

Does 'unrecorded' cardiovascular disease prevalence increase with increasing deprivation?

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1. The Care Quality Commission
2. Scope of the wider national CVD study
3. Primary medical care in England – scope and significance
4. Findings/conclusions



What does CQC do?

The Care Quality Commission is the independent regulator of health and social care in England. Our aim is to make sure better care is provided for everyone, whether that is in hospital, in care homes, in people's own homes, or elsewhere.

We regulate health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. And, we protect the rights of people detained under the Mental Health Act.



Overall aim and objectives of the national CVD study

Aim:

To assess how well Primary Care Trust's are addressing inequalities in CVD through statin prescribing and National Health Service stop smoking centres.

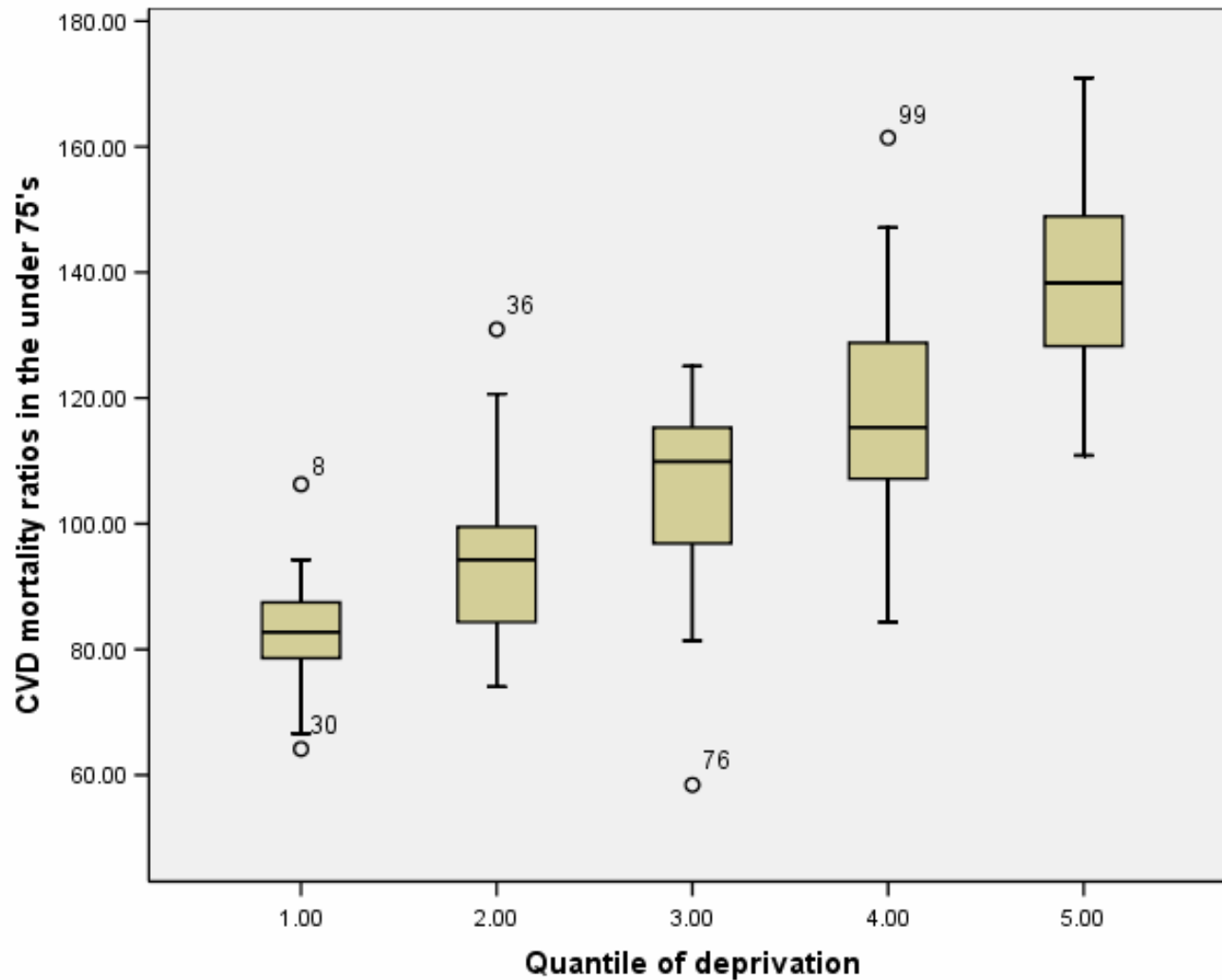
Objectives:

1. To assess the quality & availability of data on CVD & smoking prevalence, statin prescribing and stop smoking services at PCT & GP practice level
2. To collate and analyse the best available data in 1 and to assess whether PCTs & GPs are addressing inequalities in CVD
3. To produce a report & provide recommendations for organisations at national and local level to contribute to reducing inequalities in CVD

1. SIGNIFICANCE AS A HEALTHCARE PROVIDER - 300 million patient contacts each year
2. DEMOGRAPHIC AND EPIDEMIOLOGICAL CHANGE - Sig. increase in the proportion of the population aged 65 and over resulting in a significant increase in healthcare need (esp. age related conditions)
3. National PAY for PERFORMANCE SCHEME – Quality and Outcomes Framework (QOF), scheme to drive up quality standards in primary medical care
4. IMPACT ON HEALTH - Evidence shows that primary care helps prevent illness and death and, in contrast to specialist care, is associated with a more equitable distribution of health in populations¹.

¹ Starfield, Shi, Macinko. Contribution of primary care to health systems and health. The Milbank Quarterly, vol 83, No 3, 2005 (pp457-502)

Context: CVD inequalities, mortality in the under 75's





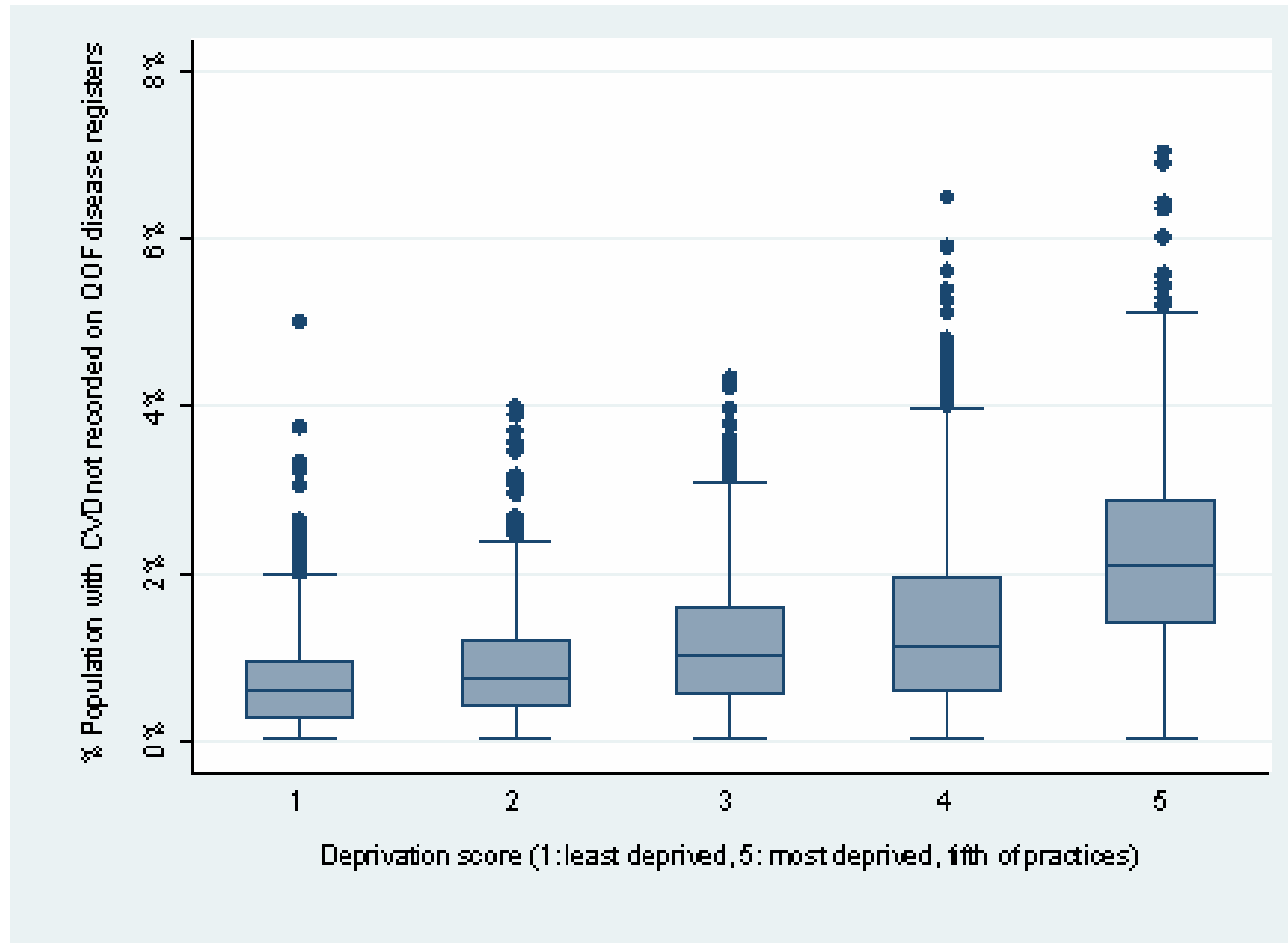
How we calculated unrecorded CVD prevalence

1. Applied the NICE lipid modification CVD prevalence data to QOF to obtain an observed CVD prevalence estimate¹
2. Commissioned 'synthetic' estimates of expected CVD prevalence using pooled population health survey data²
3. (expected – observed) = unrecorded prevalence
4. Used quantile regression to establish whether the incremental increase in unrecorded prevalence was significant

¹<http://www.nice.org.uk/nicemedia/pdf/Lipidmodificationcostingtemplate.xls>

²(Cvd and CVD + diabetes prevalence modelling. (Soljak M, Majeed A; Imperial College London. Walford H; Eastern Public Health Observatory. November 2008)

Findings: unrecorded CVD prevalence vs deprivation



Simultaneous quantile regression $P < 0.001$



Conclusions

- 1 Unrecorded cardio vascular disease prevalence increases significantly with deprivation
- 2 In overall terms the 'volume' of estimated unrecorded prevalence accounts for over one third of the observed prevalence recorded in the pay for performance QOF scheme
- 3 People with undetected disease and who also contend with poor social and economic circumstance may be at greater risk
- 4 The pattern of unrecorded prevalence that we observed for cardio vascular disease are likely to be replicated for other conditions



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