Coping with cost containment pressures

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Are we losing our way?

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Say what you will about the ills of the pre-DRG era, the prevailing ethos in hospitals was, Do what is best for the patient. As one historian has noted, "For most of the twentieth century, the American hospital has been perceived as a triumph of modern medical science, a monument to man's knowledge and his best instincts."[1] This image prevailed because the hospital system, including its financing, was subservient to the knowledge, technology, and professionalism of medicine. Suddenly, this is changing.

In an effort to control runaway Medicare costs, Congress imposed on hospitals a complex scheme in which government-printed price tags are attached to the treatment of specific illnesses. Private insurers are following suit. Dutifully, everyone in the hospital is falling in line to make the new system work. In the process, the center of power is shifting from the medical staff to administration.

On the surface, the business babble echoing from hospital executive suites is confident and soothing. But it often settles as discordant and worrisome in the minds of those who equate health care with altruism. Hospitals in the voluntary sector are trying to act like the investor-owned hospital chains, even though the latter have been shown to be less cost effective than their not-for-profit counterparts.[2] One wonders if the needs of patients are becoming overshadowed by a preoccupation with corporate restructuring, diversification, unbundling, and marketing. Is hospital care becoming a mere economic activity, motivated by no higher values than possessed by any ordinary big business? Is our nation morally prepared to let prospective pricing exacerbate the already serious problem of unequal access to care by the uninsured, the poor, and minority group patients?[3]

Within hospital pharmacy, prospective pricing has unleashed both elevating and debasing forces that are now tugging at our limbs. On the one hand, hospital pharmacists have been freed of fiscal disincentives against advocating the least expensive drug regimens among equally effective choices. But in the face of

pressure to improve operational efficiency, practitioners are being tempted to compromise essential precepts of the profession. One can hear evidence of this whenever two or more pharmacy directors gather and think aloud about coping with the pressures they are under.

Hospital pharmacy has its share of sacred cows, and no aspect of our discipline should be off limits to objective review. However, it is especially important, in this time of upheaval in the hospital field, to take direction from our most fundamental values. One of these nonnegotiable principles is that the hospital pharmacist holds ultimate responsibility for drug-use control. The term *drug-use control* was originally defined as "the sum total of knowledge, understanding, judgments, procedures, skills, controls, and ethics that assures optimal safety in the distribution and use of medication."[4] Over the years, the term has evolved to encompass, in addition to safety, the concepts of rationality, efficacy, and cost effectiveness in drug therapy.

This weighty responsibility has implications that some practitioners find difficult to bear. For example, if a serious medication error is made by a physician or a nurse, it should be viewed as a misadventure that was permitted to happen by the pharmacy department's drug-distribution system. If a hospital spends tens of thousands of dollars annually for less-than-rational antibiotic therapy, this is waste that the pharmacy department has allowed to occur. Unless we interpret our mission in this manner, how can we claim to be an independent health profession that centers on the patient's welfare?

Hospital pharmacists who practice the modern version of drug-use control are in a good position to show cost savings in drug therapy. Experience has demonstrated that the clinical services that produce these savings must be based on solid control of the drug product itself through an accurate, responsive drug-distribution system. Department managers must marshal the support and resources needed by the pharmacist staff to perform well in both the clinical and distributional aspects of pharmacy's charge.

The hospital field as a whole and individual segments like pharmacy risk losing their way unless they think carefully about their basic purposes in society. The passage of time will bring further reforms to American health care with a new set of formulas for "success." But lasting success will be earned only by those who all along have abided by the fundamental ideals of their calling.

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