manner to their patient's concerns even though they were dealing with 'same day' presentations.

Finally, with the planned extension to nurse prescribing it can be presumed that nurse practitioner consultation time lengths may shorten as they will no longer be discussing with patients the arrangements for getting prescriptions signed.

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REFERENCES

Deprived people less likely to get treatment to prevent heart disease

At Nottingham City PCT, with our own set of inequalities due to deprivation, we were very interested to read Peter Brindle et al's powerful paper.1 It is clearly an important issue that the recommended risk assessment tools may be contributing to these health inequalities.

I have three questions I would like to invite the authors to comment on:

1. For our deprived areas of Nottingham, what practical implications does this have? I hope it will not be long until the QOF addresses primary prevention but at present at the practice level we have no means of altering primary care activity. Perhaps we could all look at those in the deprived areas who are at increased vascular risk but who currently score below the threshold for action with renewed priority ... to help reduce the inequalities rather than further increase them.

2. Table 2 of the paper highlights considerable differences between the Framingham and the less healthy Scottish populations. Presumably there are also some differences between Scottish and English populations; is it a measure of dietary or deprivation differences generally? In interpreting this paper south of the border how should we take account of these differences?

3. Finally, how, I wonder, do the authors see this evidence being taken forward so that change happens in the way we make objective assessments of risk? I am aware of other risk tools such as www.riskscore.org.uk which is also based on data outside of the UK. Is there a better tool for us to use at the practice level?

In the meantime, the challenge to us all is to look wider at 'whole person risk', including ethnicity, and employ clinical judgement, recognising the influence of the non-Framingham risk factors.

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Author’s response
I am grateful to Stephen Willott for his interest in our paper, and I am pleased he has responded with three very challenging and current questions. Our paper and other work suggest that the Framingham risk score underestimates cardiovascular disease risk in people from deprived areas and with low socioeconomic status relative to more affluent people.1,2 This fits with a body of work showing that risk scores tend to under predict in high-risk populations and over predict in low-risk populations. The reason for this is that the limited number of variables in a risk score developed in one population, cannot fully account for variations in risk when applied to other populations. Currently, we can only speculate about what risk factors are missing from the Framingham equation that social deprivation seems to be a surrogate for. Dietary differences may indeed be one of them.

Willott notes that national differences in disease rates exist, but greater differences exist within countries. For example, there is a 10-year difference in life expectancy between two parts of Bristol only 3 miles apart. Currently, there is no ‘off the shelf’ risk calculator that adjusts the Framingham score for these differences, but the data is available to develop it and national guideline bodies have noted the limitations of the current system. When appropriate adjustments for social deprivation are made, the distribution of resources needed to implement these adjustments should recognise the increased workload of practices serving deprived areas.

Willott recognises ethnicity as another limitation of the present system. ETHRISK, a web-based risk calculator currently undergoing peer review, provides some guidance in that area.3 There is likely to be a significant interaction between ethnicity and social deprivation that needs to be recognised and further evaluated, as it makes no sense to adjust for ethnicity and then social deprivation if both factors are present in the same person. Until the Framingham risk score is modified, it remains in its current form the best available guide to targeting preventive treatment. As Willott suggests, it should

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British Journal of General Practice, February 2006
be supplemented with the confident use of clinical judgement.

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Limited resources?

The editorial by Ryan and Watson ‘In publicly provided healthcare systems, when limited resources are coupled with unlimited demand, decisions have to be made about the efficient allocation of scarce resources.’ If a supermarket manager wrote an editorial claiming that demand for food is infinite and it is therefore impossible to keep his shelves stocked, we would wonder how he kept his job. So why do we take seriously the claim that medical services, which, unlike food, most people tend to avoid as much as possible, are subject to ‘unlimited demand’?

Nobody would deny that some new medical procedures are costly and that medical services are subject to ‘unlimited demand’?  

The research question and questionnaire have the potential of creating situations for the participants that the researcher may be unable to deal with, therefore involving other departments without their prior knowledge. Safeguards for both the researcher and research population must be in place — access to further counselling etc as a basic minimum.

Please do not hesitate to contact me...