Cardiology and the new GMS contract for GPs

The new General Medical Services (GMS) contract for general practitioners (GPs) promises the most radical change in their terms of service since the inception of the NHS. For those non-GP readers who have yet to digest the details, under the new contract a GP's income will be determined by a variety of measures, including a Global Sum (forming at least half of income) which largely replaces much of the work currently undertaken, quality payments for achieving a number of clinical and organisational goals, payment for providing specifically determined patient services for a community or Primary Care Trust, and seniority payments.

With as much as a fifth of general practice pay now resting on meeting quality targets, there is a new focus on achieving specific clinical quality indicators. This is also in line with the objectives of achieving the National Service Framework (NSF) agenda. Much of what is listed in the new contract is already top of each Primary Care Trust's agenda in meeting the NSF for Coronary Heart Disease (CHD) and the stroke section of the NSF for Older People.

There is a big emphasis on cardiovascular disease in the new contract. In the form of hypertension, CHD and stroke, it forms three of the 10 clinical areas chosen for the clinical quality framework. Of the 550 points for achieving clinical quality indicators, almost half (247 [45%]) are for cardiovascular disease. When the 99 (18%) quality indicators for diabetes are added – where significant targets centre on blood pressure (BP) and hypercholesterolaemia – this makes nearly two thirds (63%) of the contract's quality indicators focused around the cardiovascular area.

The three interventions that attract the most points in the cardiovascular sections are hypertension, smoking and hypercholesterolaemia. Hypertension alone forms 23% of all clinical points. An average three-partner practice of list size 5,500 will earn £75 per point in 2004/2005 rising to £120 per point in year 2005/2006.Looking at the clinical area of BP alone, if the maximum points for reaching all clinical indicators in this area are achieved, the annual income per GMS GP will be £3,225 in 2004/2005 rising to £5,160 in 2005/2006. The most heavily weighted quality indicators for hypertension are that 90% of hypertensives must have a BP recorded in the past nine months (worth 20 points) and that 70% of hypertensives must have their last BP recorded as 150/90 mmHg or less within the previous nine months (worth 56 points). This means that points are given not only for recording BP but also for reaching a specific target in hypertensive patients (150/90 mmHg).

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The same applies for cholesterol measuring – there are points for recording cholesterol measurement and points for getting to a target; the chosen target being a total cholesterol of 5 mmol/L or less. The usual interventions attract points – aspirin/antiplatelet therapy for CHD and stroke patients, beta blocker therapy for CHD patients, and angiotensin-converting enzyme (ACE) inhibitor therapy for post-myocardial infarction patients. More challenging are the points awarded for having echocardiograms confirming left ventricular dysfunction in CHD patients (since there is a massive waiting list for echocardiography in some areas) and prescribing ACE inhibitors or angiotensin II receptor antagonists to 70% of patients with CHD and left ventricular dysfunction. There are also points for setting up registers of patients with CHD, stroke/transient ischaemic attack and hypertension, but few practices aren't already on the ball with register construction.

There are also organisational points for identifying smokers in practice populations and for ensuring the BP of patients aged 45 years and over is recorded in the preceding five years for at least 55% of patients.

Implications

So what will this mean for GMS GPs? We certainly won't be able to achieve targets without more time and support. This time is needed not only to identify and to treat to target our cardiovascular patients, it will also be needed for logging in data on to the computer. The whole system requires meticulous entering of data from every consultation in several different boxes on the computer screen. The cost of all the information technology will rest with the Primary Care Trust. In turn, all this computer interfacing will lead to longer surgery consultations and, inevitably, a desire for every GP to reduce their lists. UK GPs simply have too many patients per GP (or, more accurately, we have too few GPs and many of those are retiring earlier).

Once patients have had their data recorded and they are entered on a register, they will need to be managed. This will require more doctors and we will also need to approximately double our number of practice nurses and healthcare assistants (who take blood and BPs). Without increased nursing support, achieving quality indicators will be a distant dream for many practices.

Training healthcare professionals in best cardiovascular practice will be a top priority. Rational prescribing in hypertension will be an excellent place to start! Primary Care Trusts and practices will need to ensure a uniform standard of prescribing that will serve to reach BP targets using logical combination therapy. Achieving the 150/90 mmHg target for most hypertensives (and no age limit is mentioned) does, of course, mean combination therapy. Here the prescribing budget will, quite rightly, go through the roof. Since most Primary Care Trusts are overspent on prescribing anyway, it will mean that the cardiovascular prescribing alone will ensure they never meet any imposed budgetary target.

In a nutshell, the new GMS Contract has put cardiovascular medicine, particularly hypertension, centre stage. Chasing that hypertensive patient and lowering his (or her) BP to 150/90 mmHg will be financially rewarding. We must remember that many GPs are working as Personal Medical Services (PMS) GPs. This means they will not be directly affected by this new payment system. We are, however, assured that similar principles will apply. If you are registered with a local GP, then do him or her a favour and ensure he has a record of your BP. I can't imagine any readers will have a BP > 150/90 mmHg, but, if it is, try and lower it to below 150/90 mmHg before sending it in to be logged in your computer file!

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