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LETTERS

COALITION PLANS FOR ENGLISH NHS

A recipe for disaster?

PHOTOFUSION/ALAMY

Commissioning by consortiums of general practitioners (GPs) looks like a recipe for disaster for both patients and GPs.[1 2]

All general practices will be compulsorily involved in commissioning but most GPs lack the appropriate management skills, training, or experience.[3] Whether it is appropriate and cost effective to use limited clinician time in this way is questionable, and whether GP consortiums can operate as effective corporate organisations is unknown. Governance structures and accountability mechanisms have also not been worked out.

Inexperienced consortiums of GPs will be pitched against foundation trusts that have played the game for longer. The negotiating clout of these often large oligopolies of hospital providers is substantial. All will strive for financial viability, guaranteed by increased hospital activity, irrespective of appropriateness. A market led health system tends to be driven by financial priorities, not health needs.

The financial risks for GP consortiums are also considerable as the government has vowed not to bail out failing consortiums.[2] Some may run into financial trouble and end up being taken over by private health companies. The stage seems set for private organisations to enter more forcefully and substantially into the health system.

The government's plans seem to be a thinly veiled cost shifting exercise from primary care trusts to GP budgets. Undoubtedly some GPs will be champing at the bit to finally take on fully the responsibilities of commissioning. Health service management is like football management: many think they can do the job better than the current incumbent. However, GPs will not be inheriting asset rich Chelsea but debt laden Portsmouth. They will be expected to do much more with less, and the success (and failure) of the scheme will be placed squarely at their feet.

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Competing interests: None declared.

1 Ham C. The coalition government's plans for the NHS in England. *BMJ* 2010;341:c3790. (14 July.)
2 Secretary of State for Health. Equity and excellence: liberating the NHS. Department of Health, 2010. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353.
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Cite this as: *BMJ* 2010;341:c4182

A poisoned chalice?

Let us consider the task ahead for GP commissioning consortia.[1 2]

They will be responsible for the allocation of limited resources in a system where unlimited demand from patients is met by unlimited supply from provider trusts. This is not a nice place to be.

If a consortium overspends in the cold climate of the open market, it will be allowed to fail. If it successfully keeps within budget by prioritising care towards those who can benefit most, it will necessarily deny care to others. Hostile press coverage and legal challenges will surely follow.

In the current system we have scapegoats called primary care trusts. They take on the ugly business of rationing health care, leaving general practitioners free to act in the best interest of their patients. If care is denied, it is not perceived to be due to rationing by the general practitioner, and the patient-doctor relationship is maintained.

The power and potential financial rewards that come with the commissioning chalice may end up tasting very bitter indeed.

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1 Ham C. The coalition government's plans for the NHS in England. *BMJ* 2010;341:c3790. (14 July.)
2 Secretary of State for Health. Equity and excellence: liberating the NHS. Department of Health, 2010. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353.

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We need some managers

The centralised drive to meet the politically attractive target of cutting management (there is no public lobby for more bureaucracy) runs a serious risk of undermining the capacity of the new NHS to improve and spend its money well.[1] We need some people who know how to spend NHS money wisely.

Primary care trusts spent 1-2% of their budgets on management, and the new target will roughly halve this total. Only the most outstandingly frugal charities spend as little as 1% of their turnover on management. In the United States, where charities have to categorise such expenditure, typical large charities such as the American Diabetes Association, American Cancer Research Fund, and American Red Cross spend 3-5%. But some big health charities spend much more: the Mayo Clinic 12.5%, the Salk Institute 19% (www.charitynavigator.org).

This crude comparison suggests that we will be lucky if consortiums of general practitioners can do a good job of commissioning with the expected costs of management at <1% of their NHS spend. A more prudent approach would be to allow them to decide for themselves how much to spend since they can then make intelligent choices about how much they need to improve outcomes or productivity.

Good management can pay for itself. The estimated error rate in clinical coding by hospitals is more than 10%. Primary care trusts that have checked how much they pay for their activity have found that they overspend by 5%. Most trusts have probably never either noticed or recovered that money. If they spent, say, 0.5% more of their budget on management, they would have 4.5% extra to spend on other services—a good return on investment in management cost.

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Competing interests: None declared.

1 Ham C. The coalition government's plans for the NHS in England. *BMJ* 2010;341:c3790. (14 July.)

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BRONCHIECTASIS

Prevalence in general practice

Since 2004 our general practice with 5840 patients in a middle class suburban area has been proactively looking for patients with chronic obstructive lung disease. Accurate

diagnosis with careful history and spirometry has identified nearly all the cases that would be predicted from a history of heavy smoking (84, 1.4% of practice population). In addition, asthma was clearly identified—we found 371 people with asthma, 6.3% of our population.

We also identified 28 patients with bronchiectasis—0.47% of the population—or about 12 cases per general practitioner (list of 2500), which is higher than the two per general practitioner suggested by ten Hacken and van der Molen.[1] Ten of these patients had chest infections in their childhood, with two having had whooping cough. Difficult to treat late onset asthma with persistent phlegm and minimal smoking history are diagnostic pointers in our group. Identification by referral for high resolution lung scanning is the usual diagnostic pathway. Correct diagnosis helps in the management of subsequent chest infections.

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Competing interests: None declared.

1 Ten Hacken NHT, van der Molen T. Bronchiectasis. *BMJ* 2010;341:c2766. (14 July.)

Cite this as: *BMJ* 2010;341:c4163

DELAYS IN PAEDIATRIC SURGERY

"Own goal" or patients' penalty?

Perhaps it's significant that a week after publication, there were no responses to this story.[1] But what is more important, or scandalous, than the news that "the number of surgeons in England who can perform routine operations on children has dwindled"? As a surgical trainee in the early 1980s, I performed most types of children's emergency abdominal surgery under the supervision of excellent consultants. Our general hospital was proud of its care and had excellent results, rarely having to request transfer to children's centres.

But does the article illuminate the real reasons for the decline in children's surgery in district hospitals? True, there is a shocking bureaucracy and almost a culture of fear around the care of children. But why did the Royal College of Surgeons keep silent as its paediatric surgical committee made loud noises to the effect that children's surgery should be done by dedicated children's surgeons? This sent strong messages to general surgeons who had provided good children's care that their services were somehow deficient.

SIU/SPL

The chairwoman of the Children's Surgical Forum cannot now simply complain that young patients "should not have to face long journeys or delays for relatively straightforward operations which until recently would have been available at their local hospital." She should admit that this is a consequence of her specialty's earlier position.

The *BMJ* reports the Royal College of Surgeon's obtuse suggestions for "interconnected systems of service providers, agreed thresholds for transfer, and networks across boundaries." But as a profession we have allowed this situation to happen under our noses and the least the college could do is own up to it.

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Competing interests: None declared.

1 Kmietowicz Z. Trusts need to work together to avoid delays in paediatric surgery. *BMJ* 2010;341:c3711. (14 July.)

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GAVI AND WHO

Demanding accountability

Lee and Harmer's editorial marking 10 years of Global Alliance for Vaccines and Immunisation (GAVI)[1] was published before discussion of a controversial press release issued by the World Health Organization jointly with GAVI and others in 2007 after the Bangladesh study on *Haemophilus influenzae* type B (Hib) vaccination.[2-4] The press release suggested that the vaccine was useful whereas the study showed no benefit. No statistical difference was seen in the vaccination state of those with pneumonia or meningitis compared with controls. A post-hoc analysis presented without proper multiple testing was used to bolster the erroneous claim. Contrary to the implication in the press release, analysis of data from an earlier Indonesian probe study also found no benefit.[5]

This misleading press release looks like a smoking gun. GAVI (which includes representatives of vaccine manufacturers on its board) "encouraged" developing countries in Asia to avail themselves of the vaccine at subsidised rates. The subsidy came from money given by donor countries and the Bill and Melinda Gates Foundation for achieving millennium development goals. Given that the probe studies in Asia had failed to confirm benefit from the vaccine, millions of dollars from the Millennium Development Goals Fund seem to have been wasted.

Those responsible need to be called to account. If that is not seen to happen, the credibility of WHO and GAVI and other global organisations will be eroded. Widespread reporting of these events may also change how decisions are taken for developing countries.

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Competing interests: None declared.

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AIDS AND ELDERLY PEOPLE

Elderly Africans have AIDS too

Kautz and colleagues' study did not adequately account for the impact of the prevalence of HIV on elderly Africans or the role of neighbourhood effects in increasing the risk of HIV among Africa's elderly people.[1] Many patients who were infected with HIV as youths now live into their 50s, 60s, and longer, and the average age at infection has increased.[2]

The demographic health surveys (DHS) conducted between 2003 and 2007 contain limited data on self reported prevalence of HIV in men aged 50-59 in 13 African nations. On the basis of these data, the average HIV prevalence was 5%. However, self reporting usually underestimates HIV status, as exemplified by a 2001-2 study of 133 male Ethiopian cataract patients aged 50-59, which found an HIV prevalence of 9.1%, higher than the 1% prevalence reported in the DHS, as well as a 6.3% HIV prevalence in Ethiopians aged 15-49 years.[3] Also, poor elderly Africans are more likely to live in rural areas outside the economically vibrant HIV epicentres, which are experiencing rising HIV prevalence.[4]

The myths that HIV is a problem for the under 50s and that older Africans are not

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sexually active need to be dispelled. Providing culturally specific sex education to older people, improving availability of sexually transmitted disease prevention aids to elderly people, and improving the social safety net will make these people less vulnerable to HIV infection and physically and emotionally able to perform societal roles without posing the risk of HIV infection to the children under their care.[5]

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c4169

SYMMETRICAL POLYARTHRITIS

Time for treatment targets in rheumatoid arthritis

Binder and Ellis's article on investigating symmetrical polyarthritis is pertinent to recent developments in managing rheumatoid arthritis.[1] The recently published international "treat to target" recommendations for rheumatoid arthritis are an opportunity to examine the outcomes for UK patients against established and professional guidance.[2] The goal should be remission or low disease activity only if remission is not achievable.

No clearly formulated recommendations have been published on treatment targets in rheumatoid arthritis such as those routinely used in managing hypertension and diabetes. Our goal is to adopt a "treat to target" approach in managing rheumatoid arthritis in the UK.

This approach entails escalating pharmacotherapy and titrating changes towards achieving the primary target of remission in a manner agreed between doctor and patient. Frequent assessment of disease activity[1] with resulting adjustment of treatment also improves outcomes. Such principles are supported by recent guidance from the National Institute for Health and Clinical Excellence and British Society of Rheumatology.[3-5] However, current clinical practice in the UK is far from the best for patients.

We will therefore audit our units' performance against the 10 treat to target recommendations.[2] Our goal is to show nationally that treat to target protocols improve patient outcomes better than current routine care for rheumatoid arthritis in the UK.

Subscribing to the recommendations will prevent joint damage and reverse physical disability associated with the disease, keep patients more engaged in their treatment, and allow patients to participate more fully in everyday life and work. As rheumatologists, this should be our primary mission for the next decade.

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Competing interests: Consultancy and honoraria for Abbott, BMS, Roche, Pfizer, Merck.

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Cite this as: *BMJ* 2010;341:c4170

MEDICAL COMPLICITY IN TORTURE

Time for WMA to take action

In a recent correction Professor Michael Baum conceded that Dr Derek Summerfield is sincere in his belief that the Israeli Medical Association (IMA) is complicit in torture, even though Professor Baum is equally convinced that the association is not.[1] However, the IMA has still not answered several important questions about the charges.

In October 2009 one of us (JSY) outlined the IMA's failure adequately to investigate several allegations of medical complicity in torture collated in a May 2007 report.[2] The IMA has still not adequately investigated these allegations, or responded to detailed questions about them from Physicians for Human Rights—Israel, the Public Committee Against Torture in Israel, and the author of the article.

More reports continue to surface of medical complicity in torture.[3 4] The Public Committee Against Torture in Israel has received details of one case, which has been forwarded to the IMA and Ministry of Health. It includes allegations that doctors in an emergency room did not report injuries that a Palestinian prisoner was reported to have sustained during questioning by the General Security Service, returning the prisoner to detention two hours later.[3]

The IMA has repeatedly stated its commitment to the Declaration of Tokyo of the World Medical Association (WMA), which prohibits doctors from condoning or participating in torture, and requires them to speak out when they encounter it. Failure to do so is defined as complicity in torture. The WMA is aware of the allegations in the 2007 report, and of the case described above. The WMA must now take action.

Doctors in the Israeli prison service need a secure address to which testimonies can be submitted, as well as legal protection as whistleblowers. Should the WMA's hand require strengthening, the March 2009 resolution of the UN Human Rights Council provides both the authority of a UN resolution and the resources of the UN Special Rapporteur on Torture.[5]

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Competing interests: None declared.

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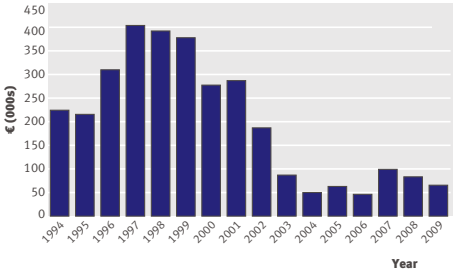
Cite this as: *BMJ* 2010;341:c4105

COMPETING INTERESTS

More queries about H1N1 scandal

Why did it take so long to detect the trick uncovered by the *BMJ* and Bureau of Investigative Journalism's inquiry?[1] In 1997, a Beecham's business manager claimed: "We started increasing the awareness of the European experts of the World Health Organization about hepatitis B in 1988. From then to 1991, we financed epidemiological studies on the subject to create a scientific consensus about hepatitis being a major public health problem. We were successful because in 1991, WHO published new recommendations about hepatitis B vaccination."[2] And as in the case of the SAGE experts group, the "WHO voice" regarding the benefit-risk ratio of this vaccination was that of the Viral Hepatitis Prevention Board, created and sponsored[3] by the manufacturers.



The H1N1 scandal provides an opportunity to challenge the view that conflicts of interest do not threaten experts' independence because their links to commercial enterprises are simply the price of their scientific excellence.[4] The figure summarises my income from the time I was a respected (and well-off) consultant to drug companies until 2009. Between 2000 and 2006 I was commissioned as an expert by French judges in several litigation cases involving drug manufacturers and some of my reports received wide media coverage. These reports were generally less favourable to the interests of "Big Pharma" than the recommendations of "independent" experts regarding swine flu—a fact that is likely to account for the drop in my income.

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Competing interests: MG is or has been a consultant for drug firms, including most of those currently involved in the H1N1 scandal.

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Cite this as: *BMJ* 2010;341:c3716

TAX ON SUGARED DRINKS

How to raise the prices of unhealthy foods

When food campaigners don't like something, their first reaction is to tax it. The latest example is the soft drink tax in the US.[1] All such taxes have failed, so we keep getting fatter and fatter.

When are public health advocates going to get clever, instead of crying conspiracy every time they lose?

Let's start at square one. People hate taxes. Americans hate them more than most. Most of all, people resent taxes on pleasures. The more visible the tax, the more they hate it. So proposing a tax on soft drinks is guaranteed to provoke consumer backlash.

Here's how to raise the price of soft drinks without a tax, using America's bloated agricultural support system for public health ends.

(1) Raise the support price for sugar. Yes, raise it so the powerful sugar lobby won't resist. The higher sugar price will feed through to higher prices for all sweetened foods, not just soft drinks. Then

(2) Cut the production quotas for US sugar. Having had a price rise, producers won't scream too loudly when quotas are reduced a bit, but a smaller supply will put further upward pressure on prices. That will only work if you also

(3) Raise the tariffs and cut the quotas on sugar imports, so that cheaper foreign supplies do not undercut the new higher US domestic price. And also

(4) Eliminate the tariff-free quotas on some foreign sugar that are a distinctive feature of US policy.

The higher price for sugar will lead quickly to a price gap between sugared and sugarless soft drinks. This will give an economic incentive to the healthier choice.

The tactical advantage of this approach is that the mechanisms behind the price rise are almost invisible to the public. Few consumers ever understand agricultural policy. The strategy also carries a nationalist halo, appearing to protect American farmers.

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Competing interests: None declared.

1 Kamerow D. The case of the sugar sweetened beverage tax. *BMJ* 2010;341:c3719. (14 July.)

Cite this as: *BMJ* 2010;341:c4177

BMJ ON OBESITY

What the journal says

The *BMJ* issue of 10 July contains the following information:

We tend to gain weight gradually year by year up to a peak of about 70, and then we start to lose it again. This figure reflects a lifetime of gaining weight.[1]

Researchers are looking at the link between weight and diseases other than those that are usually associated with obesity, such as diabetes and heart disease.[1]

The statistics on obesity, which go back to 1994, show a marked increase in the proportion of obese adults in England, from 15.7% in 1994 to 24.5% in 2008.[1]

There is a link between BMI and sexual behaviour and adverse sexual health outcomes, with obese women less likely to access contraceptive healthcare services and having more unplanned pregnancies.[2]

Conclusion: obesity is a problem.

How do other countries tackle it?

The Danish government has imposed tax increases of 25% on ice cream, chocolate, and sweets and will also increase taxes on soft drinks, tobacco, and alcohol products in a bid to reduce the burden on public health services and to tackle obesity, heart disease, and other illnesses.[3]

A cohort of 18 414 young healthy women from the US gained a mean of 9.3 kg in weight during the 16 years between 1989 and 2005. Cycling and brisk walking helped a few buck the trend, however.[4]

In the Netherlands, where 27% of the population rides regularly on an extensive network of dedicated cycle paths, the prevalence of obesity is just 8%.[4]

How does the UK plan to tackle it? In the next print issue we find out:

Government invites food industry to fund anti-obesity campaign.[5]

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Competing interests: SC believes that a paradigm shift is necessary to encourage walking and cycling as transport norms.

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Cite this as: *BMJ* 2010;341:c4175