Gordon Stueck

'Best practices' in primary care brought to life in UK

National Health Service's culture of positive change is remarkable

To a Canadian battered and bruised from the past decade of health care debacles and mounting, unresolved tensions, a utopian dream of a health care system might include:

- A patient being seen by a physician within four hours of calling for appointment
- A secondary hospital's admissions being managed solely by nurses who "troll" the acute care hospitals daily, identifying patients suitable for transfer
- Trained pharmacists who are certified to prescribe
- Pharmacists regularly visiting physicians with individualized, current statistical information in hand to discuss the physicians' prescribing habits in comparison to the national average
- Innovation that is rewarded by rolling successful programs out rapidly across the nation
- Failure that is not punished, but captured in the institutional, collective memory so as not to be repeated.

Sound impossible? Not by any means. I was among the participants in the Saskatchewan Health Quality Council who saw all the above and more on our trip to the United Kingdom.

In all likelihood we saw only the successes of the National Health Service (NHS), not the failures. However, we couldn't help noting the culture of positive change throughout the primary care trusts (PCTs) we visited. Many of the PCTs demonstrate the benefits of the "just do it" method of implementing change, and this attitude was reflected throughout the whole organization, from the maintenance people to the CEO. This positive attitude is a direct result of the NHS's setting guidelines while fostering innovation in meeting those targets.

Flexibility, responsibility, ownership — 'just do it'

To be sure, the NHS faces the same obstacles as we do: a growing elderly population with the boomers just around the corner and a current and worsening shortage of physicians, nurses, pharmacists, and other health professionals; an unresponsive regulatory environment ill equipped for change; and professional elitism and territorial disputes. What sets the NHS apart from our system is its proactive stance to address the problems. The NHS encourages and rewards the devolving of responsibilities among professionals. By reinforcing the view that current practices are unacceptable and unaffordable, the NHS has turned the players into solution-finders and ultimately, a new breed of policy-makers has risen from within the system.

So how does Canada compare? In my own view, not well. My exposure to the positive "bottom up" changes in the UK brought home the reality that we will not see change in Canada until pharmacists as individuals accept the challenge to find and implement solutions. This means accepting a blurring of the lines of responsibility and change in accountability.

Collapse is possible

Let's take a look at our profession in 2004, in Canada. Our universities are graduating record numbers of pharmacists who are trained in pharmaceutical and primary care and are willing to take on added responsibilities in disease management, monitoring, and prescribing. Either pharmacists will be successful in adopting new roles, or we will have a very unhappy group of new pharmacists seeking other, more satisfying employment.

If we are successful in gaining new responsibilities, how are we going to manage? We are already extremely short of pharmacists and the statistics show that within 20 years Canada will be short 20,000 pharmacists. Are we going to train more technicians? It doesn't matter how many technicians we train —

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there will still not be enough pharmacists. The pharmacy system will not be able to stand the strain and will inevitably collapse. Sheer necessity will force governments to act to protect the public interest, which may or may not include your vision of how pharmacy should be practiced.

If we are going to take on a new role we must be prepared to make some accommodations beforehand. It is obvious we will have to shift more responsibilities to technicians and lay people, but this will not be enough. Perhaps we should be investigating a split degree — for example, a three-year dispensing degree and a five-year PharmD degree. Can we make the required educational and regulatory changes to accommodate a split degree? Would this meet the projected demand without compromising patient safety? Are there other alternatives? As individuals we have a responsibility to the public and future pharmacists to address these issues now so we can plan and adapt accordingly.

A good start would be further integration of undergraduate and continuing education among the health care disciplines. Joint endeavours of this nature foster good relations, trust, and teamwork. Make a personal effort to push for innovative educational approaches that enable pharmacists to actively participate in the development of primary care in Canada.

Use every opportunity to engage your colleagues on the challenges the profession faces in the future. Flexibility, adaptability, responsibility, accountability, and ownership. *Just do it.* ■