Two issues to consider

Two issues are important in any discussion of competition in healthcare.

Firstly, while “any qualified provider” (AQP) now replaces “any willing provider” (AWP), comparison of the mid-2010 Department of Health procurement guidance with this month’s NHS Confederation advice shows that their commissioning processes are identical. The market based AWP commissioning process conforms to EU public procurement regulations. “AQP” is meaningless in EU law, so the AWP process has merely been renamed, with no new qualification procedure.

Secondly, the current NHS reform was delineated in 1987-8, in papers by MPs Redwood, Letwin (both ex-directors of Rothschilds’ Privatisation Unit), Willetts, and Peet. All asserted without evidence that competition would benefit UK healthcare. In 2005, Lansley proclaimed “maximising competition” as the “principle of NHS reform,” and now he prescribes competition for every NHS ill.

But 24 years after such reforms were designed, supporters can justify them only by citing a few recent observational studies claiming that competition improves health outcomes, although confounding may explain these effects.

Competition based reform involves activity based fees for service (misnamed “payment by results”). Financial incentives raise doctors’ activity levels, but this does not translate into better health outcomes. If doctors paid this way are underprovided in a community, more activity might improve outcomes. If they are overprovided (hence, competition exists), their need to make a living incentivises overtreatment.

No treatment is devoid of adverse effects, so poorer outcomes ensue. Using fees for service generates undertreatment and overtreatment, with efforts diverted away from people in medical need who cannot pay towards those who can pay but don’t necessarily need treatment.

Welfare economics provides the theoretical justification for promoting competition, but this model doesn’t fit healthcare. The main problem is information asymmetry: because the patient consults the doctor for advice and accepts the treatment recommended, the supplier controls demand. Combining information asymmetry with fees for service generates supplier induced demand, a phenomenon that absorbed 10-12% of 2009 US healthcare spending. This phenomenon disproves the theory that patient choice in a competitive healthcare market limits costs and raises quality.

Lucy A Reynolds
research fellow, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK lucy.reynolds@lshtm.ac.uk

Competing interests: None declared.

1 Reynolds L. “Any willing provider” vs “any qualified provider” in the NHS reform: different bottle, same contents (electronic response to Lister RJ. NHS reforms: Issues MPs and the media have missed in Lansley’s bill). 2011. www.bmj.com/content/342/bmj.d3194.full(reply#bmj_el_266823
3 Stevens S. Is there evidence that competition in healthcare is a good thing? Yes. BMJ 2011;343:d4136. (5 July.)

Competition could substantially benefit healthcare

In response to May’s concern that competition achieves relatively small gains, we have attempted some “back of the envelope” valuations of the gains from the choice and competition policy.

Our research suggests that an average hospital’s all cause standardised mortality rate fell by 0.3% as a result of the policy. From this we can estimate the financial benefits from the change in competition that occurred in the first year after full implementation of “choose and book.” Using a conservative value of £30 000 (€34 000; $49 000) a life year, the value of the fall in mortality is about £114 m—around 0.1% of the NHS budget. This is the value of the immediate response to the policy.

Another idea was to compare the benefits of increasing competition substantially. We used our estimates to compare the effect of moving from a local health economy with around 2.5 hospitals to one with around five hospitals. About 55 000 more life years would be gained by this move, with a value of around £1.9bn—about 2% of the NHS budget.

Clearly the gap between these estimates is huge. But it suggests that policies that allow greater choice through low cost means, such as provision of greater and better information for patients and financial incentives to provide higher quality for providers, could have large positive effects.

Martin Gaynor professor, H John Heinz III School of Public Policy and Management, Carnegie Mellon University, Pittsburgh, PA, USA
Rodrigo Moreno-Serra junior research fellow, Imperial College Business School, Imperial College London, London, UK
Carol Propper professor, Department of Economics, University of Bristol, Bristol BS8 1TN, UK
carol.propper@bristol.ac.uk

Competing interests: None declared.

1 Mays N. Is there evidence that competition in healthcare is a good thing? No. BMJ 2011;343:d4205. (5 July.)

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Preliminary findings should not be over-interpreted

Research into the effects of competition on quality of care must guard against the tendency to make over-optimistic claims of benefits on the basis of initial findings.

Despite the best attempts of excellent researchers, the three existing studies in England are inevitably limited by their reliance on routine administrative data (hospital episode statistics; HES) and the need to make some heroic but dubious assumptions (such as acute
myocardial infarctions are “easily clinically identifiable,” “adjusted mortality rates are purged of case-mix”). 3 These studies also mostly focus on one aspect of quality—safety (hospital mortality rates and case fatality rates)—and pay little attention to effectiveness, humanity (experience), or equity.

The findings of these studies need to be interpreted more cautiously. For example, the strongest evidence concerns acute myocardial infarction case fatality rates. The key finding, a dramatic decrease from 2002 to 2008, occurred in all hospitals during a time when central policies such as the national service framework and National Institute for Health and Clinical Excellence guidelines were being implemented and additional resources provided. If all methodological concerns are ignored, the research shows that for a short period (2007) hospitals in more competitive areas improved faster, although this was not apparent in 2008. This suggests that, for one specific condition, competition produced a marginal benefit, but it does not warrant the claim of “death by market power.”

If competition can help improve NHS quality, then research must be conducted in other clinical areas using data that are not subject to the limitations of HES. Until we have a clearer picture, researchers should not encourage policy makers to over-interpret interesting but preliminary findings.

Nick Black professor of health services research, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK nick.black@lshtm.ac.uk

Competing interests: None declared.

1 Mays N. Is there evidence that competition in healthcare is a good thing? No. BMJ 2011;343:d4205. (5 July.)

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BMA THE BILL

BMA has made a poor health bill worse

Disappointingly, the BMA has not championed the benefits of bringing clinicians to the forefront of commissioning. Far too much time has been spent focusing on the weak points of the government’s proposals, so losing the parts that would clearly benefit health systems and patients.

Our commissioning agenda was always how to re-patriate decisions from managers and to drive forward collaboration and cooperation among the mosaic of service providers. The concept of forming small groups of general practices to promote local cooperation and solutions seems sensible. Quality and safety of services would always be the priority of such groups, and the massive financial savings expected of the NHS can be achieved only through local engagement.

The pause in the Health and Social Care Bill, partly driven by the BMA’s opposition to the bill, has created inertia and uncertainty, and the Future Forum, together with the government’s response, has simply fuelled the centralist agenda and resulted in an ever more complex central command and control centre. Having mandatory nurse, lay, and secondary care participation in clinical commissioning groups is tokenism and insulting to GP commissioners. As GPs, we have an ingrained belief in including and respecting all parties in decision making, and we should be trusted to bring this ethos to commissioning.

We risk being marginalised by those at the centre who want the opportunity of even greater control of our profession. I think that most of the changes needed within the current framework could have been achieved without legislation. The government obviously did not think so and embarked on a rash programme. Governments tend to do that, and we as a profession should be accepting and make the best of what is offered. The only real change to the legislation should have been around the role of Monitor in promoting competition (a really bad idea) and the breathtakingly brazen attempt to release the secretary of state from the prime responsibility of ensuring provision of care for all.

Simon P Hambling general practitioner, NHS Cambridge, Cambridge, UK simon.hambling@nhs.net

Competing interests: SPH chairs the GP Commissioning Senate for NHS Cambridge and is director of the local commissioning group.

1 Delamothe T, Davies E, Godlee F. Bury the bill. BMJ 2011;342:d4050. (24 June.)

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Not the number of bureaucrats but the system’s complexity

Believers and opponents of NHS reform might find common purpose in opposing the revised health bill because it is now a baroque mess from any point of view. But one of the BMJ’s reasons for opposing the bill is nonsense and propagates one of the worst myths about the current NHS. Although the newly revised structures proposed in the bill and their baroque compromises will leave us with a bureaucratic tangle somewhat akin to the Austro-Hungarian Empire before the first world war, there are not enough managers to staff such a system. The proportion of managers is likely to be one of the smallest in any large or complex organisation in the world (it was already low before the government announced its populist target of cutting management costs by 45%).

The balance of evidence is that the NHS was under-managed before the cuts. The future NHS will most likely struggle to manage the complexity of the new structures, let alone improve productivity or quality.

Stephen Black management consultant, PA Consulting. London SW1W 9SR. uk steve.black@paconsulting.com

Competing interests: SB has worked for PA Consulting for more than a decade. Clients of this global management consulting firm, headquartered in the UK, have included the Department of Health, NHS providers, and NHS commissioners. The views expressed here are personal opinions and not those of PA Consulting.

1 Delamothe T, Davies E, Godlee F. Bury the bill. BMJ 2011;342:d4050. (24 June.)


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Do you hate the Russians more than you love your children?

Two arguments are commonly rolled out as to why we shouldn’t oppose the bill. One is that we must embrace it because it promises to rid us of primary care trusts and strategic health authorities, which were anathema to many GPs. This reminds me of the bumper sticker that was around during the cold war—do you hate the Russians more than you love your children?

Do people really hate these bodies (already endangered species) so much that they are preparing to see the NHS and the profession bombed to oblivion by the bill? It makes no more sense now than it did during the cold war. And the Royal College of General Practitioners has calculated that the amount of bureaucracy is about to rise exponentially, so farewell to reducing management costs.

Then we hear that GP commissioning is a good idea, and surely GPs can do it better. Yes, of course, that’s a no brainer. Except that what is on offer is not some commissioning nirvana, but a commissioning nightmare, with the National Commissioning Board breathing down your neck on one side, the Orwellian Co-operation and
MEASURING CLINICAL DIFFERENCE

Minimally important clinical difference

The authors of a randomised controlled trial that compared surgical intervention with rehabilitation in patients with chronic low back pain reported a statistically significant difference of less than 10 points in the Oswestry disability index between groups. They concluded that “did not clearly exceed the pre-specified minimally important clinical difference,” the value used in the sample size calculation. It is important to note that the use of a value in the sample size calculation does not make it the minimally important clinical difference, as acknowledged by the authors. The 10 points difference was not justified other than to reference another trial, which itself provided no justification. We support the view that the reporting of how sample size is determined requires greater clarity and transparency and acknowledgment of the discussion that takes place during trial design.

Clear guidance is needed on robust methods to determine what an important difference is and what trial size is needed. The different requirements of commissioners of trials, reviewers of grant applications and reports of trial results, and consumers of research need to be recognised.

The Difference Elicitation in TriAls (DELTA) project is investigating methods for determining the target difference. The project includes a systematic review of methods, a survey of current trial practice, and development of a guidance document. We hope this project will facilitate discussion in the trial community and improve this vital, yet neglected, aspect of trial design.

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Jonathan A Cook methodologist ja.cook@abdn.ac.uk
Craig R Ramsay programme director, Health Services Research Unit, University of Aberdeen, Aberdeen AB25 2ZD, UK
Luke D Vale: professor of health economics, Institute for Health and Society, Newcastle University, Newcastle upon Tyne NE2 4AX, UK On behalf of the DELTA project group

Competing interests: None declared.

TIOTROPiUM MIST INHALER

Another plausible explanation for mist inhaler’s toxicity

In seeking an explanation for the apparent increase in all cause mortality associated with tiotropium delivered by the Respimat Soft Mist Inhaler compared with the Handihaler, Singh and colleagues focus on the possibility of increased cardiovascular deaths as a result of the higher peak plasma concentrations of tiotropium achieved with the mist inhaler.

Another factor could be differences in the excipients used. The only excipient present in the capsules used in the Handihaler is lactose. One of the four excipients present in the solution used in the mist inhaler is the biocide benzalkonium chloride, which has been reported to cause bronchospasm in people with asthma when present in nebuliser solutions.

Furthermore, several cases of occupational asthma resulting from sensitisation to this chemical (confirmed by specific inhalationchallenge testing) have been reported after a latent period of exposure in the workplace. Although the airways of patients with chronic obstructive pulmonary disease (COPD) might not have the same irritant reactivity seen in some people with asthma who use nebulisers containing benzalkonium chloride, they might still be prone to sensitisation and subsequent bronchospasm on inhalation of the chemical.

No data seem to be available on whether the excess mortality associated with the tiotropium mist inhaler could be explained by acute bronchoconstriction in patients with underlying COPD, but this possibility might be worth considering as an alternative and biologically plausible mechanism.

Martini Seed consultant occupational physician, Centre for Occupational and Environmental Health, University of Manchester, Manchester M13 9PL, UK

Competing interests: None declared.

MOBILE PHONE CARCINOGENICITY

Protecting children from mobile phone radiation

Since the BMJ reported on the Council of Europe’s recommendation that children be protected from the electromagnetic radiation emitted by wireless equipment in schools,1 the International Agency for Research into Cancer (IARC) has classified such radiation as a possible carcinogen.2

The evidence for children’s vulnerability is accumulating. A recent study found an almost fivefold increase in astrocytoma in people who started using mobile phones before the age of 20.3

Because the Council of Europe has little influence over national health policy and the IARC classification will take time to translate into practical advice, medical practitioners and professional bodies should ensure that timely action is taken to protect children. Experience of previous public health threats (tobacco, asbestos, x rays) indicates that the evidence of risk often increases as research progresses. Given a latency lag of up to 20 years for many tumours, we are in danger of repeating these public health disasters.

We have an opportunity now to help public health agencies navigate this complex area of unquantified risk. We should encourage the adoption of proportionate safety measures that acknowledge the benefits of mobile phone

technology but reflect the potentially serious risks, particularly for children.

Kevin O’Neill consultant neurosurgeon, Charing Cross Hospital, London, UK; kevin.onnell@imperial.nhs.uk

Competing interests: KO’N is trustee of the MobileWise and Brain Tumour Research Campaign.

1 Watson R. Radiation fears prompt possible restrictions on wi-fi and mobile phone use in schools. BMJ 2011;342:d3428. (1 June.)
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EXAMINING PATIENTS

Feel the anxiety about examining patients and do it anyway

The assertion that some doctors are reluctant to perform certain clinical examinations for fear of upsetting patients’ sensitivities is troubling.

It is important to understand the patient’s perspective and concerns, but doctors must also be able to manage patients’ anxieties and provide good clinical care.

As medical educators we recognise the problem and openly tackle those aspects of clinical examination that are deemed personal or intimate.

One such example is breast examination training, where in a clinically realistic environment students are taught to perform breast examination on women models. The women—known as breast training assistants—are trained to supplement tutor feedback with information on student performance from the “patient” perspective. In small groups, tutors, students, and assistants openly discuss and practically explore the best approaches to breast examination.

Therefore, rather than indoctrinating undergraduate medical students with a sense of deference towards patients’ sensibilities, and perhaps their own, we support them at an early stage in their careers while they identify and manage their anxieties about personal examinations.

A failure to tackle such problems in undergraduate education risks perpetuating or facilitating a sense of taboo around body parts that is inappropriate in medicine. This is especially true when students are young and culturally diverse, with some having had limited contact with the opposite sex.

This aspect of education requires a sensitive approach, where both the clinical and communication components of the skill are integrated on delivery.

Cherry M Buckwell lecturer, Barts and the London Medical School, Clinical Skills Centre, St Bartholomew’s Hospital, London EC1A 7BE, UK
c.buckwell@qmul.ac.uk

Markus Ornstein consultant surgeon, Homerton University Hospital NHS Foundation Trust, London, UK

Annie Cushing head of clinical and communication skills

Doug Lothian clinical skills tutor, Barts and the London Medical School, Clinical Skills Centre, St Bartholomew’s Hospital, London EC1A 7BE, UK

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RESPONSE

James Malone-Lee responds to media flurry over safety of anticholinergics in elderly people

The intemperate hubbub over anticholinergic safety in elderly people, championed by the BBC on the morning of 24 June 2011, merits sober reflection.

The focus was a paper by Fox and colleagues that was unavailable until 4 pm, when placed on the website of the Journal of the American Geriatrics Society. By then the media squall had dissipated.

Recent UK history should deter such ill advised announcement of data through television, before it is published for peer scrutiny.

The article in question was a post hoc analysis of epidemiological data collected from older adults enrolled in the Medical Research Council Cognitive Function and Ageing Study. Participants were assessed using the mini-mental state examination (MMSE) in 1991 and 1993. The paper was published as an early online brief report, short on detail.

Anticholinergic exposure was measured crudely using a ranked ordinal scale that reflected the authors’ beliefs about drug potencies. Although the paper omitted the scale, the BBC website provided a copy. Disease burden was assessed by counting predefined self reported health conditions, to a maximum of three.

Under the banner “Deadly consequences,” the BBC reported an association between increased mortality and the use of anticholinergic drugs. Although it cautioned against confusing correlation with causation, it claimed that “other factors, such as increased mortality from underlying diseases, were removed from the analysis.” Causation was incited in press briefings throughout the day.

Those with overactive bladder were particularly concerned. This cause of urge incontinence is associated with older age, falls, fractures, urinary tract and skin infections, sleep disturbances, depression, and comorbidity. Options for treatment are few, and anticholinergic drugs are a mainstay.

Given our knowledge of this condition, it is not surprising that anticholinergic exposure correlated with older age, lower social class, former smoking, and more health conditions. Fox and colleagues claimed that they adjusted for age, sex, education, social class, number of self reported health conditions, and non-anticholinergic drugs. That is preposterous for two reasons: the between groups variances were not homogeneous, and, as the authors stated, the covariates correlated with the outcome measures. This naive inferential howler has been well characterised and lucidly explained.

Fox and colleagues lavishly deployed ordinal scales. Nature is inimical to categories—biological variation is continuously dispersed. We clinicians, however, manufacture error by our wishful compulsive classifying.

Heeding the BBC, several relevant organisations welcomed the research in press statements. How could they? The data were not in the public domain? The desperate patients were directed to their GP. What were our overburdened GPs supposed to make of this cacophony? The cliché, “more research is needed,” proved dispiritingly ubiquitous but I disagree with that opinion.

When anticholinergic drugs were introduced for overactive bladder, we worried greatly about cognitive effects, constipation, and torsade de pointes, a sometimes lethal cardiac arrhythmia. Thus, safety in elderly people was carefully scrutinised using intervention studies of good clinical practice standard. The hypothesis that catalysed the scare, nurtured on BBC News, has been tested and rejected by many trials over the past two decades.

Correlations should be quarantined from causation until the mandatory randomised studies are completed. Covariance analysis requires a health warning. Scientific data should be presented in journals, not through our overwrought press.

James Malone-Lee professor of medicine, Research Department of Clinical Physiology, Division of Medicine, University College London Medical School, London N19 5SW, UK

james.malone-lee@ucl.ac.uk

Competing interests: The full statement of competing interests is available in the rapid response: www.bmj.com/content/342/bmj.d4037/reply#bmj_el_264787.

1 Torjesen I. Anticholinergic effects of common drugs are associated with increased mortality in over 65s. BMJ 2011;342:d4037. (28 June.)

Cite this as: BMJ 2011;343:d4740