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WHY DON'T WE UNDERSTAND THE PUBLIC HEALTH IMPACT OF DEVELOPING STI SERVICES IN PRIMARY CARE?

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Sohal et al have attempted to evaluate the public health and economic impact of incentivized primary care services on STI diagnoses across a population. In doing so, they have illustrated the difficulties in obtaining information that bedevil the planning of sexual health services in the UK(1;2), and elsewhere(3).

A key public health motive for developing such services is the provision of improved access to testing and care. This should be measured in terms of outcomes with potential impact on transmission dynamics, particularly duration of infectivity(4). How can we tell whether this has been achieved? Measures of access, detailed trends in testing and diagnosis rates and – importantly – measures of partner notification outcomes are essential in making any such assessment.

Real challenges still exist describing whole sexual health economies, and therefore in comparing them, between areas or across time. These contribute to the vulnerability of STI services, since the impact of good and bad decisions alike is largely invisible. A continuing lack of STI testing and diagnostic data from primary care remains a handicap – yet it can provide rich information(5;6)). Economic evaluation of primary care services requires measuring rates of duplicate attendance, and these data are not available.

And without special pleading for specialist services, it is essential to consider the quality of care for patients diagnosed in the primary care service, in terms of public health outcomes. The National Institute for Clinical Excellence has now recognised the gap in provision of partner notification for patients diagnosed in primary care in its recommendations(7). No data on this key issue are available to Sohal and colleagues, and CHPCT is no exception in this respect.

Given the limitations of the available data, what has the the service described here achieved? It could be argued that interested practices are providing exactly what they provided before, after accounting for secular trends. The same practices are providing the same proportion of tests and diagnoses as before incentivization, but are now being paid for it.

It is possible that these data mask some real improvements – if partner notification outcomes did improve without duplicate appointments, if patients diagnosed with with an STI were also offered the recommended HIV test (which we know was not happening in 2000(8)), then some public health gains may have been achieved. But we simply cannot tell from the data available. It seems however unlikely that access to services has changed for the many patients registered at the practices that are doing little testing. It is even possible that the incentive has legitimised non-provision of basic testing for their patients within the practices, which is arguably within the basic primary care contract – their testing rates are not given separately.

Information is power. There is an urgent need for policymakers, researchers, and surveillance authorities to develop simple, reproducible “rapid assessment” methods, for describing and comparing both epidemiological and outcome data. And it is essential that methods of data collection are planned as a part of newly developing services. Without better information, the provision of STI services will always be a Cinderella, at the mercy of planning whims.

Competing interests

Jackie Cassell and Angela Bailey are engaged in research on sexual health services in primary care.

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