Inequalities in access to care for patients with ischaemic heart disease

In this month’s Journal there are three different studies, all about inequalities of care for patients with ischaemic heart disease in general practice. Some results challenge widely-held beliefs and others confirm and underline important problems. So what do these studies tell us? how do they fit in with what we already know? and what questions are left unanswered?

In the first paper, Gill and colleagues report a secondary analysis of questionnaire and interview data from the 1998 and 1999 Health Survey for England.1 Of the 1123 patients analysed, 19% answered ‘no’ to the question ‘are you taking any medication to treat your angina’. This is comparable with results for the UK at the time, showing under-recording.7 Their study also confirmed previous reports elsewhere in the United Kingdom (UK).5 Surprisingly, there was no association with deprivation, although the authors suggest that this could be owing to a lack of variation in the sample, which was from an area of high deprivation.

The third paper comes from Italy and uses a large validated computerised database from general practice to report on overall levels of care for patients with angina (excluding those with a myocardial infarction).6 The strengths of this study are its analysis of individual patients, drawn from a large population base, and using outcomes that are based on actual prescriptions or readings rather than self report. Three-quarters of patients had a blood pressure value recorded and more than half had poor control. Two-thirds of patients had a cholesterol value and under a quarter had treatments with lipid-lowering drugs. These results are comparable with results for the UK at the same time, showing under-recording.7 Their study also confirms other reports of sex inequalities with younger patients and male patients being more likely to be referred and receive some treatments.8-12

5. Sheldon TA. It ain’t what you do but the way that you do it. J Health Serv Res Policy 2001; 6: 3-5.

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In the first paper, Gill and colleagues report a secondary analysis of questionnaire and interview data from the 1998 and 1999 Health Survey for England.1 Of the 1123 patients with ischaemic heart disease, over 80% were taking lipid-lowering therapy. Older patients, those from deprived areas, and patients with a myocardial infarction were all less likely to be prescribed lipid-lowering drugs, reaffirming previous work by Reid et al.2 However, there was no evidence that ethnicity influences uptake of lipid-lowering therapy. Since an earlier study found evidence of poor access to coronary bypass graft for South Asian patients,3 this finding is reassuring.

The next study uses an ecological design to determine the effect of practice-level factors (such as deprivation and ethnicity) on access to care for angiography.4 The study examined angiography rates in 143 practices in East London and found no evidence of inequitable access — practices with high proportions of South Asian patients also had higher rates of angiography. One of the strongest findings was the inverse relationship between angiography rates and distance from centres performing the procedures — practices further away from centres had lower rates of angiography, confirming previous reports elsewhere in the United Kingdom (UK).5 Surprisingly, there was no association with deprivation, although the authors suggest that this could be owing to a lack of variation in the sample, which was from an area of high deprivation.

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Hayfever — practical management issues

In this month’s Journal Owen et al 1 compare the effectiveness of topical treatments, namely mast cell stabilisers (cromoglycate, nedocromil and lodoxamide) with topical antihistamines (azelastine, emedastine, antazoline and levocabastine) for the treatment of seasonal allergic conjunctivitis. They conclude that both are effective groups, but that there is insufficient evidence as to whether the benefits of potentially faster treatment with topical antihistamines are worthwhile. The importance of patient preference in deciding on treatment options is noted.

Patients with allergic conjunctivitis or rhinitis present at varying times. Some sufferers experience symptoms in April, when tree pollens are abundant. For others, symptoms start with the onset of the grass pollen season,

References

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