District-wide diabetic retinopathy screening

Sirs,

It is with interest that we read the paper by Okoli and Mackay on models for diabetic retinopathy screening. Their results were in favour of a district-wide register-based call–recall service with photography. This achieved coverage of 63 per cent and uptake of 80 per cent. The paper raises some important issues for those about to embark upon developing screening services in accordance with the Diabetes NSF and the National Screening Committee (NSC).5

Ealing PCT has a population of 290,000. A district-wide retinopathy screening service is being planned. The Chronic Disease Register (CDR) will be used as a basis for call and recall. Eighty-one of the 85 practices participate in the register. The CDR contains district-wide demographic, clinical and laboratory information on patients at risk of coronary heart disease, and diabetics. Data show that there are 11,573 diabetics, a prevalence of 4.1 per cent, but only 25 per cent have had ophthalmoscopic examination in the past year, with data missing for 43 per cent. This information highlights some of the complexity of the task ahead. Whereas systematic screening is known to be more cost-effective than opportunistic screening, it is contingent upon accurate, timely and complete data.3 The paper by Okoli and Mackay also highlights the risk of inequity of service with poor coverage if left to general practitioner-initiated appointments using practice-based registers. This is borne out by our past experience of opportunistic ophthalmoscopy.

In the system that we have since devised, the CDR will be used for call and recall, and digital retinal photographs will be taken by trained photographers and reported by trained coders, leading to action based on these results. Central storage will allow access for clinical comparison but also for reliability testing. The NSC has suggested that retinal image use is valuable for patient involvement and education. This is in keeping with recommendations of patient involvement in diabetic care and is relevant given that Okoli and Mackay reported non-attendance for follow-up appointment in 45 per cent of patients with sight-threatening retinopathy.2 Although patient satisfaction with the screening process was reported as 98 per cent, the high non-attendance suggests that much work, including the proper explanation of risk of untreated retinopathy, is needed to improve compliance.1 Valuable lessons could be transferred from other programmes, such as cervical screening.4 These suggest that administrative errors should be kept to a minimum, patient preference for venues needs to be considered, and strategies be developed to target poor knowledge, attitudes and emotional barriers. The readability of patient leaflets also needs to be considered, as does the design of an effective system of call and recall, and reminders.2 The evidence base in this area of health services research needs to be strengthened.6

Evidence concerning social capital and health inequalities is still lacking

Sirs,

We welcome publication of the paper by Paul Pilkington on social capital and health inequalities.1 However, we feel that the paper fails to provide a clear critical review of the available evidence and may mislead those new to the area of social capital and health.

Although in places Pilkington is hesitant about asserting definitively that social capital is an important determinant of health, in other places he uses phrases such as ‘the dramatic differences [in heart disease deaths] were not explained by behavioural factors, but evidentially by how closely knit the community was’ (p. 157, our italics).

In reality, there is little conclusive evidence that social capital and health are causally linked. First, as Pilkington points out, there remains considerable disagreement over the definition of social capital and it is a nonsense to state conclusively that an indefinable, and hence immeasurable, concept is causally related to anything else. Second, there are numerous examples of instances where social capital may be bad for a community's
For example, peer pressure amongst close-knit friendship groups is a well-recognized determinant of cigarette smoking behaviour amongst adolescent girls.\textsuperscript{5} Pilkington goes on to propose that interventions that improve social capital may help to reduce health inequalities and he gives some examples of these. Leaving aside the issue of whether or not social capital is an important determinant of health and health inequalities, the author cites no evidence that interventions such as those described can either build social capital or reduce health inequalities – and we know of none.\textsuperscript{4} It is merely conjecture that ‘creating more public spaces’ and ‘advocating increased leisure time’ (p. 157) will have an impact on levels of social capital or socio-economic disparities in health. This does not mean that such interventions are not important but using the improving health and reducing health inequalities bandwagon as justification for them is inappropriate and, we feel, unnecessary. Public parks should be viewed as a social good in their own right, independent of what effect they may have on health.

Finally, no reference is made within the paper to more critical and in-depth reviews of, and commentaries on, social capital in the health context.\textsuperscript{3,4,6} We feel these are essential reading for anyone interested in social capital as it applies to health.

The idea that social capital is an important determinant of health and that communities themselves can determine their health status is politically seductive. However, it is far from proven and, as the Pilkington states, ‘social capital is a debate that will … continue to be controversial for some time to come’ (p. 159). To come to a balanced and evidence-based conclusion concerning the importance of social capital to health and health inequalities, it is important that practitioners and policy-makers are aware of all the evidence and competing views and not just those that match prevailing political thought or that appear, superficially, to make ‘common sense’.\textsuperscript{7}

References


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