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LETTERS

COMMISSIONING IN ENGLISH NHS

Time to debate neoliberalism

Paton highlights the inadequacies of commissioning in the English NHS.¹ One of the recent reports from the King’s Fund and Nuffield Trust he cites illustrates the complexities of the system, including the many models available (box).²

The system is designed to increase market forces in the NHS. However, the expense and the information asymmetry between primary and secondary care are more examples of how markets fail in healthcare policy.

For the past 30 years world governments have expected markets to solve all their problems, including in the public services. Market forces and private sector management practices (New Public Management) penetrate the whole public sector:

All public services have to be based on a diversity of independent providers who compete for business in a market governed by consumer choice. All across Whitehall, any policy option now has to be dressed up as “choice,” “diversity,” and “contestability”. These are the hallmarks of the “new model public service.”³

But the evidence base for market based policies in many public services is weak, so why has this approach become embedded across the public sector? One explanation from two Labour MPs in the last government:

After years in opposition and with the political and economic dominance of neoliberalism, New Labour essentially raised the white flag and inverted the principle of social democracy. Society was no longer to be master of the market, but its servant. Labour was to offer

Current commissioning models²

- National commissioning groups
- Supra-regional specialised groups
- Regional specialised groups
- Joint commissioning with local authority
- Primary care trust (PCT)
- Whole PCT practice based commissioning (PBC)
- Locality PBC consortium
- Personal medical services (PMS) provider organisation
- Single practice
- Personal health budgets

a more humane version of Thatcherism, in that the state would be actively used to help people survive as individuals in the global economy—but economic interests would always call all the shots.⁴

It is now time for the medical profession to question the underlying political and economic philosophy of neoliberalism that has dominated the political landscape for the past 30 years.

The charge has been led by the Australian prime minister, Kevin Rudd, in an 8000 word polemic.⁵ We should at least start some debate.

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Competing interests: CP is a member of BMA Council BMA Political Board.

- 1 Paton C. Commissioning in the English NHS. *BMJ* 2010;340:c1979. (15 April.)
- 2 Smith J, Curry N, Mays N, Dixon J. Where next for commissioning in the English NHS? Nuffield Trust, 2010. www.nuffieldtrust.org.uk/publications/detail.aspx?id=1458&prID=694.
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- 5 Rudd K. The global financial crisis. *The Monthly*. Available at: www.themonthly.com.au/monthly-essays-kevin-rudd-global-financial-crisis-1421

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The market delusion

Paton is right that the idea of general practice commissioning is recurring.¹ Politicians realise that people trust their general practitioners more than politicians or faceless commissioners in the health authority, primary care trust, or whatever the organisation is called at the time; a few enthusiastic GPs with an eye to improving services for their patients—and, possibly, their income—actively campaigning to do it better than the existing commissioning body; changes are made so that all GPs have to commission; and the enterprise fails because, once everybody has to do it, the incentives to a few pilot practices disappear, and, anyway, most GPs are more interested in being GPs than commissioners.

The idea of using a market to provide people with what they want is an illusion. Basic economic theory dictates that markets work in favour of consumers only when there is an oversupply. The health service is designed to be as “efficient” as possible, with oversupply seen as inefficiency to be ruthlessly eliminated (even when it is needed to cope with outbreaks or the stochastic nature of demand). In these

circumstances, playing up the importance of providing choice is dishonest rhetoric.

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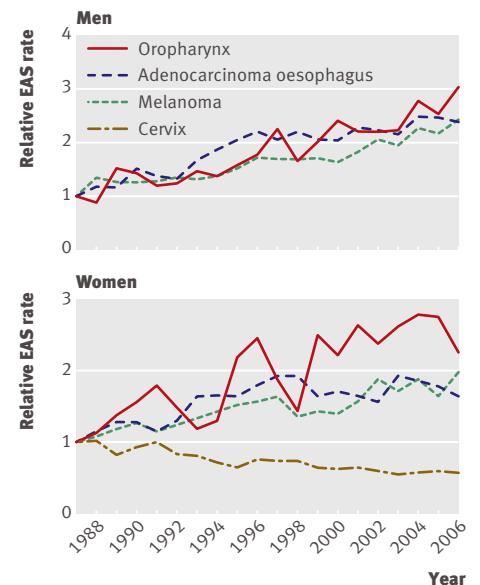
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OROPHARYNGEAL CANCER

Fastest increasing cancer in Scotland, especially in men



European age standardised (EAS) rates of various cancers by sex in Scotland, 1987-2006

Mehanna and colleagues highlight the increasing incidence of oral and oropharyngeal cancer in the United Kingdom and its likely association with sexually transmitted human papilloma virus (HPV).¹ However, by reporting oropharyngeal cancer along with oral cancer the true rate of increase in oropharyngeal cancer is probably being masked.

Using data from the Scottish Cancer Registry, we found that oropharyngeal cancer now has the greatest rate of increase of any cancer in Scotland. We grouped cancers of the base of the tongue (C01), palate (C05), tonsil (C09), and oropharynx (C010). These codes were selected because they relate to the anatomically defined subsites of the oropharynx, enabling analysis of all registered cases. Incidence increased for each site, most for the tonsil and base of the tongue.

The figure shows that oropharyngeal cancer has overtaken both melanoma of the skin and adenocarcinoma of the oesophagus. In contrast, the incidence of invasive cancer of the cervix is decreasing. Linear regression yields an estimated 2.9-fold increase in oropharyngeal cancer in men, and a 2.4-fold increase in women.

Oropharyngeal cancer associated with HPV seems to have a better prognosis than oropharyngeal cancer that is not. Population based data from the south east of Scotland showed a 34% difference in five year survival for oropharyngeal cancer in favour of women in a cohort diagnosed during 1999-2001 but no difference between men and women in a cohort diagnosed during 2003-5. Although 70% of patients present with stage IV disease, the five year survival for men in south east Scotland has now increased to 68%. Whether this change in survival relates to HPV status is unknown. However, with more younger patients surviving, the morbidity from treatment for individuals and the healthcare burden to the NHS will be significant. Perhaps vaccinating boys against HPV should be re-evaluated.

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Competing interests: None declared.

- 1 Mehanna H, Jones TM, Gregoire V, Ang KK. Oropharyngeal carcinoma related to human papillomavirus. *BMJ* 2010;340:c1439. (25 March.)

Cite this as: *BMJ* 2010;340:c2512

Australian data show increase

Australian data support the changing epidemiology of oropharyngeal cancer observed in other Western countries.¹ Our study of 302 oropharyngeal cancers from Sydney hospitals showed that the incidence of oropharyngeal squamous cell cancer positive for human papilloma virus (HPV) (p16) increased from 19% in 1987-90 to 47% in 2001-5 and 60% in 2005-6.²

On the basis of cancer incidence in Australia, we estimated that on average 1.56 cases of oropharyngeal squamous cell cancer per 100 000 males per year were induced by HPV types targeted by the HPV vaccines during 2001-5.² In Australia the quadrivalent HPV vaccine has been used in the school based, government funded programme for girls aged 12 to 13 and a two year catch-up programme for women aged up to 26. It has been approved for boys but is not subsidised by the government. Our data inform the debate on the merits of extending this vaccination programme to boys.

Randomised trials are needed to establish whether less intensive treatment is justified in

patients with oropharyngeal cancer positive for HPV.¹ Recent data suggest that any modification of treatment strategies based on HPV status may also need to take account of the effect of smoking in negating the beneficial effect of HPV on outcome.

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On behalf of A Grulich (University of New South Wales), D Jones (University of Sydney), S Lee (University of Western Sydney), S Garland (University of Melbourne), T Dobbins (University of New South Wales), J Clark (Royal Prince Alfred Hospital), G Harnett (Pathwest Lab), C Milross (Royal Prince Alfred Hospital), C O'Brien (Royal Prince Alfred Hospital), and B Rose (University of Sydney).

Competing interests: AH and GH hold shares (predating the availability of HPV vaccine). AG and SG have professional associations with CSL, SG also with GlaxoSmithKline (all unrelated to the study).

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Cite this as: *BMJ* 2010;340:c2518

COLORECTAL CANCER

Secondary care data may mislead

Two methodological concerns make it tricky to interpret the findings of Jellema and colleagues' systematic review of diagnosing colorectal cancer in primary care.¹

Firstly, studies from settings other than primary care were included. Any population that has been selected, such as the referred population, will have different characteristics from the original population, reflecting the selection process.² The authors recognise this, but we doubt that their solution of including only secondary care studies with a yield of cancer below that of the highest primary care study (15%) is correct. A study of antelopes cannot include giraffes, and it is no solution to select only small giraffes.

Secondly, the searches may have been too restrictive: perhaps the methodological filter eliminated some studies that meet the published selection criteria. We recently completed a similar review, restricting ourselves to truly primary care studies, and in our soon to be submitted paper we identified 23 studies, not the nine reported by Jellema and colleagues using similar criteria. Some of the additional studies are clearly germane—for example, two in the *BMJ*.^{3,4}

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- 1 Jellema P, van der Windt DAWM, Bruinvels DJ, Mallen CD, van Weyenberg SJB, Mulder CJ, et al. Value of symptoms and additional diagnostic tests for colorectal cancer in primary care: systematic review and meta-analysis. *BMJ* 2010;340:c1269. (31 March.)
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Cite this as: *BMJ* 2010;340:c2503

Authors' reply

Our research question was posed from a general practitioner's perspective and addressed tests that a GP might use to identify an increased risk of colorectal cancer in patients consulting with lower abdominal complaints.^{1,2} We therefore excluded studies comparing the risk of colorectal cancer in patients with and without abdominal symptoms, such as the *BMJ* papers mentioned by Hamilton and colleagues.¹

Our two reviews answer slightly different questions, and the results are complementary rather than overlapping. Our smaller number of papers has little to do with the use of a methodological filter: we used an extensive process of reference checking afterwards to ensure that we did not lose important or influential diagnostic studies.

We included settings other than primary care because primary care is defined differently in different countries. For example, facilities such as open access outpatient clinics may be directly accessible to patients with lower abdominal complaints. We also included two week referral clinics because they aim to identify patients with a high risk of colorectal cancer using signs, symptoms, and tests routinely used in general practice, and the patient populations may resemble those in general practice. However, as not all studies clearly reported whether an outpatient clinic was directly accessible to patients, we selected only those reporting a prevalence of colorectal cancer of less than 15%, the highest prevalence reported in the primary care studies, to minimise spectrum bias.

Because the performance of diagnostic tests may vary between referred and non-referred populations, we presented data separately for primary care and other settings. Table 4 shows that the results do not clearly differ by setting.² In brief, we know that antelopes and small giraffes differ and we studied them separately,

but they seemed not to differ systematically on the characteristics we studied. However, the number of primary care studies was small, prohibiting firm conclusions.

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Competing interests: None declared.

- Hamilton TW, Astin MP, Griffin T, Neal RD, Rose PW. Secondary data may mislead. *BMJ* 2010;340:c2503.
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Negative results may falsely reassure

Primary care practitioners need to be clear about the difference between carrying out faecal occult blood tests in patients presenting with symptoms and the use of the test in bowel cancer screening programmes.¹ In addition to not being recommended in patients presenting with symptoms of lower gastrointestinal cancer,² faecal occult blood testing in the investigation of iron deficiency anaemia is unsupported by national guidelines.³

I work in a practice of 4000 patients and reviewed the cases of all those who had faecal occult blood tests in 2009. In all, 71 patients underwent testing. Indications were anaemia (47), dyspepsia (13), change of bowel habit (6), and rectal bleeding (5). Nine of the 11 patients with positive results were referred, and one was found to have a rectal carcinoma; 49 of the 60 patients with negative result were not referred, but two met criteria for urgent referral.² Patients with negative results were less likely to be followed-up and have a diagnosis documented in the electronic patient record.

Negative results may falsely reassure patients and general practitioners. Until the diagnostic performance of faecal occult blood testing in primary care is clearly established, a safe approach would be to see all patients after testing, regardless of their result. The need for other

investigations or referral to secondary care could then be reassessed.

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Competing interests: None declared.

- Jellema P, van der Windt DAWM, Bruinvels DJ, Mallen CD, van Weyenberg SJB, Mulder CJ, et al. Value of symptoms and additional diagnostic tests for colorectal cancer in primary care: systematic review and meta-analysis. *BMJ* 2010;340:c1269. (31 March.)
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Cite this as: *BMJ* 2010;340:c2507

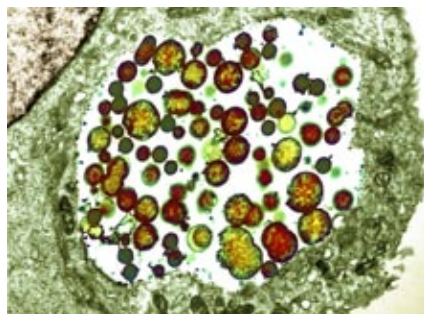
CHLAMYDIA INFECTION

Treatment may not be simple

My experience in general practice in a university population suggests that not all those who participate in asymptomatic screening for *Chlamydia trachomatis* are truly without symptoms.¹ Patients may have obtained chlamydia screening kits without having a history taken by a health professional. Some may then admit to having had symptoms when given a positive result.

Lower abdominal pain, dyspareunia, abnormal vaginal bleeding, or abnormal vaginal or cervical discharge is suggestive of pelvic inflammatory disease. These women need assessment and then treatment with antibiotics other than the simple single dose of azithromycin. The only fully oral regimen in the guidelines on pelvic inflammatory disease from the British Association for Sexual Health and HIV (BASHH) is oral ofloxacin 400 mg with oral metronidazole 400 mg twice daily for 14 days.²

Testicular or epididymal pain is suggestive of epididymo-orchitis. These men also need assessment and then treatment with antibiotics other than a single dose of azithromycin. BASHH guidelines on epididymo-orchitis most probably due to chlamydia infection or other non-gonococcal, non-enteric organisms currently recommend oral doxycycline 100 mg twice daily for 10-14 days,³ although this guideline is currently being updated.⁴ The 2009 manual (revised



BIOMED IMAGING UNIT/SPS

December 2008) for the BASSH sexual transmitted infection foundation course still recommends doxycycline 100 mg twice daily for 14 days, with ofloxacin 200 mg twice daily for 14 days as an alternative.

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Competing interests: None declared.

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- British Association for Sexual Health and HIV (BASHH). Clinical Effectiveness Group page. www.bashh.org/groups/clinical_effectiveness_group.

Cite this as: *BMJ* 2010;340:c2499

Don't forget contraception

The review of *Chlamydia trachomatis* infections does not mention the potential interaction between antibiotics and combined hormonal contraception.¹ The national chlamydia screening programme in England is aimed at all sexually active young people aged 15-24, and 54% of women aged 20-24 take the contraceptive pill.² Thus a large proportion of the women diagnosed through the screening programme will be using combined hormonal contraception. The Faculty of Sexual and Reproductive Health Care states that women using such contraception should be advised to use additional precautions when taking short term antibiotics because they may reduce the efficacy of the contraception.³ Abortion rates are highest among those aged 20-24 (32 per 1000 women) but peak at the age of 19 (36 per 1000)⁴; there is no room for complacency about the risks associated with contraceptive failure.

The national strategy for sexual health and HIV aims to reduce the prevalence of undiagnosed sexually transmitted infections and rates of unintended pregnancy.⁵ Both aims must be remembered. When treating chlamydia, ask women if they are using combined hormonal contraception and if so advise them to avoid sexual contact to prevent not only re-infection but also potential pregnancy.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;340:c2496

Screening needs more answers

Oakeshott and colleagues focused on clinical pelvic inflammatory disease in their evaluation of chlamydia screening.¹ In infertility clinics, however, most women with tubal factor infertility and a high chlamydia antibody titre do not remember such a “typical” presentation of clinical signs and symptoms. The true outcome factor for cost effectiveness analyses is infertility, and more evidence about the clinical pathway of chlamydia infection is needed.²

Patient indicators (major outcomes averted) and societal indicators (prevention of transmission) are measures of the impact of screening for infectious diseases such as chlamydia. Two national trials, in the Netherlands and Australia,^{3,4} assess the impact of multiple screening rounds on forward transmission of chlamydia. Both indicators are needed to enable policy makers to prioritise prevention programmes.

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Competing interests: None declared.

- Oakeshott P, Kerry S, Aghaizu A, Atherton H, Hay S, Taylor-Robinson D, et al. Randomised controlled trial of screening for Chlamydia trachomatis to prevent pelvic inflammatory disease: the POPI (prevention of pelvic infection) trial. *BMJ* 2010;340:c1642. (8 April.)
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MORTALITY AND THE PILL

Wrong conclusions drawn, again

Hannaford and colleagues again made headlines in the popular press with their claim of a 12% decrease in the rate of death from any cause with oral contraceptive use,¹ echoing the similar reduction in overall incidence of cancer claimed for their 2007 paper.² However, once again,³ detailed analysis suggests no such benefit, and even an opposite trend, given current trends of oral contraceptive use.

The lack of any significant life saving benefit is easily discerned from the difference



between results for the full dataset and the general practice observation subset. Common sense suggests relying on the results from the smaller, better, dataset whenever statistical trends differ materially. However, the authors state: “The pattern of relative risks was different when we used the smaller general practice observation subset. In this subset, the adjusted relative risk for any death between ever users and never users was very close to unity (0.98, 0.88 to 1.10).”

Troubling trends of increased morbidity and mortality are also apparent in young nulliparous women, who constitute only a small minority of users in this study cohort but predominate among current users. For example, there was an almost threefold increase in death from any cause among women under 30, and a threefold increase in death from breast cancer for women under 45 between five and nine years after stopping use of oral contraceptives. Moreover, despite the decreased risk of death from breast cancer 10 or more years after stopping use of oral contraceptives in this latest report,¹ the 2007 report showed a dramatically increased incidence of breast cancer (relative risk 2.45) persisting up to 20 years after stopping use.² Such trends, however, are easily diluted by data from the majority of women in this study who overwhelmingly used oral contraceptives only after bearing one or more children and for a few years, contrary to current patterns of oral contraceptive use.

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Competing interests: None declared.

- Hannaford PC, Iversen L, MacFarlane TV, Elliott A, Angus V, Lee AJ. Mortality among contraceptive pill users: cohort evidence from Royal College of General Practitioners' oral contraception study. *BMJ* 2010;340:c927. (11 March.)
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- Brind J. Study shows greater cancer risk. *BMJ* 2008;336:59.

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Authors' reply

Brind thinks that common sense suggests that we should use the smaller, better, dataset when statistical trends differ materially.¹ We presented both datasets so that readers can decide which one(s) they wish to use. Neither dataset showed

substantial evidence of an increased risk of all cause mortality among ever users.

A higher proportion of observation periods in ever users related to current and recent pill use in the general practice observation dataset compared to the main dataset. This explains the increased risk of all circulatory disease and of breast cancer in ever users who had stopped oral contraception 5-9 years previously in the general practice observation dataset. Similarly, in the age stratified analyses of the main dataset, ever users under 30 had much more current and recent use than older ever users. That ever users under 30 had nearly three times the risk of death of similarly aged never users is therefore not surprising.

Most of the adverse mortality effects of oral contraception occur in current and recent users, effects which diminish with time since stopping.² Our latest findings are compatible with our previous publications, and broadly in line with the collective evidence from other studies. A substantial proportion of the observation periods in the ever user group in the main dataset relates to pill use many years in the past. Unlike Brind, we think that the information provided by this dataset is valuable. We continue to interpret the results as not suggesting a substantial increased overall risk of death among ever users, especially since many events occurred long after the pill was stopped. Thus any medical treatment and death certification is unlikely to have been influenced by the doctor's knowledge of a woman's pill use.

We have tried to be careful when interpreting our results. Thus, we have stated clearly that the reduced overall risk of death in ever users in the main dataset may be due to selection processes or residual confounding rather than a direct effect of oral contraception.

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