BMJ on the iPad

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About BMJ

• Around since 1840
• One of the “top five” weekly general medical journals
• 120 000 print circulation (BMA members, personal subs, libraries)
• 1.67m online visits per month
• 66% of web traffic from outside the UK
BMJ digital so far

- 1995 – first general medical journal with a web presence
- 1998 – paperless letters to the editor
- 2008 – full online first publishing model
- 2009 – iPhone apps for Student BMJ and others
- 2010 – first general medical journal on the iPad
- 2011 – move to Apple Newsstand (November)
- 2012 – other (Android) tablets, plus Kindle?
Why the iPad?

• 2011 Market research – 22,000 readers worldwide
• “A sense of the print issue”
• Potential as point of care tool in medicine
• Landscape/portrait format
• Aesthetics
• October 2010, of the 40,812 visits from mobile devices, 7,803 were from the iPad
• October 2011, of the 76,910 visits from mobile devices, 27,957 were from the iPad
The iPad cometh

“Hallelujah, the iPad is among us...If you haven’t seen one, it is a thing of beauty: the size, the colour and depth of the images, the tactile screen... we hope to be available on the iPad by the summer. This will give us time to do more than simply replicate either the website or the print journal.”

Fiona Godlee, May 2010: *BMJ* 2010; 340:c2835
Objectives

• “Late summer” launch planned
• Capitalise on continuous publishing model
• A “journal” channel plus live feeds of news, blogs, podcasts, video
• Archive links to drive web traffic
• Boost video and podcast traffic
Pricing

- £2.99 single issue
- £9.99 four issue subscription
- No annual sub planned for launch
- Target audience international doctors
- Not a BMA membership benefit
Promoting successful ageing through integrated care

Diip V Jeste

The most important step is to improve society’s attitudes towards older people

Longevity increased in most countries during the first half of the 20th century mainly as a result of reduced infant mortality from infections and other preventable causes. However, since the 1950s the average lifespan has again increased, mainly because older people with chronic illnesses such as cancer, heart disease, and stroke are living longer. Data showing that the proportion of older people with depression and other mental illnesses will grow disproportionately faster than the overall older population are less well known. One reason for this is a higher risk of these mental illnesses in people born in the post-second world war baby boom than in those born before the war.[1] The changing demographics have been described as a “silver tsunami,” pointing to the high healthcare costs of the ageing population. A more constructive socioscientific approach would be to develop means of keeping older adults healthy.

The linked randomised controlled trial by Von Korff and colleagues (doi:10.1136/bmj.d9612) assessed an important model for promoting healthy ageing in people with multiple chronic illnesses.[2] The authors sought to improve hyperglycaemia, hypertension, hyperlipidaemia, and depression by integrating a treat to target programme for diabetes and risk factors for
A return to “health as a right” is needed to reduce inequalities, says report

The current global economic model needs fundamental change if the goal of health equity worldwide is ever to be reached, the third edition of the Global Health Watch report warns.

The report, written by academics and activists worldwide and billed as an “Alternative World Health report,” argues that the failure of the current economic system, ongoing financial, food, and fuel crises, and the challenges of climate change and poverty mean that global health has not improved as it could.

Marion Birch, director of Medact, one of several international health charities coordinating the report, said, “By exposing the link between the health of individuals and a system based on constant growth in an inequitable world, Global Health Watch reveals the true cost to health of a flawed system.”

The report highlights growing concern over a massive increase in speculative finance in recent years which, according to Ms Birch, has led to major investment in areas such as biotechnology and genetic medicine rather than spending on more basic public health which could immediately benefit huge numbers of people.

“Increasing sums of money are out there just trying to multiply instead of being used,” says Birch.

Speculative investment in commodities has also distorted food and fuel markets, with knock on effects on health, the report warns.

The report is designed as a reference tool for those studying global health policy and campaigning for change. And, amid the current economic climate, it is aimed at highlighting problems in the way public money is being spent on health.

With chapters on the global political and economic architecture, health systems, the effect of market trends on health, and the weaknesses of international organisations working to improve health, the report paints a bleak picture of the status quo.
Martin McShane: Integrated reflections concluded
Here is my third and final blog on the USA trip: After Seattle’s integrated care organisations, we visited CalPERS. They fund $6.7bn worth of healthcare for 1.3 million people (roughly twice what we have per person in Lincolnshire). They see themselves as “active” purchasers: managing the market to reduce costs. About two thirds of their members are in capitated plans (for instance Kaiser) whilst the remainder are in a PPO plan (Preferred Provider Organisation). Simple examples of their interventions were to remove co-pay from preventative care for members, to have fiscal and chronic disease management targets and to set a tariff for knee replacement—it all felt familiar. What wasn’t was their analysis by price for knee replacement. It revealed a staggering variation from $15k to $120k. With 46 hospitals they agreed a tariff of $30k but patients could choose to use hospitals that refused the tariff—so long as they paid the difference. It made me think why a tariff for planned procedures may not be such a bad idea.

It was clear from listening to the executives at CalPERS that they faced similar challenges to us. For example, they have just as many, if not more, problems with collating, analysing, and using data because of regulation and legislation.

The big new initiative in the USA is accountable care; visits to the Blue Shield Foundation and the Centre for Health Policy at Stanford gave us an insight into the challenges which health care reform faces in the USA. Accountable care has the aim of increasing access to insurance, improving quality, and reducing costs. Yet again, at its heart, is primary care. Whether it will deliver the three aims intended is open to debate – in a society that retains bad memories from managed care and a social construct that is very different to the UK.

Returning home I felt reinvigorated. I was proud to work for a health system that did not need to concern itself whether individuals could afford the care they needed. I felt excited by the conviction that, for integrated care to work, it needs to be driven by primary care.

What are the three key lessons I brought back?
Amyloidosis

Malvyn Benjamin,1 Sim Inder

After several months of investigation, Malvyn B. with amyloidosis. Here experience of the condition

I was diagnosed with amyloidosis. The sequence of events was interesting. I had been attending the hospital for months, seeing consultants in the nephrology and respiratory departments, unfortunately to no effect.

For several months my ability to walk long distances had been impaired by extreme breathlessness on a journey of 10 to 15 minutes. I would have to stop 20 or 30 times to catch my breath. At one point, after such a walk, I collapsed in a synagogue—which was actually a good place to collapse, as I was surrounded by many doctors.

After routine blood and urine tests at my general practitioner’s surgery, my doctor telephoned me to say that she had spotted something and made an urgent appointment with the hematologist department in my local hospital.

There, I was put through a battery of tests and was told my results would be sent to the National Amyloidosis Centre for examination. Of course, I had never heard of amyloidosis. Before going to the centre, I had a bone marrow test—not the most pleasant experience—and later, at the centre, I had various other tests, including an electrocardiogram and a full body scan.

When the results of the tests and scan came through, I was told by the doctor at the centre that I had amyloidosis and that I did not receive treatment for it would not last beyond the end of the year.

My condition involves amyloid deposits in my...
Publishing flow: Thurs/Friday build/QA
Advertising
The EGFR App – Free for the iPhone and iPad

A resource for:
- Understanding more about non-small cell lung cancer
- Receiving guidance for ordering and assessing EGFR mutation tests

The EGFR App. Free testing guidance at your fingertips.
Marketing to iPad users
Immediate feedback January 2011

- “Missed opportunity…”
- “Absolutely scandalous”
- “Very pretty....but I’m not paying extra”
- “Fantastic app...you are here to represent us, not exploit us.”
Turning around negative feedback

• Free access for BMA members
• Priority to get better reviews/star ratings
• Will better reviews drive paid for subs?
• Lots of interest from other publishers
Latest feedback

“The iPad app is superb and has meant that I now spend more time viewing my BMJ.”

“The app is excellent and very very useable. As a GP appraiser I am constantly looking for ways for appraisees…the ability to read and the email the link for an article is excellent. This is a huge step forward and has re-energised my reading of your journal.”
Next steps and challenges

- 77,898 downloads so far
- 140 ratings by 28/12/11 (3 star average - 56 5*/57 1*)
- Feels more “international” – need to market this more
- “Can I stop getting the print issue?”
- More ads
- Sort institutional access
- Print and web redesign – iPad next?
Thank You