With appropriate incentives, general practice can improve the coverage of the National Chlamydia Screening Programme

INTRODUCTION AND CONTEXT

The National Chlamydia Screening Programme (NCSP) is already underway in England and the last phase of the programme rolled out in April this year, with the aim of covering all primary care trusts (PCTs) in England by 2007.

The pilot studies that took place in Portsmouth and the Wirral in England demonstrated general practice is feasible as a venue for screening; it identified the most number of cases outside GUM in both pilot sites, with positivity rates of up to 10%. Since the rollout of the screening programme, general practice comprised 42% (131 out of 310) of all screening sites in phase 1. Although participation of general practices was not mandatory, it was included on a ‘cost-neutral’ basis. Compared with the pilots, a much lower proportion of screening was done in general practice (10%) but the positivity was comparable with that of community contraceptive clinics (10% versus 10.9% respectively).

The first annual report acknowledged engaging general practice was a challenge, even though some innovative strategies were used to facilitate this. By the time the second annual report was published in November 2005, general practice comprised a third of screening sites but yielded only 10% of the total number of tests; despite this, the positivity remained stable at just under 10%.

COVERAGE OF A SCREENING PROGRAMME

An adequate coverage of the at-risk population is crucial to the success of the chlamydia screening programme. The pilot studies in Portsmouth and the Wirral quite clearly demonstrated the excellent coverage provided by general practice, which detected up to half of cases in Portsmouth and a quarter in Wirral.

Family planning clinics may be accessed by women who seek advice about reproductive health and request contraception. Women who are less informed about sexual and reproductive health might not access such clinics and therefore could be at higher risk of STIs and unplanned pregnancies. Young men are unlikely to access family planning clinics as these venues traditionally target women.

There is evidence from survey data and prevalence studies to suggest that the sexually active population of both sexes attend general practices, and in some instances have STIs diagnosed and treated too.

BARRIERS TO EFFECTIVE IMPLEMENTATION

Despite the potential of general practice to offer a good coverage for chlamydia screening, there are still concerns from GPs and practice nurses on the implementation of screening. They feel they have little information about the benefits and effectiveness of screening. The opportunistic nature of the programme means raising this in a seemingly unrelated consultation, that some may feel uncomfortable about. Another difficulty is trying to prioritise this in the context of many other targets in the new GP contract.

The practices participating in the pilot studies were paid an honorarium for taking part in the research, which may have accounted for the high screening rates. Since the financial incentive was discontinued, the proportion of tests done in general practice dropped significantly.

STRATEGIES FOR INCREASING COVERAGE

Many public health interventions, such as cervical cytology screening and influenza vaccinations, have been successful in general practice. Health promotion and prevention strategies in general practice have historically been incentivised, and chlamydia screening should, therefore, be considered in the same context.

Financial incentives would increase the cost of the screening programme, but unlike cervical cytology, the current technology available for chlamydia testing enables clinicians’ input to be minimised. There is evidence to support the use of non-invasive sampling such as urine and self-taken vaginal swabs for screening. These have been shown to be acceptable to those who are screened.

More recently, the Chlamydia Screening Studies (ClaSS) group suggested the use of general practice in a mixed economy of opportunistic and systematic screening could help increase the coverage of the screening programme.

CONCLUSION

A screening programme requires a high coverage to achieve success, and a high number and range of screening venues to make it equitable. Current deficits in
many PCTs in England have resulted in some areas not implementing or withdrawing screening, and thereby threatening the coverage and effectiveness of the programme. It is unacceptable to rely on the goodwill of the few enthusiasts in general practice to support chlamydia screening. Recent agreement among the General Practitioners Committee (GPC) of the British Medical Association, the NHS Employers and the health departments of the four nations in the UK on the redistribution of points in the Quality and Outcomes Framework of the GP contract has been a disappointment for advocates of sexual and reproductive health. Yet again, another opportunity was missed to incentivise GPs to improve the sexual health of the UK’s population.

We have an opportunity to get GPs involved in sexual health promotion; this ought to be reflected in the GP contract. If the GPC and Department of Health see fit to incentivise GPs for largely political initiatives such as ‘Choice and Book’, they should broker a deal on something that has a tangible public health benefit.

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Competing interests
Dr Richard Ma is a member of RCGP Sex, Drugs & HIV Task Group. He is also a GP member of the National Chlamydia Screening Steering Group (NCSSG) and was invited by NICE Public Health Intervention Advisory Committee (PHIAC) to give expert opinion on sexual health interventions. This article was written to reflect the views as a GP and not of RCGP, NCSSG or NICE PHIAC.

REFERENCES