fpo: pic as used in previous

No fooling

Far from being April Fool's Day, April 1 was a really serious day, says Roy Carlisle of PharmaSolutions. It's when the new GMS Contract came into force! What are the implications for pharmaceutical marketing?

The General Medical Services Contract? Quite frankly, I wouldn't be surprised if your gut reaction is to turn the page! After all, it's more fun to work on brand strategy or positioning, or more importantly, to ensure we deliver our 'numbers' for the company.

Perhaps even doing the annual sales forecast or monthly production forecasts is stimulating by contrast!

So, by all means turn the page but, before you do, maybe you should first consider the following.

From April 1, those who continue marketing pharmaceuticals in the same old way may ultimately find that they are the fools, stuck in a cul-de-sac with their business stagnating, while their more enlightened colleagues are maximising the opportunities provided in the new environment. Is this overstating the case? Many people in the Industry don't think so.

To reinforce this point, I can recall the first NHS changes proposals back in the late eighties and early nineties, while I was working for a major pharmaceutical company. One of our bosses at the time commented that they were 'not worth getting too excited about.' We would be keeping a 'watching brief,' but until we decided what to do about it, it was 'business as usual.' Not exactly pro-active or visionary, and it will come as no surprise that the company concerned was gone by the end of the decade, snapped up at a bargain basement price to broaden someone else's portfolio.

In the meantime, the Industry has moved from treat and cure to heath promotion and prevention, from me-too to evidence-based outcomes, and from affordably priced to cost-effective, as well as a whole host of other pharmacoeconomic measures. Some may say that, as most companies now have NHS/healthcare and market entry/access teams, they should easily be able to cope with this latest environmental turbulence.

But how well have we studied, understood and adapted the opportunity provided by the GMS Contract and, indeed, the new Pharmacy Contract?

Key is that we continue to evolve our businesses to appeal on a rational and emotional level and meet the needs of our customers in a relevant and cost effective way! Even a cursory scan of the new GMS Contract indicates that much will change[1], including the motivation and encouragement for GPs to hit targets in their daily practice.

So what's the new GMS Contract all about? Firstly, as Dr Gerard Panting wrote[2]: 'The major difference between the old contract and the new is that the new one will be between the practice and the primary care organisation, not between each independent contractor within the practice and the primary care organisation. GMS practices will be providers, whilst individual healthcare professionals will be termed performers.'

What does it all mean?

So what is the background to these changes and what do they mean?

Speaking at recent PM Society meeting, Dr Brian Dunn, chairman of the Northern Ireland GPC and a GPCUK negotiator[3], had the following comments from the perspective of the British Medical Association. He said that the background to the new contract from the Government perspective is declining GP recruitment and retention, closed lists and quality agenda. Current contract issues from the GP perspective include excessive workload, increasing demands, a lack of recognition of high quality care, repeated unilateral contract changes and a resource/demand mismatch. This meant that GPs, at an emotional level, felt that they had no control and were becoming increasingly disillusioned, with major recruitment and retention problems occurring as a result.

According to Dr Dunn, the new GMS Contract will improve the situation, as it will be practice-based, enable workload management, out of hours opt-out, a quality and outcomes framework and an improved infrastructure. Funding will be fairer, with guaranteed funding floors, while infrastructure

will be modernised in conjunction with reduced bureaucracy.

The contract will comprise four types of services: normal essential, normal additional, national enhanced and local enhanced. Normal essential will be mandatory for the practice to provide and will include the management of chronic disease, as well as terminal and palliative care. Normal additional services, which practices may decide to opt out of on a temporary or permanent basis, will include cervical screening, contraceptive services, child health surveillance and basic minor surgery.

Meanwhile, enhanced services are essential or additional services delivered to a higher standard, or further services not currently provided. Some of these enhanced services will be 'directed,' and it will be mandatory for the PCO to ensure their provision. These will include child vaccinations, flu immunisations and services for violent patients. Other services will be provided according to mandatory national protocols and pricing, including anti-coagulation monitoring, care of the homeless, sexual health, and alcohol and drug abuse.

Outcomes control

But how is the quality and outcomes framework constructed?

The GMS Contract is an evidence-based quality and outcomes framework containing four main domains, the largest of which is the clinical domain containing key performance indicators for ten major disease areas, each of which, when fulfilled, will attract a score as illustrated (see table). The maximum score is 550 points.

The organisational domain contains indicators measuring the quality of records, information, education, training, and practice and medicines management, with a maximum score of 184 points. The additional services domain covers cervical screening, child health surveillance, maternity and contraceptive services, with a total points maximum of thirty-six. And, finally, the patient experience domain attracts 100 points for patient surveys and for meeting consultation length targets. Holistic care payments of 100 points, in conjunction with quality care payments of thirty points, bring the total to 1,000 points. This can be further boosted by achieving an access bonus of fifty points.

As the main document summarises: 'Points are awarded for depth of quality and breadth ►

of achievement across the framework[1].'

Clearly there will be benefits for patients in terms of a higher standard of care and services available. Also, if GPs have a reduced workload, practices should be better organised and increasingly committed to proactively interacting with patients to understand their needs. For GPs, the contract offers a reduced and more flexible workload, in conjunction with enhanced financial rewards and a broader and more satisfying career.

And what does it mean for PCTs? Surely, if trusts can commission directly, they can manage their budgets, allocate appropriate resources and use the new framework to monitor practice performance more accurately, as well as provide appropriate guidance to those who are under-performing?

Speaking at the recent PM Society meeting, Janet Fitzgerald of Reading PCT[4] said the strategic opportunities presented by the GMS Contract would include chronic disease management, the concept of being able to match resources and services to local needs, and improved relationships with practices. However, she felt the implementation could be fraught with potential pitfalls, and identified the key issues for PCTs as being strategic planning, and the capacity and capability of the PCT to manage the new contract, especially in terms of the commissioning agenda and risk management.

General Medical Services Contract 2004/2005 Scorecard	Points Total
Clinical Indicators	
CHD including LVD etc	121
Stroke or transient ischaemic attack	31
Cancer	12
Hypothyroidism	8
Diabetes	99
Hypertension	105
Mental Health	41
Asthma	72
COPD	45
Epilepsy	16
Clinical Maximum	**550**
Organisational Indicators	
Records and information	85
Patient communication	8
Education and training	29
Practice management	20
Medicines management	42
Organisational Indicators Maximum	**184**
Additional Services	
Cervical screening	22
Child health surveillance	6
Maternity services	6
Contraceptive services	2
Additional services Maximum	**36**
Patient Experience	
Patient survey	70
Consultation lengths	30
Patient Experience Maximum	**100**
Hollistic care payments	100
Quality care payments	30
Total for clinical, organisational additional, patient experience, holistic care and quality service	1000
Access Bonus	50
TOTAL	**1050**

*registration of patients in different areas designed to identify highest risk patients. Important with older patients who may be at greater risk due to multiple pathology and need practice to focus additional support on their treatment.

Rising to the challenge

And, finally, what does the contract mean for the pharmaceutical sector? Certainly, Dr Dunn suggested that the Industry faces a challenge in understanding the contract, and in gaining access to GPs while needing to focus the product credibly in terms of the PCO and market drivers.

'Many GPs currently feel 'jaundiced' in terms of the relevance of current pharmaceutical industry contact,' he commented. However, if it could provide audit, GP education and partnership working with practices and PCOs, while focusing on the appropriate areas, there could well be scope for mutual benefit.

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The key issues for GPs, according to Dr Dunn, will be treating to target, with proof of efficacy and simple dose titration likely to drive increased usage. The fact that prescribing costs may rise en route to delivering the quality indicators has been factored into the equation by the Government.

Kim Sergeant, business unit director at WestawayGillis agrees: 'The new GMS contract is a great opportunity for the pharmaceutical industry. There is a real drive for quality, which means that that there will be great support for evidence-based medicine. In fact, the focus on chronic disease management and primary care development will increase prescribing opportunities.'

Those companies with products that can be market aligned to the quality outcome framework's ten therapeutic areas will be the main beneficiaries. Products that can be enhanced to show cost-effectiveness or treatment outcomes, which in turn enable targets to be met, will clearly have increased usage and success.

Clearly, additional opportunities will be created for marketing departments to produce service offerings that help achievement of targets within the framework, and that meet the priorities of a wider customer and stakeholder base. Each marketeer must understand these new customer needs and ensure that their brand offering – especially its evidence-base – matches those needs.

Of course, while there are benefits for the switched-on marketeer, the GMS Contract may also raise barriers and slow the traditional adoption curve for those products that have inadequately aligned evidence. Although the prescribing of drugs that help targets to be achieved will increase, past experience raises the question: 'At which stage will access to treatment be limited because of insufficient funds?' Furthermore, when National Service Frameworks and NICE guidance are taken into account, will there be a clash of priorities with the GMS clinical indicators?

Will pharmaceutical companies become joint stakeholders in helping GPs and other healthcare professionals deliver their objectives by developing mutually beneficial solutions? Rather than a supplier-customer relationship with the NHS, can we in the Industry now realistically aspire to the marketing nirvana of a fully strategic relationship with our customers?

Kim Sergeant says that the first step for pharmaceutical companies will be a review of their operations. 'Companies may need to analyse the market and interact with their customers in new ways to find how they can develop interest. This may mean higher quality relationship-orientated calls rather than old-fashioned details. There may need to be salesforce restructuring in an environment where the key customer may be the practice manager and the lead GP. Nurses and practice managers may be the key deliverers, with PCTs needing to be engaged to support practices in achieving success.'

Are you switched on?

So does this mean that the switched-on company can now offer 'disease management' solutions? 'Quite possibly,' says Kim. 'The new key account management lead could initiate practice discussions focused on disease management, with empowerment to drive local activity. We see key account managers helping practices achieve their targets by assisting with the process and implementation.'

Indeed he notes that, given company tendencies to work in marketing silos, there is an opportunity to offer a PCT and practice-focused portfolio solution. 'The new GMS Contract will be a catalyst for change. The key is whether pharmaceutical companies want to be followers or leaders. This will depend on how a given company sees the NHS developing over the next three years, plus their portfolio and strategic intent.'

What is the chance of long-term survival and business growth of a company that does not get on board with the GMS Contract and, oh yes, the new Pharmacy Contract as well?

Who says pharmaceutical marketing is boring? Only an April Fool! ▲

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