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Article (Unspecified)
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difficult as both provide services unavailable in the other. Therefore, we have focused on the costs for the PCT in each venue as opposed to a comprehensive health costs analysis.

The £2000 retainer fee added to the £930 cost per STI diagnosed by local-enhanced service GPs. The local-enhanced service costs are increased by the one-third of practices that received the retainer but made no STI diagnosis. The decision to pay per positive diagnosis, rather than per STI test, was unpopular with some GPs, but is supported by feedback from other PCT (H Wheeler, personal communication).6

As STI testing in primary care becomes more established, this service may evolve. The sexual health local-enhanced service may provide support for GPs wishing to diagnose and treat STI.

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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, because 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.6 7 Economic evaluation of primary care services requires measuring rates of duplicate attendance and these data are not available.

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 Health and Clinical Excellence has now recognised the gap in the provision of partner notification for patients diagnosed in primary care in its recommendations.8 No data on this key issue are available to Sohal and colleagues1 and City and Hackney Primary Care Trust is no exception in this respect.

Given the limitations of the available data, what has 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 incentivisation 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),9 then some public health gains may have been achieved. We simply cannot tell from the data available. It seems unlikely, however, 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 the 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. It is essential that methods of data collection are planned as a part of evaluating effectiveness, and comparing both epidemiological and outcome data. It is essential their impact on transmission dynamics, particularly the duration of infectivity.10 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.

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Commentary

Sohal et al1 have attempted to evaluate the public health and economic impact of incentivised primary care services on sexually transmitted infection (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 United Kingdom3 and elsewhere.4 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 the duration of infectivity.5 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.


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