

A new dawn or an inevitable dusk?

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Like most community pharmacists, we have high hopes for the new contract. We hope that it will be fair, that it will support professional and business aspirations by developing services that meet local community needs, and that it will support the long-term financial needs of the network. Now that we have read the Pharmaceutical Services Negotiating Committee's booklet and the Department of Health's document, "The new contractual framework for community pharmacy", we are delighted by some of the areas covered. However, we are concerned and disappointed by others. It has become apparent to us that some people who were looking for a new dawn will actually see a dusk: an undignified exit from their pharmacies as a result of betrayal by their trusted negotiators.

However, first, let us examine the good things in the contract. It has two main strengths. First, the quality agenda and patient safety are now formally embedded in the core practice of dispensing prescriptions. Second, there is a regularisation of the uncovenanted profit to what is now termed "profit on purchasing". This puts finances on a more secure basis but, despite what the PSNC says, there does not seem to be any money — just newly labeled money.

Quality of service will improve as a result of requirements for clinical reviews of prescribed medicines, inclusion of patients in their reviews, accreditation of service providers and premises, requirements and standards for consultation rooms, reduced medicines wastage, working with GPs to manage chronic conditions, repeat dispensing, introduction of near patient testing, and improving patient safety by prescription intervention schemes. But these services have cost factors which will need to be monitored to ensure that there is no under-funding and cross-subsidy from other areas of activity. There will also be "significant additional regulatory burdens on contractors".

There is also more good news for those who want strategically important IT links. To be able to participate in electronic transmission of prescriptions (ETP), to communicate electronically with other members of the primary care team and to access the NHS Care Records Service, pharmacies will be required to use a National Programme for Information Technology in the NHS-compliant pharmacy system, which will need to be connected to N3, the new NHS national network. The costs of the new IT which will be required to deliver the contract will be met by the NHS and while pharmacies continue to provide an ETP service they will receive an allowance for maintenance and connectivity.

On the financial side there is an agreed formula with a number of components for funding the pharmacy contract. Reviews will take place at three-yearly intervals as to whether a new cost inquiry is needed. Agreement has also been reached to ensure that the levels of supply chain profit reflect independent contractors' ability to secure those levels. This means that vertically integrated chains will see an advantage in retaining profits untouched by discount inquiries in the wholesaling arms. The DoH will remove £300m from retained purchase profit by reducing Drug Tariff generics reimbursement prices. This money will be used to fund the new national contract, ie, not for locally commissioned enhanced services. The Government's express objective of paying pharmacies as closely as possible what they pay for the medicines they dispense under the NHS is now truer. The reliance of pharmacies on purchase profits has been recognised by the DoH and thus money released from a reduction in reimbursement prices for generic medicines will be used to contribute to funding the new contract.

There are three levels of contract: two in the national framework (essential and advanced) with nationally negotiated payments and, discretionary to primary care trusts, the local enhanced level. This means that PCTs, some of which have insufficient resources, will determine whether or not a service is required and how much to pay for it. All pharmacies will have to provide essential services and, in the first year under advanced level services, there will be an opportunity to provide a maximum of 200 simple medication reviews if the accreditation is obtained.

The down side

On the down side, our analysis of 20 pharmacies indicates that there will be less income from the nationally negotiated fees in the future than from the current arrangements. An average pharmacy dispensing 5,000 items per month with a 25 per cent margin will see a reduction in overall profit margin of 3.45 per cent to 21.55 per cent, which is equivalent to a 13.8 per cent decrease of the margin. In hard cash this amounts to £30,983 for the year. Since the PSNC has not provided contractors with a tool to calculate and compare their existing and future incomes, we are publishing our own tool on the internet (see www.nellpc.org.uk). Our model indicates that there is no new money, just reduction and redistribution.

For small contractors the future appears dire. Various ministers' proclamations that the new contract will reward quality not quantity are unjustified. Those with the spare capacity to improve pharmacy contribution to meet

the challenges of the modernisation of the NHS and meet local needs are going to be penalised. Those dispensing fewer than 2,000 items a month will have to forfeit up to £20,000 a year.

In para 3.1 of the DoH framework document it says: "All contractors, large and small, depend at present on profits from purchase of medicines dispensed for the NHS to supplement the global sum income. This income source is substantial, but was not recognised under the present arrangements." It is not recognised in the new contract either. All other contractors are benefiting from the change in "recalibration of the Drug Tariff". This is not only discriminatory but also anti-competitive because it raises barriers to entry.

If unchallenged this will lead to reduction in the number of pharmacies, especially independents. With profits retained in the wholesaling arms of the vertically integrated companies and cheaper sources of money on the market, we should now expect a buying surge of large pharmacies in private hands. The combined impact will be the reduction in the independent sector to a level which within three to five years will be less than 30 per cent of total pharmacy numbers. Consequently, after transferring financial power, market conditions will force changes in the political power at national and local level. Community pharmacy's future, but possibly not the profession's future, thereafter will be in the hands of accountants and the Stock Market. And many independents will see a demise without dignity.

The PSNC booklet was received by contractors just before last weekend. The ballot closes on the 22 November, which is less than three weeks away. No one outside the PSNC or DoH had seen the service specifications or the contents before this. This certainly cannot be described as open government or inclusiveness; indeed the Society still has to work up standards for services. This is unacceptable. What is going on in our opinion is a series of Machiavellian moves to get an agreement from contractors before the regulations come into force. The contractor's ballot is one hurdle but the other is the regulations, and no one should think that the ballot result alone will finalise the contract. If people want the contract to change before the regulations come into force, they must lobby their MPs and PCTs about changes that they are sure will better serve the public.

We believe success in professionalism and business is built on relationships that are founded on trust. It works because of clear communication and co-ordination of action, supported by solid values. The PSNC has betrayed contractors. The minister has failed to deliver on the Vision for Pharmacy.