New formula for GP prescribing budgets

General practitioners in England need to understand its implications

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In today's *BMJ* Rice and colleagues describe the derivation of a formula for allocating prescribing budgets to health authorities and primary care groups in England (p 284).[1] The formula is based on the most comprehensive analysis of general practice prescribing costs so far and—despite criticisms such as those outlined by Baines et al on p 288[2]—is likely to be the best available for the foreseeable future. The new formula will be used to help set target allocations and has several important implications.

Firstly, the new formula represents a major change in the methods used to allocate NHS budgets. The various formulas currently used have four main components: a population count; weightings for age and sex; measures of health need; and a component for unavoidable factors. The most important is the population count. Traditionally the population counts have been the estimated resident population for each health authority. The new formula for prescribing budgets will use general practice lists as the population base.

Under the new system each general practice in England will have a target prescribing allocation; the primary care group prescribing budget will be the sum of the budgets for each general practice in the group; and the health authority budget will be the sum of the budgets for each primary care group in the authority. Budgets for hospital and community health services may also eventually be allocated using general practice lists as the population base. Many general practitioners have called for such a shift in the population base used to allocate budgets because they believe practice lists measure the population more accurately than population estimates based on the 1991 census.[3] However, practice lists were never designed to be a population register and there are problems with this approach.[4]

Secondly, the new formula will be used to set *target* prescribing allocations. These will differ from current allocations to health authorities and primary care groups, and for some primary care groups these differences may be large. How quickly the budgets of health authorities and primary care groups change to reflect the new target allocations will be negotiated between the NHS Executive and health authorities (for health authority allocations) and between health authorities and primary care groups (for primary care group allocations). Those health authorities and primary care groups that gain under the new formula will want a rapid shift so that budgets reflect the target allocations as soon as possible.

Because primary care groups will have unified budgets for prescribing costs, hospital and community health services, and general practice infrastructure costs, changes in prescribing allocations could affect the services they can offer their patients.[5] Some primary care groups will find that their prescribing budget will increase, and if they do not spend all the extra funds on prescribing this will release resources for additional hospital or community services. Others will find that their prescribing budget will decrease, and if they cannot cut their prescribing costs, funds earmarked for hospital and community health services or for investment in general practice will have to make up the shortfall. Hence, to avoid disrupting current services, changes to prescribing budgets will have to be introduced carefully. This is particularly important at a time when so many health authorities and NHS trusts are in financial deficit.

Thirdly, many primary care groups will use the new formula to guide their allocation of prescribing budgets to general practices. Doing this will not be straightforward because the formula uses estimated variables for general practices rather than actual values and because any formula based on routine data cannot include many factors that affect prescribing costs. For this reason, factors such as the impact of patients with high clinical need are likely to continue to be negotiated locally between health authorities, primary care groups, and general practitioners.[6] However, because general practices can retain up to £45 000 of the total savings they generate for their primary care group, many general practices will want to know what their total budgetary allocation for health services is to give a figure to base their savings on.[7] Setting a prescribing budget is one part of this process.

Finally, the new formula represents yet another step towards a health service in which budgets are increasingly allocated through formulas.[8 9] Although the new formula may work well overall, there will always be situations where the target allocations set by the formula do not fully reflect the prescribing costs of some general practices. These practices will have to satisfy their health authority and primary care group that their above average prescribing costs are justified if they are to continue to meet the needs of their patients. Although there are considerable pressures on NHS budgets, health authorities and primary care groups must not become overly fixated on costs and must also ensure that the quality and appropriateness of prescribing are given due weight when examining the prescribing patterns of general practices.[10]

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