

What can the proposed White Paper really deliver for pharmacy in England?

By Rob Darracott, chief executive of the Company Chemists Association

At the All-Party Pharmacy Group meeting in November 2007, health minister Dawn Primarolo promised that the expected pharmacy White Paper would be aligned with the Lord Darzi's review of the NHS in England and would join pharmacy policy with the rest of NHS thinking and planning. It is an ambitious aspiration, but one that is long overdue.

The APPG inquiry identified many of pharmacy's barriers to progress and proposed solutions. The Government listened and recognised the good sense of many of its recommendations; hopefully we will see echoes of the inquiry in the White Paper.

Today pharmacy has a wide range of professional tools available to it in the form of enhanced pharmacy services, pharmacist prescribing and pharmacists with special interests. But unless these tools are put into practice in the context of a commissioned service, their existence will be meaningless.

Commissioning policy is central to achieving change in the NHS; but it is also central to pharmacy's aspirations to expand and develop. This is where pharmacy policy and the bigger NHS picture converge.

Governance challenges

The NHS commissioning environment is evolving. In the past 12 months, we have seen how current commissioning policy is translating in practice. It is clear that practice-based commissioning is not delivering significant change for patients and that it is rife with governance challenges. There is evidence that "choose and book" is being manipulated to protect the interests of legacy providers by, for example, making it difficult for GPs to find listings for private hospitals within its software (*Financial Times*, 27 January 2008, "Code to promote the use of private hospitals"). There are powerful forces at work, and they are resisting change.

But not for long. Chan Wheeler, the new commercial director at the Department of Health, has promised that from April 2008, when a new marketing code is introduced for NHS providers, such restrictive practices will no longer be tolerated; and there will be "a non-discriminatory view of choice". This sounds promising. But in primary care, such a level playing field between providers remains a pipe dream.

The pharmacy White Paper and the Darzi review provide an opportunity to address this and increase the chances of pharmacy services being commissioned. For us, achieving a level playing field in primary care should be non-

negotiable; and it happens, it will prove a major barrier to the delivery of an expanded clinical role for the profession.

Our thinking at the Company Chemists Association has led us to the following conclusions.

Get policy right

First, we want the NHS to get commissioning policy right. We want a level playing field between primary care providers, and a commissioning environment that is fair, transparent and delivers value for money. Any providers who prove themselves competent and willing to provide should be considered. And the elephant in the room — the political power base of incumbent providers — must be addressed.

That said, we need clinician involvement in commissioning. But this input needs to be professionalised. We see this as a new skill base, and we are calling for the introduction of an NHS management competency programme for healthcare professionals engaged in commissioning, including pharmacists.

We also want a new cross-provider incentive scheme that rewards investment in service redesign and innovation. This would replace practice-based commissioning but retain its core principle that providers who help improve use of NHS resources should share the financial benefit this brings and be enabled to reinvest their share of the savings in patient services. We would also like to see this principle extended to the reimbursement system for community pharmacy so that if, through its effective purchasing, pharmacy saves the NHS more money than expected, some of that money is recycled into patient care provided from pharmacy.

We believe that a major weakness in the current system is the marginalisation of secondary care from the commissioning process. We believe that service redesign only works if everyone wins. So we are calling on the NHS to explore the concept of "integrated commissioning", first proposed by The Nuffield Institute ("Commissioning in the English NHS: the case for integration", The Nuffield Trust, 2007) that would see commissioning evolve into a multidisciplinary process that facilitates collaboration, and is inclusive. We believe this model would help the NHS achieve swifter progress on redesigning care closer to home.

We also want to see provider incentives created so that primary care trusts can facilitate, encourage and reward collaboration between pharmacists and GPs.

We believe that the general medical services quality and outcomes framework (QOF) should drive general practice activity to focus on case management of people with multiple conditions and the provision of care closer to home, leaving the management of those with chronic conditions and minor ailments to pharmacists. Over time, we believe that primary care contracts should be more closely integrated and we would like the feasibility of doing this explored sooner rather than later.

We also believe that there is a need to clarify competition law in the context of primary care. GPs are in the process of setting up provider consortia to contract with the NHS for primary care services. In many cases, these consortia will constitute a monopoly — or at very least a market dominant — provider within their locality. Despite the attractions consortia hold for commissioners, as a sector highly sensitive to the constraints of competition law, pharmacy has been reticent about embracing this organisational model.

UK competition law prohibits any business practice that enables a provider to exploit a dominant market position. We believe that primary care provider consortia do this. But since the NHS is an atypical market, this does need further clarification. The key thing is that the rules of provider engagement are clear and consistently applied. We would like the DoH to clarify "acceptable" organisational models for collaboration between providers so that no primary care provider is in danger of knowingly or unwittingly breaching UK competition law.

Reward mechanism

We want to see innovation in service redesign rewarded so that if a provider invests in service development, there is a clear mechanism in place to reward the risk that this investment represents.

And we want to see greater access to "private" primary care, with the NHS scoping through consumer research a range of medicines and services, which the public would like easier access to and would be prepared to pay for. This recognises the trade off that people increasingly make between price and convenience, and might allow the NHS to re-focus some resources on areas of greater need.

It does not look like the standard policy shopping list and neither should it. This White Paper will be about putting pharmacy into the bigger picture. It is time to look beyond the confines of our own world. Are we up to that challenge?