

ON THE CONTRARY **Tony Delamothe**

# Behold the Elderflower Revolution in healthcare

After the king's speech, the committee stages

To Downing Street, for a prime ministerial reception for “pathfinder” general practices. These are the shock troops for the reforms spelt out in the Health and Social Care Bill and to me they looked as scary as any other large group of general practitioners. After a day at the Department of Health the pathfinders weren't that much clearer about what was expected of them. One was disconcerted to discover her every word being faithfully transcribed by department officials, as if she might hold the key to how it would all turn out.

Prime Minister David Cameron swept in and made an eve-of-Agincourt speech, beautifully crafted and delivered. You can read his actual words on the number 10 website, although they sounded like:

We few, we happy few, we band of brothers:

For he today that sheds his blood with me

Shall be my brother; be he ne'er so vile,

This day shall gentle his condition;

And GPs in England now abed

Shall think themselves accursed they were not here.

The prime minister apologised for the lack of alcohol as the elderflower cordials were passed around. There were photo opportunities for all, and if some of the contingent were disappointed by the absence of free pens they did their best to conceal it.

Perhaps there was a similar function for the 120 odd hospital trusts being frogmarched to foundation status by 2014 and my invitation got lost in the post. If so, it's a shame because I'm even more in the dark about the proposals for secondary care than I am for primary care. One thing is clear, however. If the bulldozer of change is coming, and the options are being part of the bulldozer or part of the road, then it's secondary care that ends up as the road.

The new bill and its associated documentation run to many

hundreds of pages and even so, many questions remained unanswered. Doctors have begun to send them to us, and we would compile a series of frequently asked questions if we knew the answers. At this stage the best one can do is follow the deliberations of the different committees that are working their way through the bill. Illumination comes only in fits and starts.

Take the vexed issue of hospital closures. It's widely expected that changes in patient referral patterns, instigated by the new GP consortiums, will leave some hospitals high and dry. This is obviously more likely in large conurbations with a choice of providers than in rural areas. “What happens if a foundation trust goes bust for any reason: just no demands for its services or actually it's a right old shambles?” asked the chair of the public accounts committee. Or, added a committee member, “it's crippled with a huge PFI [private finance initiative] bill?” The short answer is that details of the special administration regime have yet to be worked out.

Half way through a much longer answer, David Nicholson, the NHS's chief executive, stopped to admonish the committee: “I'm sorry, you're not supposed to laugh when I say that.” Later on the chair described the new lines of accountability of foundation trusts as “a bloody nightmare” and “absolutely bonkers.” At one point, one of the committee members was moved to say, “I suppose as a child of the sixties, the rock-'n'-roll nature of all this should appeal to me really.”

The scrutiny committee of the new bill held its first four sessions last week, with its last scheduled for 31 March. Will it throw any light on the speed and extent of the private sector's entry into the secondary care



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market—the main concern of many opponents of the reforms?

In its evidence to the committee the BMA argued that, as existing foundation trusts would become more like private than NHS entities, they would be subject to the same rules and regulations that apply to other private companies including UK and EU competition law. But in the concrete example of GP commissioners nominating the local hospital to provide a service, the man from Monitor (the new economic regulator) said that the Department of Health's procurement guidelines, rather than the European Union's, would come into play. This suggests that the newly unleashed competitive forces might be weaker than originally feared.

The issue of compensating private providers for “playing field distortions” remains unresolved. The bill says that: “The majority of the quantifiable distortions work in favour of NHS organisations; tax, capital, and pensions distortions result in a private sector acute provider facing costs about £14 higher for every £100 of cost relative to an NHS acute provider.” The idea is that the playing field will somehow be levelled.

No one (other than private providers, presumably) seems keen for a rerun of the independent sector treatment centre debacle, a costly exercise to introduce competition at the margins of the NHS. Monitor, responsible for ensuring competition in the reformed NHS, admits that the 14% figure is based on incomplete analysis. So let's add the completion of that analysis to the revolutionaries' to do list. With the line by line scrutiny of the bill beginning this week that list looks certain to grow ever longer.

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## MEDICINE AND THE MEDIA

# The other Twitter revolution

Social media sites allow immediate scrutiny of the government line on the NHS reforms and give voices to the voiceless, say **Martin McKee and colleagues**

Mention the words “Twitter” and “revolution” to most people and their thoughts will, not unreasonably, be drawn to events in Tunisia or Egypt. Yet over recent weeks a growing number of tweets have been discussing another revolution: that being unleashed on the NHS in England by the Conservative led government. As with revolutions elsewhere in the world many of those engaged in these discussions are frustrated by the information they are getting from politicians, whom they often distrust, and from the mainstream media, which they see as recycling press releases and repeating the opinions, not always informed, of the same select group of commentators.

So it was on Twitter that you could read of the immediate incredulity that greeted the claim

on the BBC’s *Question Time* television programme by Caroline Spelman, secretary of state for environment, food, and rural affairs, subsequently repeated by the prime minister, that “someone in this country is twice as likely to die from a heart attack as someone in France.”<sup>1</sup> Did this mean, asked some of those tweeting that evening, including seasoned political observers such as the former Liberal Democrat health spokesman Evan Harris (@DrEvanHarris on Twitter),<sup>2</sup> that someone in the United Kingdom who had a heart attack was twice as likely to die from it as their counterpart in France? If so, then it would indeed be a condemnation of performance in the NHS. Or did it mean that the overall death rate from ischaemic heart disease in the UK, with its diet of fried food, was higher than in France, with its Mediterranean diet?

Twitter users could rapidly learn that no comparable data exist to substantiate the first interpretation (and those data that do exist indicate that in-hospital mortality in the UK, albeit

subject to numerous methodological caveats, is only slightly above the average for countries in the Organisation for Economic Co-operation and Development).<sup>3</sup> They could also discover that the evidence on overall death rates was being cited highly selectively, ignoring substantial improvements in the past decades. Researchers interested in pursuing the story could learn that the chief economist at the healthcare think tank the King’s Fund, John Appleby (@jappleby123), was planning his comprehensive rebuttal of the government’s claims,<sup>4</sup> saving them the trouble of duplicating it, and those who don’t read the *Guardian* could learn of the wide ranging critique by Ben Goldacre (@bengoldacre) showing the absence of evidence for the reforms overall.<sup>5</sup>

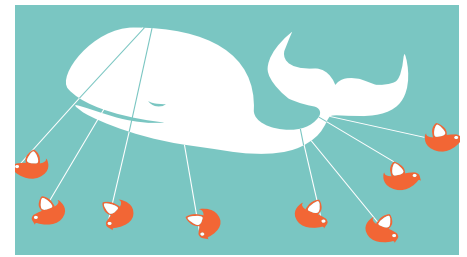
Those interested in the NHS face the challenge

of ascertaining what the government’s proposals will mean in practice. Is it, as Andrew Lansley, the health secretary, asserts, simply evolutionary change, or should we believe the chief executive of the NHS when he says, “It’s such a big change management, you could probably see it from space?”<sup>6</sup>

Readers can seek an official answer at @DHGovUk. However,

such is the volume of material coming out of the Department of Health that only a few people will have read the NHS white paper, and even fewer will have the energy to wade through the 353 pages of draft legislation.

Except, that is, for a few enthusiasts, some of whom are active on Twitter. One (@lecanardnoir) contrasts the 75 mentions of general practitioners in the NHS white paper with a handful in the draft legislation, raising the question of whether general practitioners will end up with any role in commissioning at all. We can gain other insights from those such as @mellojonny, who points us to a report by the Cabinet Office minister, Oliver



Twitter overload: keeping government in check

Letwin, written when he was in opposition, suggesting that the current proposals may be part of a plan to move to healthcare funded by competing insurance funds.<sup>7</sup>

Yet others (such as @HPIAndyCowper) have dredged through the lengthy accounts of the House of Commons Public Accounts Committee to locate the struggle by the permanent secretary of the health department and the NHS chief executive to explain how accountability might work in the proposed new NHS and, in particular, the comment by the committee chairwoman, Margaret Hodge, that the arrangements were “absolutely bonkers.”<sup>8</sup> Meanwhile, John Appleby’s tweets draw our attention to the confusion about hospital tariffs in the same document.

These are only a few examples of what is being tweeted on the reforms. There is much more, some of which can be located by following “hashtags,” which serve to identify themes. Relevant ones include #NHS, #NHSSM, #saveourNHS, and #PublicHealth. However, it is remarkably difficult to find any tweets in support of the reforms, except perhaps for the argument by Muir Gray (@MuirGray) that the “tectonic” shifts being proposed could engage clinicians more effectively.

Eric Pickles, the secretary of state for communities and local government, justified his abolition of the Audit Commission with calls to “mobilise an army of armchair auditors” who would exploit information on the internet to hold local government to account.<sup>10</sup> Instead it seems that it is central government that has been held to account. Perhaps this may serve as a reminder to politicians to be careful what they wish for.

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A longer version of this article with references and competing interests is on [bmj.com](http://bmj.com).

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## MEDICINE AND THE MEDIA

# How useful are lifetime risks of disease?

Recent figures claiming that the lifetime risk of breast cancer is 1 in 8 were widely reported. But the meaning of lifetime risk may be more complex than it seems, says **Margaret McCartney**

The UK media, including the *BMJ*, enthusiastically covered the charity Cancer Research UK's recent figures about the incidence of breast cancer (*BMJ* 2011;342:d808). But just how useful was this latest round of publicity about risk of breast cancer?

Under the headline "One in 8 women will get breast cancer as lifestyle blamed for a huge rise in cases," the tabloid newspaper the *Daily Mail* reported that "One in eight women will develop breast cancer in their lifetime and the rate is rising, alarming figures show" (4 February) The BBC's website ran with much the same headline: "One in eight women will get breast cancer, charity says," and reported that "Dr Rachel Greig, senior policy officer at Breakthrough Breast Cancer, said the figures were a wake-up call and should not be ignored."

The press release responsible, from Cancer Research UK, was headed, "One woman in eight will get breast cancer," and read, "The lifetime risk of getting breast cancer has risen from one woman in nine to one in eight—according to Cancer Research UK. New figures published today on World Cancer Day also show that breast cancer rates in the UK have increased by 3.5% in 10 years with 47 700 women diagnosed with the disease in 2008 compared with 42 400 in 1999. The biggest rise in rates was among women aged between 50 and 69 where cases increased by more than 6% in the same 10 year period. Rates among younger women aged 25 to 49 dropped slightly by 0.5%."

Cancer Research UK has used a new method of calculating risk, the Sasieni method, rather than the older Esteve method, which the World Health Organization uses. As yet the Sasieni method is not published, although it is forthcoming. The charity says that it is justified in using it because the old method would have resulted in the same "1 in 8" result. The main difference between the two methods is apparently that the Sasieni method is more reliable at excluding women who have been diagnosed as having more than one primary breast cancer.

Yet the figures as adjusted for multiple primaries reveal a more subtle trend than the increase in lifetime risk from 1 in 9 to 1 in 8, which is an apparent, and incorrect, change from 11.1% to 12.5% chance of getting breast cancer. Using the new method, in 2004 the lifetime risk of getting breast cancer was 12.09%. In 2007 the risk was 12.29%. The most recent figures, on which Cancer Research UK has based its "1 in 8" statistic, is 12.51%. The rise between 2007 and 2008, the last two years available, when the rise from 1 in 9 to 1 in 8 has supposedly occurred, represents a difference in lifetime risk of just 0.22%. No wonder the public has a poor handle on the statistics.

Even then, the rounding of lifetime risks is liable to confuse. The most recent figure of 12.51/100 is 1 in 7.99, which has been rounded up to 1 in 8. But the previous three years' adjusted figures, as used by Cancer Research UK—for 2007, 2006, and 2005—have been rounded up too: a lifetime risk of 8.14% to 1 in 9, 8.05% to 1 in 9, and 8.10% to 1 in 9.

So what seemed to have been a large leap in incidence of breast cancer has been a much slower rise. Additionally, other factors that may have contributed to this—for example, increasing age at death and screening, understanding the meaning of lifetime risk may be more complex than it first appears. We already know that more screening results in more breast cancers being diagnosed that were never going to maim or kill, so we are "artificially" increasing inci-

dence: the most recent Cochrane review would suggest that for each woman who has her life prolonged by screening, 10 others are diagnosed as having cancer who would not have otherwise been harmed by the disease diagnosed (*Cochrane Database Syst Rev* 2009;4:CD001877). Additionally, lifetime risk is a prospective measurement and is based on all diagnoses over the lifetime of a population even if the average lifetime is less

than this. Should lifetime risk be used at all for public understanding when it is actually a complex statistical figure? Catherine Thomson, head of statistics at Cancer Research UK, thinks that the charity is right to use it. "We had the information that there was now a 1 in 8 risk of breast cancer, and we didn't want to hold that back," she says.

**"Lifetime risk is not very useful on its own—after all there's a 1 in 1 chance that you will die of something or other"**

However, Professor David Spiegelhalter, professor of the public understanding

of risk in Cambridge, is less sanguine about the usefulness of lifetime risks. "It's controversial," he says. "This is a hot topic in cardiovascular risk, where 10 year risks and lifetime risks will tell you different things. I feel that a lifetime risk is not very useful on its own—after all there's a 1 in 1 chance that you will die of something or other. What's important is the age profile—are you likely to get cancer before you're too old, and what you can do about that risk. At least a third of us will get cancer, so on its own a lifetime risk is not that useful." In terms of an "advertising slogan" of a health message, would something else be better than lifetime risk calculations? After all, the risk being calculated by CRUK includes risks for women aged over 85—and most UK women don't live that long. "Exactly. The crucial thing is early preventable death or disease and what you can do about it," says Professor Spiegelhalter. "There's interest now in showing how risk accumulates as you get older and how a disease impacts on lifespan." But, of course, more detailed but more accurate information is not amenable to so straightforward a slogan to advertise with.

Those of us who deal with people's concerns know the problems of poor health communication by the media. Health charities, however, often see themselves as champions of information while not necessarily critiquing their own information. "The communication risk literature is quite clear that better modes of communicating risk do not necessarily increase the behaviour you want," says Professor Spiegelhalter. Indeed, the truth may be uncomfortable: patients may be better informed by fewer headline stories.

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Headline news: the *Daily Mail*'s version of the story