

evaluated in US settings predominantly with self-selected well educated participants.⁹ It is being rolled out nationally before the local evaluation is completed, and despite the fact that initial results from the evaluation suggest poor uptake.¹⁰ More disappointing is that the Department of Health may find that they have bought a time-share when, in fact, there was an equally good cottage around the corner. The Angina Plan, for example, is a UK developed and evaluated self-management programme for people with recently diagnosed stable angina, which is facilitated by a health professional. In a randomised, controlled trial it was shown to reduce frequency of angina by over 40% while reducing physical limitation.¹¹ A community cardiac rehabilitation team at Darlington Primary Care Trust devised an innovative programme using the Angina Plan in a leisure centre, which was a finalist in the recent Department of Health's Health and Social Care Awards, but this has not attracted the sort of attention of the brightly coloured foreign import. Let us learn from abroad, but do it wisely and without forgetting the great resources for effective innovation on our own doorstep.

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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 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.

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

Cross-sectional studies, such as these, can be a powerful and rapid method for demonstrating differences between different patient groups with respect to uptakes of treatments. Although it is reassuring that patients from different ethnic groups seem to be getting a fair deal, it remains concerning to uncover yet more inequalities by age, sex, location, and possibly deprivation.

These studies (and cross-sectional studies in general), however, leave us with many questions unanswered. They do not tell us why inequalities arise or at what point in the total care pathway they are most likely to occur — qualitative analyses and cohort studies are needed to address this.

These studies tell us little, if anything, about the potential impact of inequalities on hard outcomes such as mortality and reinfarction, and 'softer', but equally important, outcomes such as patient quality of life and satisfaction. We don't know whether inequalities are getting better or worse. Time series analyses are needed to determine this and to enable us to make future predictions.

We need studies such as these to identify and quantify problems, but we also need to focus on developing and evaluating effective interventions to reduce inequalities and maximise the health gain for the whole population. *Our healthier nation* aims to improve the health of the worst off in society and to narrow the health gap.¹³ Whereas some national policies, such as the *National service framework (NSF) for older people*¹⁴ and the *NSF for diabetes*,¹⁵ have the reduction of inequalities as key objectives, others have curious incentives that could inadvertently make things worse; the *NSF for coronary heart disease*, for example, specifically targets patients aged under 75 years.¹⁶ Older patients (and indeed those from deprived areas) tend to have higher absolute risks and therefore have the most to gain, and the most to lose if forgotten in the rush. We need to be vigilant about any perverse incentives within the new GMS contract that could adversely affect older and disadvantaged high-risk patients. The risk would come if care was more focused on patients with single diseases rather than those with complex comorbidities, including conditions such as connective tissue diseases or chronic neurological disorders, which are not included in the targets. Access to care is of fundamental importance in the National Health Service (NHS), since it was founded on the principle of equity of access for equal need. Furthermore, as society changes — and the NHS with it — the public increasingly expects to receive not only prompt, convenient, and effective services, but also fairness in access to care for all.

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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,