oral contraceptive pills in unselected women seem unlikely.

Now that the data are published, it seems clear that the Committee on Safety of Medicines did what it had to do. Delaying its announcement until all the studies had been published would have incurred a further 500 000 uninformed woman years of use of the third generation oral contraceptive pills, which might have resulted in 80 new cases of venous thromboembolism and possibly one death. We have no clear idea how many women responded to the committee's advice and in what way, so these numbers are speculative, but the number of additional unwanted pregnancies, and related cases of venous thromboembolism, will appear in official statistics in a few months' time. The cost in terms of anxiety and the new side effects from switching over to second generation pills cannot yet be measured. However, the committee's advice should have included, for all the data available, simple standardised point estimates of risk (with corresponding confidence intervals) for second and third generation oral contraceptive pills. People would then have been able to assess the nature and consistency of the evidence for themselves.

From the four studies we now have a pooled estimate of relative risk of venous thromboembolism in unselected women of around 2.0 (95% confidence interval 1.4 to 2.7). We also have important data, from the second paper published in this issue⁸ and from other studies,⁹ that the greatest risk to health comes from smoking while taking the pill, rather than from the type of pill being used. Young women smokers who use the pill are 10 times more likely to suffer myocardial infarction than users who don't smoke (odds ratio 10.1; 5.7 to 17.9).⁸ This risk is higher among users of second than third generation pills, but the difference, unfortunately for those who believe that third generation pills improve the lipid profile, is not statistically significant. During the next century, large numbers of young women will certainly die from smoking related diseases; about half of regular smokers will die prematurely from their addictive habit.¹⁰ Although the secretary of state for health, Stephen Dorrell, felt unable to

ignore the expert advice from the Committee on Safety of Medicines, he continues to ignore the published advice of his own department's report.¹¹ By his prompt action, he may have prevented one death from venous thromboembolism, but he will not be around to count the cost of his government's inaction in vital areas of tobacco policy.

Now that the dust has settled, the message for doctors seems clear: when advising patients on which pill to take, a careful personal and family history for increased risk of venous thromboembolism is essential, followed where appropriate by screening for thrombophilia. Women with risk factors for venous thromboembolism should probably not start taking third generation pills; but once informed of the small excess risk, women already taking them satisfactorily may choose to continue using them. Let us hope that any disproportionate fear of litigation soon gives way to intelligent and well informed collaborative decision making.

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Men's health

Unhealthy lifestyles and an unwillingness to seek medical help

Differences in men's and women's health experience and behaviour are well recognised.¹ Although policy makers have focused for some years on women's health, men's health has been less well defined. There are now signs that the profile of men's health is growing. Increased interest is expressed in, for example, the 1992 annual report by England's chief medical officer²; a national conference held in London in July; and increasing media coverage is reflected in the growth of men's health magazines.

The growing interest has largely concentrated on aspects of men's health relating to diseases of the prostate and testicle. This sex specific approach encourages comparisons with the women's health movement, with campaigns for national screening programmes for prostatic and testicular cancer analogous to the screening programme for breast cancer. Such an approach has its place. Prostate disease is extremely common, but there is little agreement about effective treatment.³ Half of all men have benign prostatic hyperplasia by the time they are 60 years old, and 90% by the time they are

85. Prostate cancer is the second commonest cancer in men in Britain and the numbers diagnosed are increasing, particularly in older men. Occult cancer exists in about 30% of men over 50 and there is currently no way of distinguishing which tumours will remain dormant and which will metastasise rapidly. The much vaunted test for prostatic cancer, prostate specific antigen, is not sufficiently sensitive or specific to be effective as a diagnostic screening tool.⁴ Similarly, population based screening for testicular cancer has not been recommended, even though it is the commonest cancer in men in Britain aged 20-34 and early treatment has good results. There are, however, good arguments to support campaigns to raise awareness, such as the Cancer Research Campaign's "Keep your eye on the ball," which was launched in September 1995.⁵

Although much needs to happen in such sex specific areas of men's health, concentrating on these areas ignores the important effects of psychosocial pressures on men within modern society. Statistics show that men are likely to die

younger from common diseases and to suffer illnesses in which environment and lifestyle play an important part. Men are more likely than women to have unhealthy lifestyles, to drink too much alcohol, to smoke tobacco, and to eat a less healthy diet.⁶ Risk taking and aggression, commonly exacerbated by alcohol, are more prevalent among men, as reflected by the higher accident fatality rates. Men in England and Wales have an average life expectancy that is six years shorter than women's, a 3.5 times higher risk of death from coronary heart disease under 65, a suicide rate double that of women, and a greater risk of contracting HIV and AIDS. The recent report on variations in health⁷ showed not only that there is a gap in mortality between men and women but that it is increasing. This has also been noted in the United States.⁸

It is not just the impact of lifestyles and biology but society's expectations of men that need to be addressed. Such expectations have created an environment in which men are less able than women to recognise physical and emotional distress and to seek help. Available data show that for most illnesses men are less likely than women to consult their general practitioners,⁹ yet their hospital admission rates for diseases such as coronary heart disease and stroke are higher.

The common assertion that women consistently report higher levels of ill health than men is now being questioned. MacIntyre and colleagues have found that the direction and magnitude of sex differences in health vary according to the particular symptom or condition in question and the patient's phase of life.¹⁰ They suggest that sex differences have become oversimplified and should be re-examined periodically to monitor the impact of changes in sex roles on people's experiences of health and illness.

Differences in health status between groups of men are also of concern. The inverse social gradient for mortality is unlikely to be due solely to social class differences in individual lifestyles. Research shows that men of lower social status suffer more financial problems, more stressful life events, less adequate social support, and more feelings of

disempowerment within the workplace. In Britain, Asian men have higher rates of heart disease than do their white compatriots,¹¹ and, as noted by Professor Michael Chan at the Medical Group conference on men's health in London last July, Afro-Caribbean men are more likely to suffer from severe mental illness and to be admitted to secure wards. Professor Chan, director of the NHS ethnic health units, suggested that improving the health of men from ethnic minorities will depend on reducing stress generated by unemployment, poor housing, and other forms of racism.

There is little evidence for effective interventions to remedy the inequalities in health faced by men, but the experience of the HIV/AIDS programmes suggests that men need to be targeted, particularly at places where they meet together.¹² Even if equitable health status for all men will be achieved only by redressing social inequalities, more could certainly be done to increase men's access to health care and to promote health, especially in the workplace.

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Contestability: a middle path for health care

Combines competition with planning

Quietly in the night, competition in British health care has slipped away, its passing unremarked and little noticed by those who brought it into this world. The death sentence was first signalled by William Waldegrave when he was secretary of state for health. As Mr Waldegrave commented at the time, the NHS market "isn't a market in the real sense . . . it's competition in the sense that there will be comparative information available."¹ The change of direction was confirmed by Virginia Bottomley. In her valedictory speech in 1995 Mrs Bottomley extolled the virtues of planning and collaboration; the word "competition" scarcely crossing her lips.² Her successor, Stephen Dorrell, has echoed this line, most notably in a personal letter to the chairs of health authorities and trusts. In his letter Mr Dorrell referred to the achievements of the NHS management reform, and at no point did he mention markets and the benefits that would arise from competition in future. Indeed, when was the last time any health minister urged those in the NHS to leave behind the legacy of planning and grasp the competitive opportunities available to them?

The decoupling of markets and health care is not a uniquely British phenomenon, as developments in Sweden and to a

lesser extent the Netherlands indicate. After a decade in which competition was seen as the solution to the problem of inefficient health service provision, new ideas are under debate. It seems as if the competition vogue may have had its day, although in the eddying currents of political debate it is not always clear when the tide has finally turned.

Why has the attempt to bring markets into health care been a policy failure? In the British context there are several reasons. To begin with, the scope for competition in many parts of the NHS is limited by the existence of monopoly providers. Furthermore, even where there is a choice of providers, it has been difficult to control the effects of market forces. The result has been harmful instability, particularly in London and other cities where major changes in hospital provision have emerged onto the agenda. In recognition of the limits of competition, managers and doctors have moved increasingly to establish collaborative arrangements in which purchasers and providers work together on a long term basis. Not only is this a pragmatic response to weaknesses in the original policy design, but also it has been justified by reference to best practices in industry. Successful companies, it is argued, work in partnership with their suppliers and seek