GPs will earn more money for providing better services. Will pharmacists, too?

General practitioners will receive more money for providing better services under their new contract. Jonathan Buisson looks at what this might mean for community pharmacists and their new contract

THE most ambitious attempt to reform primary care services since the creation of the National Health Service in 1948 is how Health Minister John Hutton is describing the new general medical services (GMS) contract.

"The new contract is a something for something deal," the Minister said last week. "Extra resources come in exchange for far-reaching reforms. For the first time, GPs' pay will depend on the quality of the services they provide. The better they do, the more they will get. And the contract proposes that the more NHS work GPs do, the higher the rewards will be."

Under the proposed new contract, services will be split into three tiers (*PJ*, 11 May 2002, p641). Essential services will be provided by all GPs to all patients. Most GP practices will also provide additional services such as vaccinations and child health. The top tier of enhanced services will attract the most funding. Top tier services could include minor surgery, specialist clinics or diagnostic procedures normally performed in hospitals. This will replace the existing contract, defined by the "red book" — the GP equivalent of the Drug Tariff —which consists of a mixture of capitation fees, practice allowances, expense reimbursements and item of service payments.

Alan Castell, vice-chairman of North East London Local Pharmaceutical Committee, has looked at the available details for the new GP contract. He says that about one-third of projected earnings for GPs will be capitation based, one-third dependent on meeting targets linked to national service frameworks — "the payment by results part" — and the final third, mainly new money, will be linked to providing a variety of new services — "the something for something part".

Medical practices rather than individual GPs will hold the GMS contract. Funding will be allocated using a weighted formula that takes into account the number of chronically ill or elderly patients on the practice list. Primary care organisations will have responsibility for funding information technology and arranging out-of-hours care.

The British Medical Association (BMA) says that funding for general practice from the four United Kingdom health departments will rise by 33 per cent over the next three years, from £6.1bn to £8bn. This should "boost the incomes of most GPs substantially over the next three years", it says. Full details of the new contract, which are not yet available, are to be presented to GPs at a series of roadshows. There will then be a ballot. If GPs approve the new contract, legislation to implement it should be introduced by April 2004.

The Pharmaceutical Services Negotiating Committee's chief executive, Sue Sharpe, sees great opportunities for community pharmacy to develop its services to complement the new GP contract. She notes that Health Minister John Hutton said that the GP contract "will allow other primary care staff — such as nurses and pharmacists — to benefit".

Mrs Sharpe says: "A national minor ailments service provided by community pharmacists is a good example of the way we could work more closely with GPs and improve patients' access to the NHS."

A NEW CONTRACT FOR PHARMACY

The PSNC's also wants to see a new contract in place by April 2004 (*PJ*, 22 February, p255). The new pharmacy contract is expected to have two tiers. A lower tier, similar to the current contract, will cover dispensing. The higher tier will cover additional services such as medicines management. Any new pharmacy contract will be put to a ballot of contractors before it is finalised.

Alistair Buxton, the PSNC's head of NHS services, adds that GPs are keen to reduce their workload and that the Government has given a commitment to this.

"Services such as minor ailments, medicines management and repeat dispensing are all sensible ways in which community pharmacy can contribute to this," he says. Patients also support this. In recent survey for the BMA, 84 per cent of respondents agreed that they would be happy to see a pharmacist instead of their GP for a repeat prescription.

Alan Castell says that any new pharmacy contract will inevitably have to parallel that for GPs. However, he is concerned that splitting the existing global sum between two tiers of services will not provide sufficient funding for additional pharmacy roles.

"Where will the funding come from for all the enhanced services such as chronic disease management, diagnostic screening and monitoring, public health promotion, smoking cessation and supplementary prescribing?"

He is worried that if money is allocated to primary care trusts and GP practices, community pharmacists will "end up scrapping for crumbs from the GP's table".

He adds that to look at the implications for pharmacy of the new GP contract, one has to follow the flow of funds. Just like community pharmacies, GP practices are businesses with overheads and operating costs (staff and premises) to be balanced against income-generating activities. Practices will have to maximise income, while minimising expenses, to prosper.

The implication for pharmacy in the GP contract is that if additional money is available, it will come with strings attached. The majority of the funding will probably be for top-tier services delivered to agreed quality standards and documented as such. Evidence-based medicine will drive the pharmacy contract as much as it will the GMS contract.