it connects people through all their tasks. Relationship is the invisible yet potent force that forges and sustains action beyond the immediate task to hand.

If relationships are good, then technique is likely to be masterful and systems sustainable, because a connected web of people will pay attention to them. If not, technical skill becomes brutal and systems obfuscatious and flawed. Neglect is a random and destructive force that can swiftly wreck systems.

Everything that went right (90 per cent) and wrong (10 per cent) with my transition from ‘normal person’ to ‘person with cancer’ related to these three factors.

Most of my NHS experience was superb, from GP reception to oncology ward. I am fortunate to live near University College London Hospitals foundation trust, a major teaching hospital.

I could wax lyrical about so many aspects of the service I received: the skill and kindness of NHS staff, the speed of interventions (waiting only a few hours for complex procedures), the quality of the building and equipment.

For years I’ve travelled the world as a health policy wonk. I know I would not have received better care anywhere else. The NHS transformed what should have been a crisis into a humane, manageable process.

So what went wrong? Two things, both common. The most obvious was the contrast in quality of care from the contracted staff on minimum wages, the ‘invisible’ people: the tea ladies, the porters. Employed on sometimes daily contracts, the potential for relationship and contribution from these people is systematically minimised.

Polly Toynbee’s book Hard Work: life in low-pay Britain makes this plain and is a must-read for anyone concerned with patient-centred care. These people are not invisible to patients, who face them full-body many times each day.

I had the tea lady from hell. I woke on the first morning in quiet shock to be greeted by a short, angry person wielding a large trolley. ‘Yes, coffee, sugar,’ she barked, staring angrily at me. I asked her what’s for breakfast.

‘What there always is,’ she shouted. I told her I wasn’t here yesterday. ‘Cornflake Special K Rice Crisp’, she said, fingering a bowl on a tray and pushing it at me. She looked like she wanted to explode. I wanted to cry. I tried to get her to be nice to me. I failed. Every hour for four days.

As a patient, it is impossible not to be affected by these people’s lack of belonging, training, and troubled personal situations. And despite the minimum wages and flexibility that agency contracting allows, it is not clear that the sums add up, given the opportunity cost from compressing so many people into the nearest human package possible.

Having already lost a friend to severe brain damage when an orderly who didn’t know the ward mistakenly gave her food (she had initially suffered a mild stroke and had difficulty swallowing), I suspect that the true cost is far greater than simple accounting admits.

It would be interesting to know the cost of medical errors alone resulting from this form of non-join-up-working.

The second issue, the discharge process, was another example of how transition between systems — hospital and community — still isn’t completely joined up. I was surprised by how vaguely chaotic the process remains and by how much I was affected: a patient-doctor who more or less knows the ropes. The key problem is that you are discharged at an unspecified time in a disoriented state with no map to guide you.

You’re addled by having sat in a strange bed for a week on new drugs with new routines. You know you have drugs to take. But what more? On my first night I got breathless. The home oxygen tanks hadn’t arrived because ward staff were fixated by the order forms (they turned up a week later).

I was desperate to avoid accident and emergency. I didn’t know what my GP’s out-of-hours service provided. I knew there were further cancer support teams out there somewhere, but not their hours, phone numbers, or precisely what I could call them for.

Patients need an idiot’s guide to going home. It should tell you who to call for what; what to do if a crisis arises; and who does what so you don’t spend hours fretting, waiting for the wrong switchboard and bothering the wrong people.

The usual ports of call: 999, GP, NHS Direct are fine when you’re well. But when you come home after the awesome spaces of the hospital, unravelling and apprehensive about what lies ahead, you need an orientation guide.

A pack of drugs is not sufficient. A condition-specific, up-to-date guide with local phone numbers, names and functions would make a big difference.

For all that, my experience of the NHS in a centre of excellence was, well, excellent. I am left in no doubt that the NHS is capable of the best in the world. God Bless the NHS. I mean it.

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12 April 2007 Health Service Journal 15
Having cancer again is making me increasingly mindful of guilt between reality and rhetoric in our healthcare system. Thankfully, there are not too many. But one area where there’s much more talk than walk is the patient choice and responsibility arena.

I’m all for patient choice and responsibility. It would make doctors’ lives easier for one thing. But from an individual patient perspective the words are meaningless.

In today’s NHS, it is difficult to identify any stage of a patient’s journey where they can meaningfully exercise personal choice or responsibility.

People sit in outpatient clinics and hospital beds looking alternately bewildered and bored, clutching admission letters and hoping someone might tell them the basic facts of their treatment or procedure: why exactly they are in hospital in the first place; what that means in the longer term; how long they might be in here for; what to expect when they eventually go home; and who to contact if things go wrong.

And because it’s difficult to get answers for these kinds of questions, people rarely ask other questions that they probably should, such as what their treatment options are and how each compares in terms of benefits, harms and hassle.

The dearth of intelligible information is probably why people end up venting their frustration on radio stations, demanding things that cannot be provided and rarely articulating the larger issues at stake.

A recent example from Radio 4 on mandatory single-sex wards – as if it’s not difficult enough managing high-dependency beds without further constraints. Or ‘modest’ NHS robes that untie at the back – which is entirely necessary so tests can be performed.

Had no-one told the interviewee you can write your own obituaries once the tests are done? Probably not, come to think of it. The larger issue underpinning both demands is patient dignity, which is a real issue and needs concerted management strategy to address.

It’s not surprising that people don’t get all the information they need from health professionals. Doctors and nurses rarely have the time to explain things properly. Few doctors are naturally good at explaining and, sadly, we’re not trained to teach.

And even when doctors and nurses explain things carefully, people don’t take much of it in because they’re too busy putting their shirt back on and worrying about whether the parking meter is running out.

What is even more surprising is that, as yet, there are no professional information systems in place to support people in making such meaningful choices and taking responsibility for managing at least some aspects of their condition at home.

Patient leaflets are rarely up to the task. I’ve never actually seen anyone reading one. Patient websites are seldom designed to meet the average levels of functional literacy. And virtually none are able to provide practical information.

It is not sufficient to transcribe medical and policy websites, akin to writing computer instructions directly from technicians’ manuals. Nor does it help to pepper unseeable information with the odd citation, as if that makes it trustworthy. That’s what you do in school essays before you know any better.

Of the millions of pieces of published medical research, only a tiny fraction are reliable enough to base decisions on. Any medical claim, however bogus, can be cited by a study of some kind to make it appear scientific.

Producing high-quality consumer information in any industry requires specialised skills and, just as importantly, continuous updating to ensure it stays relevant, reliable and usable.

But maybe the current state of affairs is not really surprising. The policy of a ‘patient-led’ NHS denotes a lack of seriousness.

The term ‘patient’ (rather than, for example, ‘customer’ or ‘consumer’) keeps people passive. Patients must indeed be patient. Similarly, the term ‘patient-led’ invites disbelieve, since no-one seriously imagines that patients (or even consumers) are going to actually lead the NHS. Just as no-one would suggest that consumers should lead the banking system. Consumer-informed, definitely Consumer-led? I don’t think so.

Previously, I might have argued that this kind of policy is good strategy, since the NHS has enough to worry about without having to take its consumer views into account as well.

But that would be to deny the real problem: without consumer input it is virtually impossible – in any industry – to improve the quality of service.

Consumers are the only ones who can supply ‘hard’ information about service quality because they are the only ones who experience it.

Obtaining valid feedback for service improvement is a professional and costly activity which virtually all industry sectors have been investing in for many years now. I’m talking about professional customer research that is serious about improving the quality of care, not a morning tea session.

Things are not all bad. Some hospitals recognise patients as consumers and are investing in professional quality improvement. I am delighted to include my own hospital in this. But many still have a long way to go.

That it is still novel to interview NHS consumers about customer service in their own voice is an indication of the poor state we’re in.

I very much doubt British Airways or Tesco would be so cavalier in their approach.

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HSJ hosts the Business Management for the NHS conference, in Leeds on 28 June, www.hsj-businessmanagement.co.uk
It will be interesting to see how all the parties envision healthcare with Gordon Brown at the helm and the Conservative health ‘white paper’ on the table.

The difficulty all parties face is that there are few policy ideas to choose between. There are only so many ways you can steer the NHS, which has the scary potential to lose the election and sink the economy.

Whichever side you are on, you can’t much improve the way the NHS is financed from direct taxation. The NHS enjoys the cheapest and fairest finance system in the world and in one of their right minds would change it. The market failure inherent in competitive health insurance, which hobbles the US, is something for which we should all give daily thanks we don’t have in the NHS.

Despite enthusiasm for a non-partisan, its, hard to envisage big changes to how we govern the NHS. Whether it likes it or not, the Commons has to care what the NHS does, because it employs more than a million people; makes headlines because it cures and kills people; and has the power to make or break the national budget.

Even if governance is handed over to a non-elected body, that body will soon be as political as the Commons, if perhaps not quite as partisan. In other words, the NHS can’t avoid political controversy, because what it does is too important, complex, and subject to debate.

You can’t do much about the ageing population, unless you allow more young workers to immigrate to Britain. Migration from the EU may help a bit.

You can’t keep wages down for any length of time. You might even have to put them up if you want to keep our (and other countries’) nursing staff.

You might be able to change the name and rhetoric around service goals and targets (a welcome change for doctors at least). But you can’t withdraw too many without risking plummeting and inconsistent standards, which will cause electoral bother. It is hard to see how the public will be happy, for example, if you start removing the two-week maximum for cancer diagnosis and the four-hour maximum stay in accident and emergency.

It is difficult to introduce performance-related pay without increasing management costs and alienating the unions. If you want to promise voters more frontline workers and fewer managers, this isn’t the way to do it.

But if you want true competition in primary care, it might be worth examining Australia’s model, where patients can pick and choose between any GP at any time, paying a ‘Medicare’ card which entitles them to care.

It’s great for patients, because they can visit one practice when they’re at work or on holiday, another when they’re at home, and choose general practitioners for different kinds of problems.

People who care most about continuity of care can stay with one GP – it’s their choice, not the doctor’s. It puts real pressure on GPs to stay on top of their game. Such a reform, however, would require a different kind of billing system (fee-for-service v. capitation) and risks alienating doctors. So not for the faint-hearted.

You might be able to promote healthy competition between hospital providers but, as with railways, past experiments have not worked brilliantly, because there are too few hospitals to give consumers much of a choice. It’s just possible that the private providers of elective procedures are having a positive effect on NHS providers with improved outcomes overall, though by no means certain. You could push this further; you’ll need the courage to stop if it’s proving destructive.

You should be able to keep improving procurement efficiency. One of the NHS’s biggest strengths is its purchasing power. Walmart wouldn’t hesitate to exploit this to the maximum and there’s no reason why the NHS shouldn’t do so either, so long as it doesn’t compromise quality. This can extend to medical technologies, to dampen the year-on-year price rises above normal inflation. The same caveat on quality applies, of course.

A reform that would make the NHS easier to run is to divide the whole thing into one insurer-gatekeeper and many provider units. In most countries, this division of labour is normal: a national insurance body makes decisions about what mostly will be covered, while local provider deliver care with reasonable degrees of flexibility.

The NHS is unusual in that insurer and provider functions are still carried out at all levels, so frontline workers sometimes make on-the-spot coverage decisions.

This is like your mechanic having to mind your car and deciding whether your insurance should pay for it. Such an old-fashioned arrangement, a legacy from the NHS’s pre-war origins, is inefficient and inequitable, resulting in postcode lotteries (the Herculean debacle, for example). Sorting it out would make the whole system easier to manage.

There are many exciting IT innovations to be introduced which would please all punters: electronic patient records, seamless prescription and procurement systems, booking systems, to name a few big ones still waiting to happen.

And there are the crowd-pleasers like cheap broadband internet, phone and music. Doing this across an organisation the size of the NHS is not easy to achieve and can cost the earth (£12.4bn so far), so you need to know what you’re doing.

None of the options are partisan because in healthcare, economic realities swamp most ideological preferences. And the NHS is already suffering reform fatigue. So it will be interesting to see what the parties come up with to distinguish themselves. I know what I’ll be looking for: not too many changes; a steady hand at the tiller, and a good head for economics to steer the NHS through increasingly difficult waters. Call me boring.

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5 July 2007 Health Service Journal 17
OPINION

ANNA DONALD

ON DRUGS IN THE HEADLINES

Hardly a day passes without press reports on products of one kind or another, be they heart drugs, vitamin tablets or laser surgery. Of late the diabetes drugs Avandia and Actos may cause heart failure. Our national heart disease director Professor Roger Boyle thinks all men older than 50 should take the anti-cholesterol drugs statins to reduce Britain’s rates of heart disease and stroke. Mobile phone masts are safe after all.

What does it all mean for managers and clinicians? No doubt it would be foolish to jump with every headline. Nonetheless, the relative value of the thousands of available products changes frequently enough, and with enough impact on health outcomes and budgets, to warrant regular review of those that we buy and use.

There are two reasons for the rapid turnover of “best buys.” The first is the arrival of new products, such as statins and Viagra, that put older ones in the shade. The second reason is the continuous arrival of new research (more than 20,000 studies each week) revealing previously unknown effects in products that have been around for a while.

This is usually due to the research being carried out over a lengthy period to reveal effects that shorter studies could not; involving more participants than previous, small studies so identifying effects with more certainty; or having less biased methods and conduct so revealing new effects.

The big HERS trial in the US, revealing the cancer risk and surprising lack of cardiovascular benefits from hormone replacement therapy is an example of how new research can dramatically change products’ rankings.

Given the avalanche of research and new products, it is not surprising that the “best buy” list of products keeps changing.

And when products not only help and harm people in very different quantities, but can also vary 500-fold or more in price, it makes sense to review products – old ones as well as new – regularly, at least once a year, with some kind of alert system for dramatic findings requiring more urgent action.

How to do it? That is a good question. Most hospitals have pharmacist-based systems for reviewing drugs and the National Institute for Health and Clinical Excellence issues guidance on a selection of new technologies. But given the pounds and lives that could be saved, surprisingly few NHS organisations have established systems for regularly reviewing the stockpile of drugs and devices, old and new, that they currently buy and use.

It should not be rocket science to do so. If we are that way inclined, an interesting preliminary exercise is to walk around any ward, department, surgery or theatre to see the drugs and devices and to ask ourselves, how well do they work? Which are best value? Which are gathering dust? What systems exist to know these things? When last were they reviewed and decluttered? What is the likely financial and health cost our institution and patients of any discrepancy between these products and the best currently available?

While some wards are pristine, many are like my wardrobe – containing things which look terrible but cost a lot, or which were donated by a well-meaning aunt so cannot be thrown away, or which look fancy and are too complicated to use (or which still have shoulder pads – eek).

All too often, I meet people (typically at dinner parties, where I have learned that it is easier if no-one knows you are a doctor, let alone an evidence-based one) receiving treatments which were superceded years ago and whose doctors have not pressed the update button.

Which of course gives me the fun dilemma (not) of whether to launch into an evidence-based lecture or let them enjoy their carrots in peace while risking their heart/stomach/logbrain. Is it worth the cost and hassle to update?

Usually it is. Among drugs and devices, there is virtually no relationship between quality and price. This means that today’s most effective treatment may well be one of the cheapest.

Take aspirin, for example, for reducing the risk of second strokes. At less than 0.3 pence a day, it is more than 100 times cheaper as well as being more effective than the next best treatments currently available.

Decluttering your medical products to include the best and exclude the worst will usually save you money. The problem, though, with the lack of a price-quality relationship, is that price cannot tell you what to do. The best treatment might be the cheapest, the most expensive, or somewhere in between.

This state of affairs is unusual, to say the least. It is hard to think of another industry in which price – as well as look and feel – does not give some indication of quality of the product: refrigerators, fruit, cars.

Frustratingly, with most medical products, price does not tell you much and can even be downright contradictory. And it is usually impossible to ascertain clinical quality by the look of a tablet or a machine that goes ‘ping’.

That is why scientific evidence is so important, because it is usually the only way to tell what is best to buy, given available choices.

Hopefully, this state of affairs will change.

Earlier this year, the Office of Fair Trading published its pharmaceutical price regulation scheme report, highlighting the problem and calling for pricing changes so that the market works more efficiently. Watch this space.

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Registered users can download the OFT’s full report by accessing this article in the Opinion section of www.hsj.co.uk

16 August 2007 Health Service Journal
Having a Medicare card makes you feel like a normal human being with rights you can exercise