It is therefore important that the new indicators should include direct measurement of benefit experienced by patients.

This point is inadequately covered under the criterion 'attributable' in Attachment C of the document. Under the criterion 'important' there is no mention of patients, whereas policy makers, health professionals and managers are given prominence. This is a serious omission.

The indicators of 'effective delivery of health care' and 'patient care experience' need to include outcomes that access both the individual experience of care and the impact on the population health gain. The risk in concentrating solely on the clinical and cost effectiveness of interventions and the efficiency of service delivery is that patients become 'conditions' that do or do not have potential treatments, that may or may not be used appropriately and efficiently. This depersonalizes care, maintains a medical model of health, and is difficult to reconcile with moves towards promoting patient autonomy and its 'population perspective', healthy communities. Unless at least one area of outcome and performance measurement is not directly disease, device or community. Unless at least one area of outcome and performance measurement is not directly disease, device or death orientated but measures peoples' experience of health care there is little hope for the new world!

I favour the addition of measures that directly link clinical performance to the holistic care of patients. This could involve a process that included:

1. Developing specific goals with patients, based on evidence of clinical effectiveness (personal outcomes), at the time the patient is informed, a plan of action agreed and consent to treatment obtained; indeed, good clinical practice as defined by the General Medical Council already demands that patients should be properly informed and a prediction of likely outcome given (prognosis);

2. Identifying such goals in the patients' records or on the consent forms;

3. Assessing, jointly with patients, on discharge or completion of episodes of care, whether the agreed outcomes have been achieved as part of standard audit procedures;

4. Reporting the percentage of patient outcomes met.

Such a measure could be included in Area V, Annex 1, p. 15.1

References


Accepted on 29 April 1998

Yours faithfully,

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To reintroduce school BCG or abolish it – the dilemma for the newly formed health authorities

Sirs,

During the recent reorganization, the merger of school BCG operating districts with those that had abandoned it resulted in conflicting immunization policy in a number of newly formed health authorities (personal communication). Although the Department of Health recommends school BCG immunization its appropriateness has been seriously questioned. Consultants in communicable disease control are to face the grim choice between introducing school BCG where it was abandoned or abolishing the programme where it is operational. As an aid to decision making we have compared the incidence of tuberculosis (TB) in school BCG operating and non-operating areas.

Using data from the 1991 Census, two boroughs (A and B) within the health authority with closely matched demography, ethnic mix, socio-economic groups, unemployment level and housing condition were selected. Area B had abandoned the programme in 1980 whereas area A continued it. Cohorts of 12-year-old children, the target age for school BCG immunization, were followed up between 1982 and 1994 and the cases of TB were ascertained from statutory notifications, laboratory reports, hospital histopathology records and only confirmed cases from the Patient Episode Database for Wales (PEDW). The appropriate age-period cohort person years at risk (PYAR) were obtained by using the population estimates from the National Statistical Office. Analyses were done using GLIM to perform Poisson regression taking PYAR into account. Children born during the follow-up interval were also included, thus providing an under-12 pre-BCG control group.

The numbers under 12 years old and between 12 and 24 in the two areas are shown in Table 1, together with rates per 100 000 with 95 per cent confidence limits (CL) and the PYAR relative risk (RR) of area A (with a BCG programme) compared with area B (without a BCG programme). 'Post-BCG' rates are about 32 per cent lower in the area still using BCG (RR = 0.68,
Table 1 Observed number of TB cases in cohorts of children aged 0–11 years and 12–24 years and estimated rate per 100 000 in areas A and B

<table>
<thead>
<tr>
<th>Age group 0–11 years</th>
<th>Area A</th>
<th>Area B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases observed</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>PYAR</td>
<td>137373.6</td>
<td>1611402.2</td>
</tr>
<tr>
<td>Estimated rate/100000 (95% CL)</td>
<td>5 (2–11)</td>
<td>2 (1–6)</td>
</tr>
<tr>
<td>RR (95% CL)</td>
<td>2.73 (0.71–10.58)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age group 12–24 years</th>
<th>Area A</th>
<th>Area B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases observed</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>PYAR</td>
<td>80106.2</td>
<td>108766.2</td>
</tr>
<tr>
<td>Estimated rate/100000 (95% CL)</td>
<td>5 (2–13)</td>
<td>7 (4–15)</td>
</tr>
<tr>
<td>RR (95% CL)</td>
<td>0.68 (0.20–2.25)</td>
<td></td>
</tr>
</tbody>
</table>

95 per cent CLs 0.20–2.25). Although the lower 95 per cent CL suggests that the risk may be as much as 80 per cent lower this does not differ significantly from unity ($p = 0.52$).

In the children under 12 years old the risk appears higher in area A (RR = 2.73), although not significantly so. The fact that compared with the non-BCG operating area (B) the incidence is higher in the pre-BCG group (i.e. under 12 years) and lower in the post-BCG group in the BCG operating area (A) may be interpreted as the effect of school BCG immunization, and the way the pre- and post-12 rates differ is significant at 5 per cent level ($p < 0.03$). However, studies in populations of this size cannot be taken as conclusive when the rates being compared are so small. It would appear that more extensive national results are needed before the health authorities can make an evidence-based decision about the future of the programme.

References


Accepted on 9 June 1998

Does breast cancer screening depend on a wobbly hypothesis?

Sirs,

Although Watmough et al. make some valid points about breast screening, we find many of their arguments unhelpful.

They state that the high rate of interval cancers in the North Western Regional Health Authority (NWRHA) is ascribed to lower than expected sensitivity of the test. However, they do not distinguish between low test sensitivity, which results in true false negatives, and true interval cancers, which only start to form in the interval between screens and could therefore not be detected previously with any conventional test, however sensitive. It was the main conclusion of the paper from the NWRHA that the screening interval was too long.

The Forrest Committee did not emphasize ‘that a precondition for successful screening required a clear understanding of the natural history of the disease’, but rather considered ‘the extent to which breast cancer meets these [Wilson and Jungner] criteria’. Although knowing the natural history is helpful, it is probably the least important of the Wilson and Jungner criteria, provided that the benefits of the test are otherwise demonstrated.

The graphical analyses presented within this paper are interesting and seem to give weight to the arguments discussed. However, basic statistical analysis of Fig. 1(a) displaying cancer detection rates for various studies shows that the 1963 study may be an outlying result, and exclusion of this result would demonstrate that study year and detection rate have little association. This highlights the problems of performing least-squares linear regression on such a small number of studies. In addition, because of the wide confidence intervals for the quoted individual studies, a contrary interpretation of the data presented would be equally possible. The authors point out that the studies are heterogeneous, but they make no attempt to adjust for this in plotting the data from the different studies on the graph.

Yours faithfully,

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