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Parallel Session C

Cardiovascular disease and inequalities

OP46

REDUCING SOCIOECONOMIC INEQUALITY IN CORONARY DISEASE TREATMENTS: THE NHS FINALLY TRIUMPHS?

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Background Health inequalities are evident across the United Kingdom, exemplified by large and persistent social gradients in premature cardiovascular mortality. Four simple medical therapies improve survival in patients with coronary heart disease: antiplatelet agents including aspirin, β -blockers, statins, and angiotensin converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB). But are the founding National Health Service (NHS) principles of equity and universality translating into equitable delivery of these life-saving therapies? Previous studies have been limited in size, method of classifying socioeconomic status, range of treatments examined, and trends over time.

Methods Socioeconomic status was defined using the Index of Multiple Deprivation, a weighted composite of seven deprivation domains. Small areas (approximately 1500 individuals) were aggregated into equal quintiles by ranked deprivation score. Three patient cohorts were defined: myocardial infarction ($n=111,990$), secondary prevention ($n=677,522$), and stable angina ($n=984,807$). Treatments for all myocardial infarction patients in 2003 and 2007 was obtained from the Myocardial Ischaemia National Audit Project. Angina and secondary prevention treatment data in 1999 and 2007 were derived from the General Practice Research Database, the world's largest longitudinal database of primary care records linked with morbidity and prescribing information. Treatment uptake estimates were age-standardised.

Results The uptake of all therapies increased in all patient groups between 1999 and 2007, in both men and women. Improvements were most marked in the community, where use of β -blockers, statins, and ACEI/ARB for secondary prevention and treatment of angina essentially doubled, from around 30% to over 60%. Small age gradients persisted for some therapies, possibly reflecting ageism, appropriateness or clinical contraindications which could not be assessed. No consistent gender differences were observed for 'hard' diagnoses (myocardial infarction, postrevascularisation), although some inequality was apparent in the treatment of younger women with angina (a less precise category). Socioeconomic gradients were likewise absent for both myocardial infarction and secondary prevention, and gradients in patients with angina apparently favoured greater treatment uptake in the most deprived.

Discussion For a decade the National Service Framework has spearheaded efforts to reduce cardiovascular mortality. The marked improvements reported here represent a triumph for the NHS. An equally important success story lies behind these headlines. The NHS is generally delivering equitable cardiovascular treatment, independent of socioeconomic status. However, there is no room for complacency. Future strategies should aim to further increase overall treatment levels and eradicate the remaining age and gender inequalities.