Reviewer’s report

Title: Postcode lotteries in public health - The NHS Health Checks Programme

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Reviewer: Linda Marks

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General comments

This article brings much needed attention to the topic of the uneven distribution and variable prioritisation accorded to preventive services. Despite much rhetoric, these remain the poor relation compared with clinical services when it comes to analysing access, level of service or effectiveness. It is important to identify postcode lotteries in preventive care and the research question is highly relevant. The article is clearly written and presents interesting findings related to use of risk calculation tools and differences between PCTs in resource allocation, level of provider payments and proactive case finding. It argues for improved knowledge exchange across PCTs.

The article demonstrates great variation in spend on the NHS Health Checks Programme across PCTs. A degree of variation is not surprising as full roll out of the programme was intended from 2012/13 and PCTs were able to exercise discretion in implementation and speed of the roll out according to resources, local needs and national and local priorities. As the authors point out, the important question is how to interpret variation in spend.

While it is stated that variation is not due to differences in health need, there is scope for further discussion of other possible reasons for variation, including the impact of different phases of roll out and associated costs, and contextual factors. For example, the NHS Health Check programme builds on a wide range of initiatives in CVD risk factor screening and proactive case finding, often set up to meet the 2010 national health inequalities target. CVD screening checks were established, at the discretion of PCTs, through Local Enhanced Services for GPs and community pharmacists, through partnership initiatives and ‘QoF plus’ schemes. In some cases, such programmes were mainstreamed. This raises the question of the extent to which other initiatives are being rationalised (or not) through the NHS Health Checks programme, and, by implication, the extent to which large differences in spend reflect differences in budget headings for related preventive services. In the same way, do wide differences in payment for health checks reflect varying incentive arrangements, differences in the level of service provided, or are some PCTs simply paying more than others for exactly the same services?
Major compulsory revisions

1. The results section in the abstract refers to PCT budgets varying from 69k to 1.4 million per 100,000 population but, as Table 2 makes clear, these figures do not refer to actual budgets but estimated spend (per 100,000) for the population aged 40-74. As this target population is less than 100,000 in the majority of PCTs in the study, the total 2010/11 budget for NHS Health Checks for these PCTs is substantially less than the estimated spend per 100,000 for the target group. The difference between actual and estimated spend should be clarified in the abstract and the text (as in the first line of the section headed ‘Funding and payment structures’ where estimated funding is described as ‘made available’): size of the target population could be included in Table 2 as could percentage of the eligible cohort who have received a check.

2. Methods are described very briefly and the article is based on 8 questionnaires, completed over a two week period by the Health Check lead for each of the 8 PCTs. It is a small and geographically limited study and limitations of the data could be discussed in more detail. The questionnaire would be of interest to those implementing health checks and could be made available.

3. Possible reasons for such large differences in spend could be enlarged upon in the discussion. Contextual information could include overlapping initiatives, if any, and the extent to which these may have been rationalised under the NHS Health Checks scheme; degree of development of a risk management infrastructure and decisions over how the programme was to be rolled out over time. NW London has been a comparatively high performer compared with the rest of London in implementing the NHS Health Checks programme: some national context would be useful to put the findings in perspective.

4. As discussed in the article addressing health inequalities is an important part of the programme and there is scope for more detailed discussion of how Health checks are being targeted in disadvantaged groups/areas/practices in disadvantaged areas in the 8 PCTs, whether any equity audits were carried out as part of monitoring and evaluation processes or whether there is a systematic approach to addressing health inequalities through health checks.

5. Local flexibility is described in the conclusions as essential to the programme but Table 5 (which expands on mandatory standards, expected elements and those left to local discretion) only includes method of invitation and setting of health check as areas to be left to local discretion. Are there others that could be included in relation to reaching disadvantaged groups and areas, for example?

Discretionary revisions


2. Information from the 8 PCTs drawing on the mandatory data set itemised in Box 2 would provide useful context for the differences in spend.

3. Information on levels of deprivation in the 8 PCTs would also provide useful
context, especially given that reducing health inequalities is one aim of the NHS Health Checks. This could be included as part of Table 2.

4. The role of PCTs as commissioning organisations could be explained for an international audience.

5. The consultation on the funding and commissioning routes for public health (DH 2010) indicates that arrangements for commissioning NHS health checks in England are likely to change. Conclusions could refer to funding (and other) implications of local authorities becoming lead commissioners of health checks as currently proposed, as well as possible impact of the economic climate on preventive services.

Minor issues not for publication

Consistency: post code/postcode
Abstract, results, line four. patients’
Results section, headings not consistent in use of capitals
Monitoring and Evaluation section, Line one, insert full stop after London, Line 7, insert full stop after outcomes
Box1, Point 2 is repeated in point 9
Box 1, point 7, replace comma with full stop
Background line 8, replace ‘cardiovascular disease’ with ‘vascular diseases’
Methods, line 2, remove full stop and delete ‘This’
Line 8. Remove capital letters from ‘monitoring and evaluation’
Equipment and screening instruments section, line 4, Replace table with ‘Table’ (consistency with rest of text).
Monitoring and evaluation section, Replace box with Box (consistency)
Discussion, line 10, replace CVD with vascular diseases
Discussion para 7, line 9, replace ‘Diabetes’ with ‘diabetes’
Conclusions para 2, line 4, replace ‘entire of England’
Conclusions line 6 replace CVD with vascular diseases
Conclusions, para 3, lines 7-8, incomplete sentence
Conclusions, penultimate para. Reword ‘makes take’
Conclusions penultimate para last line replace ‘table’ with ‘Table’ (consistency)
Table one identifies Hillingdon PCT
Tables 4 and 5 – inconsistent use of capitals in headings
Table 5 heading needs punctuation
References heading require proof reading

Level of interest: An article of importance in its field
Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests