Access controls on bmj.com

Restore true open access to bmj.com

EDITOR—I joined the BMA when it ran a principled campaign in opposition to Margaret Thatcher's proposals for "reforming" the NHS. There have been other occasions when I have felt proud to be a member—for example, when a BMA spokesman took a principled stand recently about the scandalous acquiescence in NHS recruitment of staff trained at the expense of some very poor countries.

In contrast, I feel ashamed of the BMA's decision to restrict access to bmj.com,^{1 2} and I am one of several people who have tried (so far unsuccessfully) to prompt debate about this decision at the annual representative meeting. Making bmj.com available to the world without charge reflected creditably on an association of well paid professionals. At a time when the reputation of the medical profession is under attack from a variety of quarters, this generous spirited gift to the public could have been highlighted by the BMA. Instead, it decided that it would not continue to subsidise open access.

I regard the creation of a fully open access bmj.com as the most important single advance in medical publishing during my professional lifetime. Not only did it bring research, educational material, news, and views to a very wide readership at no cost to readers, it developed a unique forum for lively debate, engaging a wide variety of individuals and constituencies.

The bmj.com of 2005 is not what bmj.com used to be, and I am already accessing it less than I used to now that the site demands passwords from me. Members of the BMA should be given the opportunity to debate at this year's annual representative meeting the decision to withdraw support for fully open access to bmj.com. I believe that decision has further tarnished a professional image that had actually been enhanced by the creation of the pre-2005 bmj.com.

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Letters appearing here are an edited selection of rapid responses originally posted on bmj.com

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- 1 Access controls on bmj.com from 7 January. *bmj.com* 2004. <http://bmj.bmjournals.com/cgi/content/full/329/7478/DC1> (accessed 7 Apr 2005).
- 2 Godlee F. Open access, and proud of it [Editor's choice]. *BMJ* 2005;330. (2 April).

Enable accessibility and avoid formation of two tier journal

EDITOR—It is a great shame that a charge is now levied for access to bmj.com,¹ and I am particularly conscious that this will restrict access by those such as students and doctors in training, not to mention the public and colleagues outside the United Kingdom. Only last month at a hospice conference I suggested that delegates referred online to an editorial by Richard Smith in 2000.

For me as a clinician and academic, the greatest success and advance of the *BMJ* in the past few years has been its website and easy access to its archives. In addition is the opportunity to debate in an electronic forum such as bmj.com.

Although I also subscribe to the *Lancet*, I realise that for many, electronic access to this journal (unlike the *BMJ*) is not possible or affordable and so will reduce the size of the readership and circulation.

In an electronic response on a similar theme, about charging authors to submit papers,² I said: "Yes, open access might reduce the cost of scientific publishing, but at what cost? Introducing a fee to authors for publication could quickly lead to two tier research as access to publishing research in online journals would be limited to a small number of practitioners who may have gained the necessary research funding. This would result in a potentially limited pool of advances in medicine being disseminated to the scientific community and thus quality journals such as the *BMJ* with their present reputation would be lost."³

This issue should be debated further.

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List of countries with free access seems incomplete

EDITOR—As a BMA member based in Scotland, I am not directly affected by the recent changes in access to bmj.com.¹ However, while expressing gratitude at the number of countries to which the *BMJ* has granted free access (including those benefiting from the charitable gesture in the wake of the tsunami), I note that the list is taken directly from the World Health Organization's Health InterNetwork Access to Research Initiative (HINARI, www.healthinternetwork.org) project for free library resources in poor countries.

If the BMA really wished to make a difference in poor countries it needs to know which countries really are poorest—gross national product per head and gross national income per head are reasonable methods of estimating this. Would it not, therefore, make most sense to look to the data held by international or economic institutions, rather than that held by health organisations?

The World Bank might suffice as an appropriate authority on the level of poverty of individual countries. According to its data,^{2 3} many countries not included by HINARI ought to be classed as low income, such as India and Pakistan (with a gross national income of \$530 and \$460 per head, respectively).

If the *BMJ* wishes to continue to be seen as a caring establishment, it should perhaps rectify this oversight.

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- 1 Access controls on bmj.com from 7 January. *bmj.com* 2004. <http://bmj.bmjournals.com/cgi/content/full/329/7478/DC1> (accessed 7 Apr 2005).
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Switching prescription drugs to over the counter

Consumers may benefit financially in examples from the US

EDITOR—Cohen et al say that switching drugs to over the counter increases costs for most insured patients in the United States because of resultant changes in drug benefits.¹ Most health plans restrict drug coverage and increase copayments when

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one member of the class is made available over the counter. However, evidence from recent switches from prescription to over the counter shows that patients benefit financially despite such restrictions and increased copayments.

The switch of loratadine has been shown to be cost effective for consumers, insurers, and society.²⁻³ An examination of the average out of pocket cost for second generation antihistamines shows that health plan members paid less for loratadine after it was made available over the counter. Previously at least one second generation antihistamine was available through most health plans as a preferred brand product, with a copayment of some \$17 (£8.99; €13.11) per month.⁴ Recent pricing for generic over the counter loratadine (10 mg once a day = \$8.50/month; www.drugstore.com, 10 Jan 2005) shows that it is much less expensive than the average copayment before the switch. In addition, the price of over the counter omeprazole (20 mg once a day = \$19 per month; www.drugstore.com, 10 Jan 2005) is equivalent to the average copayment in 2003 for preferred branded drugs (\$19).⁵

However, the opportunity cost of obtaining a prescription drug must include the time cost of the doctor and pharmacy visit (two to three hours at \$20 per hour).³ Although some insured patients may suffer from loss of coverage or higher out of pocket costs, evidence from the most recent switches from prescription to over the counter in the United States shows that most insured (and uninsured, as argued by Cohen et al) patients benefit financially from over the counter availability.

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Chicken and egg scenario is possible

EDITOR—Cohen et al suggest that prescription drugs become candidates for switching to being available over the counter if they meet three criteria: use for non-chronic conditions, easy to self diagnose, low potential for misuse.¹ Whether this is the policy of drug regulators is unclear.

Perhaps this view is drawn from examination of current over the counter products? Drugs available over the counter generally meet these criteria; therefore they must be the basis for approving switches. Could this be a chicken and egg scenario?

Most switches are instigated by the manufacturers to generate profits. This requires a potential market for the switched drug, which itself relies on consumers recognising the need for the drug and being motivated to buy it. People less involved in their own health might not see the need for preventive drugs, making switching likely to fail owing to poor sales. So the manufacturers never apply in the first place.

So are the three "chicken" conditions creating a switched "egg," or does the egg of what would succeed in the marketplace create the chicken conditions?

Today people are better informed about their health and are exposed daily to messages about improving it. The huge growth in statin margeterines, for example, shows that they are open to new interventions to reduce surrogate markers of coronary risk. So is the reason behind over the counter simvastatin a change in con-

sumer behaviours rather than a change in regulatory conditions?

Debate over the evidence has been described elsewhere,² but examination and extrapolation of the existing evidence base shows that there should be benefits, albeit possibly small.

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Competing interests: MH was paid to write professional guidance on over the counter simvastatin by the Royal Pharmaceutical Society of Great Britain.

- 1 Cohen JP, Paquette C, Cairns CP. Switching prescription drugs to over the counter. *BMJ* 2005;330:39-41. (1 January)
- 2 Hird M. Over-the-counter simvastatin—is it hype or a genuine hope for the future? *Pharm J* 2004;31 July:156-60.

Willingness to buy statin over the counter is not related to risk of heart disease

EDITOR—Appropriate self treatment is an important aspect of both the European and American healthcare systems.¹ In August 2004 simvastatin 10 mg (Zocor Heart-Pro) became the first statin approved for over the counter sale by pharmacists for people at "moderate" risk of a major coronary event.² Is this another ill conceived example of "creeping privatisation" or a reasonable attempt to empower consumers?³⁻⁴

We compared the characteristics of people who when questioned expressed a willingness to buy simvastatin with those who did not. JQ, also a locum pharmacist, selected subjects who seemed likely to be

Characteristics of people willing to buy simvastatin 10 mg, Bristol, August 2004

	No	% of subjects willing to buy		P value (χ^2 test)
		Yes	No	
Male	51	47	53	0.8
Female	51	45	55	
Smoker	24	50	50	
Non-smoker	78	45	55	0.7
Ex-smoker:				
Yes	32	44	56	
No	50	48	52	0.9
First degree relative with coronary heart disease:				
Yes	48	46	54	
No	54	46	54	0.9
Pay UK prescription charges:				
Yes	48	52	48	
No	54	41	59	0.3
Drug treatment for coronary heart disease:				
Yes	16	56	44	
No	86	46	54	0.4
Have, or have had, diabetes:				
Yes	7	57	43	
No	95	45	55	0.5
Drug treatment for high blood pressure:				
Yes	22	41	59	
No	80	48	52	0.6
Irregular heartbeat:				
Yes	8	75	25	
No	94	44	56	0.09
Thyroid problems:				
Yes	11	55	45	
No	91	45	55	0.6

among the target population as they entered one of three pharmacies in Bristol over 10 days in August 2004. An anonymised, self completion questionnaire was administered, with informed consent, to people who were not taking statins.

Four weeks after deregulation only one purchase had been made in the three pharmacies. Altogether 102 people responded to the questionnaire (51 men, mean (SD) age 56.8 (10.6) years). Overall 47 (45%) respondents were willing to purchase simvastatin (24 men, 23 women), but we found no differences in willingness to buy by any of the variables investigated (table). Forty three (94%) of those who were willing to buy would do so only after consulting their general practitioner. Sources of previous knowledge of simvastatin among the 34 participants who had heard of it were television or radio (17), general practitioner (10), magazine or newspaper (4), and friends (3).

Simvastatin is as likely to be used by people at low risk of coronary heart disease as by people at higher risk, which shows limited potential impact of over the counter statins on population health. Most people would consult their general practitioner first, which implies that patients lack faith in their own ability to manage their cholesterol concentration.

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- 1 Cohen JP, Paquette C, Cairns CP. Switching prescription drugs to over the counter. *BMJ* 2005;330:39-41. (1 January.)
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Over the counter licensing is linked to direct to consumer advertising

EDITOR—Cohen et al ask what is driving increased availability of drugs over the counter.¹ I believe that the main reason the manufacturers of simvastatin have lobbied (successfully) for permission to sell a 10 mg dose over the counter in the United Kingdom is to enable direct to consumer advertising of this previously prescription only drug.

People with a 10 year risk of ischaemic heart disease of 15% or greater (28.4% of men and 6.7% of women in the 1988 health survey for England) who approach their pharmacist in response to the advertising will be directed to their general practitioner for an NHS prescription even though, owing to budgetary restrictions, many primary care trusts advise treating only those with a 10 year risk of 30% or greater. Anyone with a 10 year risk of 10-15% will be offered the chance to buy the drug at full cost from the pharmacist, but of

course these people are likely to approach their general practitioner to ask why if the drug is as effective as the advertising has led them to believe they cannot obtain it on the NHS.

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- 1 Cohen JP, Paquette C, Cairns CP. Switching prescription drugs to over the counter. *BMJ* 2005;330:39-41. (1 January.)

Direct to consumer marketing

Switch to over the counter can become indirect advertising directly to consumers

EDITOR—Mansfield et al raise concerns about how advertising directly to consumers may cause inappropriate pressures to use drugs and may exaggerate benefits while minimising risk information.¹ They state that the purpose of advertising is to persuade rather than inform. The same edition of the *BMJ* contained a review of switching prescription drugs to over the counter.² Can this switch enable consumer advertising?

Simvastatin 10 mg (Zocor Heart-Pro) is supplied over the counter to reduce the risk of a first coronary event in people who are at 10-15% risk of coronary heart disease over the next 10 years. People like this would not normally be treated with statins, after a formal risk assessment in the NHS.³ There is no direct evidence that simvastatin 10 mg daily works here; no trials exist of statins sold over the counter, no data on adherence to therapy, and no knowledge on the safety of using the drug over the counter. Pharmacovigilance is lacking.

Advertisements for simvastatin over the counter advise that the drug can be used if risk of a cardiovascular event is "one in seven" and propose reduction of risk by a third over three years. They do not describe potential harms nor discuss lifestyle changes, such as smoking cessation or increased exercise. They do not explain the limitations and uncertainty of benefit; one estimate from a review of primary prevention studies, using higher doses of statins, is that 71 patients with greater cardiovascular risk have to be treated with a statin for three to five years to prevent one heart attack or stroke.⁴ One assumption with lower dose and lower risk is less or no benefit. Possibly, instead of long term purchase of simvastatin, people will pressure their general practitioners to prescribe,⁵ and thus the switch to over the counter becomes indirect advertising directly to consumers.

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Advertising directly to consumers may affect patients' safety

EDITOR—Mansfield et al discussed direct to consumer advertising of drugs.¹ Consumer advertising on television is different from drug advertisements in newspapers and magazines.

Television advertisements mention risks very quickly, whereas the required "brief summary" in print advertisements includes more detailed information. Unfortunately, such summaries are usually illegible (because of tiny type sizes), unreadable (because of long and complicated sentences), and incomprehensible (because they require consumers to understand specialised research and pharmacological and statistical concepts).²

My readability analysis of six brief summaries found them to be written at a graduate school reading level; four "patient summaries" were written at grade 11-12 (for students aged 17-18), which was better, but still too difficult for many consumers.³

Cyclo-oxygenase 2 inhibitors were widely promoted through consumer advertisements. But how could patients understand their risks if they couldn't understand the brief summary that described those risks? At some point, do patients (and their doctors?) choose what ultimately become unsafe drugs because they can't understand the risks?

Direct to consumer drug advertisements aren't just about risks and benefits but about how patient safety can be compromised by incomprehensible information.

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Mapping choice in the NHS

Analysis is only as good as data

EDITOR—Living in the north of England, I was drawn to the article by Damiani et al on mapping choice in the NHS by the large red patches on the maps that covered what I think of as my local area.¹ Large areas of the north of England seem to be an unacceptably long travelling time from the nearest hospital.

However, looking a little closer I realised that large hospitals at Ashington, South

Shields, Carlisle, Hexham, Whitehaven, Barrow, Lancaster, and Preston are missing from the map. This lack of accuracy on hospital locations in the part of the country that I know makes me worry about the accuracy of hospital locations plotted in the rest of the country.

The authors say that they obtained the postcodes of all NHS trusts dealing with acute conditions. I suspect that they may have obtained a list of postcodes of trust headquarters. Unfortunately, this is an extremely inaccurate method of locating hospitals, particularly when some trusts are responsible for several acute hospitals that are many miles apart.

I remember being taught that any analysis is only as good as the data on which it is based. In this article, a potentially interesting analysis seems to be based on fundamentally flawed data on hospital locations. I only hope (for the sake of all who work in the NHS north of Watford) that policy makers do not base decisions about our long term future on similar data.

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Competing interests: None declared.

1 Damiani M, Propper C, Dixon J. Mapping choice in the NHS: cross sectional study of routinely collected data. *BMJ* 2005;330:284. (5 February.)

Authors' reply

EDITOR—The facilities marked on the maps are trust headquarters, so fewer hospital locations are marked on the maps than there are hospitals dealing with acute conditions. We marked only headquarters because some of the administrative data we use (beds, waiting times) are available at trust level alone. Some data were missing for a few trusts undergoing change.

We do not consider that using trust data seriously alters our analyses or our conclusion that the pattern of potentially available facilities across England is very different if only supply (be that beds or hospitals) alone is considered compared with supply allowing for the number of people already waiting for treatment at that supply.

When calculating the facilities that people in a location have access to we take into account all the facilities in a trust. This will mean that in rural areas for some locations the number of beds that can be reached will be upwardly biased, while for other locations in the same area the number of beds that can be reached will be downwardly biased. To overcome this we deliberately presented our results as maps that average over largish areas. (The specific case of the Lake District is discussed on bmj.com in the longer version of this reply.)

We do not think that the relative position of areas will be strongly biased by the use of trust headquarters. It may give rural areas—which are neither the whole of

the country north of Watford nor located solely north of Watford—slightly longer travel times than non-rural areas. But our results were robust to changing travel times, so we do not believe that this bias will be large.

We would not advocate the use of data at trust level for analysis of travel patterns within a region, for precisely the reasons that Walmsley notes. But we consider our results to be robust as an analysis comparing the relative pattern across the country. We also hope that this paper will stimulate greater use of administrative data, which can only improve as a result.

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A longer version of this reply is available on bmj.com

Rising healthcare costs, equity, and electoral success constitute trio of tensions

EDITOR—All governments are seeking to find healthcare strategies that tackle the challenge of rising costs and patients' expectations while retaining popularity with their voters. Both UK and Australian governments have developed policies to reduce long waiting times in state funded hospitals. In their analysis of the effects of increasing use of private insurance on the Australian healthcare system Hall and Maynard identify that the strategy of subsidising insurance premiums has been expensive but electorally successful.¹ The UK government has chosen to buy increased capacity from the independent sector while not specifically encouraging individuals to take out private insurance.

An important downside of the Australian government's health policy, as Hall and Maynard observe, is that it has differentially favoured rich people. In the United States, private medical insurance, the predominant vehicle for funding health care, has disadvantaged poor people.² This is not the case in Canada, which has maintained a tax funded, universal healthcare system. A comparison with the United States showed no significant association between income inequality and mortality in Canada at provincial or metropolitan level.³ In the United Kingdom there is evidence of a growing divide in cancer outcomes between rich and poor.⁴ The Australian experience may serve a timely caution to overdependence on the independent sector.

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We must argue against choice

EDITOR—Godlee raises concerns about the choice bandwagon,¹ but I disagree that it is hard to argue against choice in health care. Choice is great when buying a car or a bottle of wine, but the advantages transfer to health care only if patients are consumers in a marketplace. Such a model is in nobody's interest. Patients do not need choice but properly funded high quality accessible local facilities, coupled with robust mechanisms to ensure that doctors are fit to practise.

Choice is sold to us by politicians to increase patients' confidence in the care they receive. If patients choose their doctors from league tables they will be satisfied that they are getting the best. But if one patient gets the best, the next, by definition, will get second best, with an implicit assumption that for some people to get better care than others is acceptable. If patients avoid certain doctors, and doctors in turn avoid risky patients, how can any kind of coherent health service be planned and delivered on the basis of need? Out go the NHS founding principles of universality and equity.

Of course the public has a right to feel confident that doctors are up to the job. Revalidation and the increasingly rigorous mechanisms of clinical governance will help. Quality data should be used to ensure good clinical care, not to compile league tables to facilitate spurious and ultimately damaging choices.

Politicians need us to embrace the concept of choice to impose their mixed economy of health care. When I refer patients for specialist care, they will soon be given a choice of five providers, one in the private sector. An increasing proportion of NHS revenue will end up paying the shareholders of private healthcare companies.

We should have no illusions: choice is wholly a political agenda, whose hidden aim is to privatise the NHS incrementally. Argue against choice we must.

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Competing interests: None declared.

- 1 Godlee F. Heading where exactly? [Editor's choice] *BMJ* 2005;330. (26 March.)