EDUCATIONAL INEQUALITIES IN STATIN TREATMENT: USING DATA ON FATHERS/PARTNERS TO STUDY

Inequalities in the use of statins between educational groups may contribute to cardiovascular inequalities. The mechanisms leading to these differences are unknown, but both health seeking behaviours and clinical factors may contribute.

**Results**

For the same level of cardiovascular risk, individuals with lower educational attainment were less likely to receive statins. Adjusted for age and social deprivation. Strategies aimed at addressing the social determinants of health are needed to reduce future burden on health and social care systems, particularly in the North of England.

**Conclusion**

For the same level of cardiovascular risk, individuals with lower educational attainment were less likely to receive statins. Comparable ORs in men were 1.04 (95% CI 1.04, 1.05) for 7 years of schooling and 1.08 (95% CI 1.08, 1.08) for 20 years of schooling. These inequalities were also present in analyses using primary care data.

**Method**

We used logistic regression to explore the association between i) QRISK3 score and ii) educational attainment on self-report statin use. We then stratified the association between QRISK3 score and statin use by educational attainment to test for interactions. We then replicated analyses using QRISK or QRISK2 scores recorded in primary care data and statin prescriptions recorded in primary care prescription records.

**Results**

There was evidence of an interaction between QRISK3 scores and education. For an equivalent QRISK3 score, more educated individuals were more likely to report taking statins. In women with 7 years of schooling, a one unit increase in QRISK3 score was associated with a 7% higher odds of statin use (OR 1.07, 95% CI 1.07, 1.07). In women with 10 years of schooling, a one unit increase in QRISK3 score was associated with an 14% higher odds of statin use (OR 1.14, 95% CI 1.14, 1.15). Comparable ORs in men were 1.04 (95% CI 1.04, 1.05) for 7 years of schooling and 1.08 (95% CI 1.08, 1.08) for 20 years of schooling. These inequalities were also present in analyses using primary care data.

**Conclusion**

For the same level of cardiovascular risk, individuals with lower educational attainment were less likely to receive statins, likely contributing to cardiovascular inequalities. The mechanisms leading to these differences are unknown, but both health seeking behaviours and clinical factors may contribute.

**Method**

We used logistic regression to explore the association between i) QRISK3 score and ii) educational attainment on self-report statin use. We then stratified the association between QRISK3 score and statin use by educational attainment to test for interactions. We then replicated analyses using QRISK or QRISK2 scores recorded in primary care data and statin prescriptions recorded in primary care prescription records.

**Results**

There was evidence of an interaction between QRISK3 scores and education. For an equivalent QRISK3 score, more educated individuals were more likely to report taking statins. In women with 7 years of schooling, a one unit increase in QRISK3 score was associated with a 7% higher odds of statin use (OR 1.07, 95% CI 1.07, 1.07). In women with 10 years of schooling, a one unit increase in QRISK3 score was associated with an 14% higher odds of statin use (OR 1.14, 95% CI 1.14, 1.15). Comparable ORs in men were 1.04 (95% CI 1.04, 1.05) for 7 years of schooling and 1.08 (95% CI 1.08, 1.08) for 20 years of schooling. These inequalities were also present in analyses using primary care data.

**Conclusion**

For the same level of cardiovascular risk, individuals with lower educational attainment were less likely to receive statins, likely contributing to cardiovascular inequalities. The mechanisms leading to these differences are unknown, but both health seeking behaviours and clinical factors may contribute.

**Method**

We used logistic regression to explore the association between i) QRISK3 score and ii) educational attainment on self-report statin use. We then stratified the association between QRISK3 score and statin use by educational attainment to test for interactions. We then replicated analyses using QRISK or QRISK2 scores recorded in primary care data and statin prescriptions recorded in primary care prescription records.

**Results**

There was evidence of an interaction between QRISK3 scores and education. For an equivalent QRISK3 score, more educated individuals were more likely to report taking statins. In women with 7 years of schooling, a one unit increase in QRISK3 score was associated with a 7% higher odds of statin use (OR 1.07, 95% CI 1.07, 1.07). In women with 10 years of schooling, a one unit increase in QRISK3 score was associated with an 14% higher odds of statin use (OR 1.14, 95% CI 1.14, 1.15). Comparable ORs in men were 1.04 (95% CI 1.04, 1.05) for 7 years of schooling and 1.08 (95% CI 1.08, 1.08) for 20 years of schooling. These inequalities were also present in analyses using primary care data.

**Conclusion**

For the same level of cardiovascular risk, individuals with lower educational attainment were less likely to receive statins, likely contributing to cardiovascular inequalities. The mechanisms leading to these differences are unknown, but both health seeking behaviours and clinical factors may contribute.