

# A Spectrum of Health Policy Methods: Lessons from the British

Theodore G. Ganiats, MD  
La Jolla, California

Americans receive more health care than the British, and Americans devote a greater portion of the gross national product to health than does our overseas neighbor. A major reason for this difference rests in the fundamental health care system differences between the two countries.

Whether the British spend too little or we spend too much is not the purpose of this editorial. Instead, this editorial highlights how the *process* of deciding health policy varies between the two countries. Two events in 1997 highlight a fundamental difference between how health policy is set in the United States and Great Britain. The following vignettes speak for themselves.

## USA: MAMMOGRAPHY AND POLITICS

In January 1997 the National Cancer Institute (NCI) presented its new clinical guideline on screening mammography.<sup>1</sup> This statement is the product of untold hours of evaluating the current state of knowledge in breast cancer screening. One particularly sensitive and controversial issue is mammography screening in women younger than 50 years old. The NCI surprised many by stating that the evidence was insufficient to make a clear recommendation. This position is similar to the US Preventive Services Task Force statement from the prior year.<sup>2</sup> The NCI then went one step further to recommend that, "Each woman should decide for herself whether to undergo mammography" based on her personal preferences in consultation with her physician.<sup>3</sup>

While both sides of the controversy may have felt slighted, when the data are less than compelling, who best to make the decision than the patient? Unfortunately, after the NCI statement, our government apparently felt that too much power had been

given to the people. A "Sense of the Senate" resolution authored by Senator Olympia Snow (Maine), a member of the Senate Budget Committee, supported the concept that all women between 40 and 50 years old should have routine mammography. Further, Senator Arlen Specter (Pennsylvania), a member of the Senate Appropriations Committee and chair of the subcommittee that funds all Public Health Service agencies, including the NCI, threatened the NCI with reduced funding if the statement were not revised to recommend mammography. So the US Senate (that well-known bastion of medical knowledge?) took this controversial issue out of the hands of the women affected. In a paternalistic move, the Senate forced the NCI to accept a new recommendation that all women over age 40 years get a screening mammogram every 1 to 2 years.<sup>3</sup>

But is there more? Should health policy be based on more than the political whim of a Senator?

## GREAT BRITAIN: COLORECTAL CANCER AND A SYSTEM

There are several "national" policies in the United States dealing with colorectal cancer screening. Unlike mammography, none of these are government policies. Instead, they are policies of a large group, the American Academy of Family Physicians, American Cancer Society, US Preventive Services Task Force, and so forth. Likewise, there is no government colorectal cancer screening policy in Great Britain. Interested in exploring this issue, the British National Health Service (NHS) in May 1997 held the first of two workshops to determine whether the NHS should have a colorectal cancer screening policy. The conference participants included key NHS members and three expert overseas advisors, two from the United States and one from Denmark.

The morning was spent reviewing the evidence. Most of the data come from the two European fecal occult blood test (FOBT) studies recently published in *Lancet*.<sup>4,5</sup> The earlier American study<sup>6</sup> was mentioned but because of its low specificity

*Dr Ganiats participated in the first British National Health Service colorectal screening workshop. Address correspondence to Theodore G. Ganiats, MD, the Department of Family and Preventive Medicine, University of California San Diego School of Medicine, 9500 Gilman Drive, La Jolla, CA 92093-0622.*



(see below) it was not highlighted. After the presentations, the participants split into three groups for focused discussions. One group was to decide the degree to which the evidence for colorectal cancer screening meets the criteria agreed upon by the National Screening Committee. The second work group was to agree on a set of objectives for such a colorectal cancer screening program. The third group was to identify critical success factors that would need to be in place to assure that adequate quality control could be established and maintained over a 10-year period.

The issues raised were quite provocative, and only some were resolved at the first workshop.

*Who should do the screening?* The NHS argues that the primary care provider cannot do the screening because the physician would likely delegate this task to staff. If each of Great Britain's primary care providers delegated this responsibility to several people over a 10-year period, tens of thousands of these staff would perform the FOBT. Quality control in such a system would be jeopardized and would not reproduce the high quality achieved in the randomized trials. The NHS argues, quite effectively, that if the expectation is to see results comparable to a clinical trial, then systems should be set up to replicate key elements of that trial. Performing the FOBT is the central element of an FOBT-based screening program. Lowering the quality control on the performance of the FOBT could have disastrous results. Thus, the NHS favors a centralized program with mailed-in specimens, since that system offers the greatest opportunity for quality control.

*How do you assure quality?* The concerns of quality extend beyond FOBT performance. Recruitment, follow-up, and colonoscopy or barium enema performance all have quality issues. Maintaining high quality is relatively easy in the first year of the program. But what about the seventh year of the program when the people (patients and medical staff) might become more lackadaisical? It is often easier to maintain high quality in a randomized trial than in actual clinical practice, and any decrement in quality affects the program's effectiveness and cost-effectiveness.

*How do you recruit and follow up patients?* If you have centralized data collection, this would most likely be done by a letter. How would the letter be worded? When would you send it?

*How do you follow up a positive FOBT?* This is

important because of the limited resources within the NHS. For example, there is currently a waiting list in Great Britain to receive a colonoscopy for *symptomatic* disease. Following up all patients with a positive FOBT with colonoscopy further burdens the system. Who would take precedence, the person with the symptom or the person with a positive screening test? Similar issues could be envisioned for following up a positive FOBT with barium enema. This one point, the difficulty in following up a person with a positive screening test, is the major reason the NHS wants to focus on maintaining the high specificity (low false positive) test. With a lower specificity comes a greater number of positive results and therefore a greater number of false-positive results. Each patient with a positive result requires a follow-up, and the NHS simply cannot handle that volume or expense.

*How can we assure the high specificity?* Sensitivity (the cancer detection rate) is not as important as specificity to the British because increasing the sensitivity decreases specificity. A lower specificity leads to a greater need to follow up positive tests, which, as mentioned, cannot be absorbed by the British system. In fact, the workshop participants discussed several ways to increase specificity (to the detriment of cancer detection)—something that we avoid in the United States. For example, two suggested ways of increasing specificity were to use unhydrated slides and to obtain the test every 2 years.

*How would you fund the screening?* The NHS lives within a fixed budget. It is felt unlikely that the Members of Parliament would increase funding to the NHS to pay for colorectal cancer screening. It would be difficult to take money away from another program, such as prenatal care, to fund colorectal cancer screening. Funds might be shifted to colorectal cancer screening from other programs in gastroenterology, oncology, or prevention. By the end of the meeting this issue remained unresolved.

*What is the opportunity cost?* In other words, if extra money for colon cancer were found, is colorectal cancer screening the best place to spend this new-found money? For example, in Great Britain colon cancer is treated less aggressively (and less expensively) than in other countries. If new money were found, would it be better spent in colon cancer treatment instead of screening?

It is important to realize that these questions and



answers involve the details of the program that the NHS feels need to be worked out *before deciding whether the program could or should be implemented*. At the end of the first workshop, Sir David Carter, the head of the NHS, said that he predicted that ultimately colorectal screening would be implemented as policy. It appeared that up to 40% of the participants were uneasy with his assessment, since it was not yet clear that all the details could be worked out so that the benefits of the program justify its opportunity costs. The second workshop will be held later in 1997 to determine the fate of an NHS colorectal cancer screening policy.

## SUMMARY

Two vignettes about two health care systems (actually, one system and one non-system). Two different cancer screening programs. Two different approaches to developing a national health

policy. This is not an issue of money; either approach could be used inside any budget. One approach looks at the entire health care delivery system, trying to maximize gain while assuring appropriate care is provided. The other approach tries to get votes.

Is there any doubt which is the better method?

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