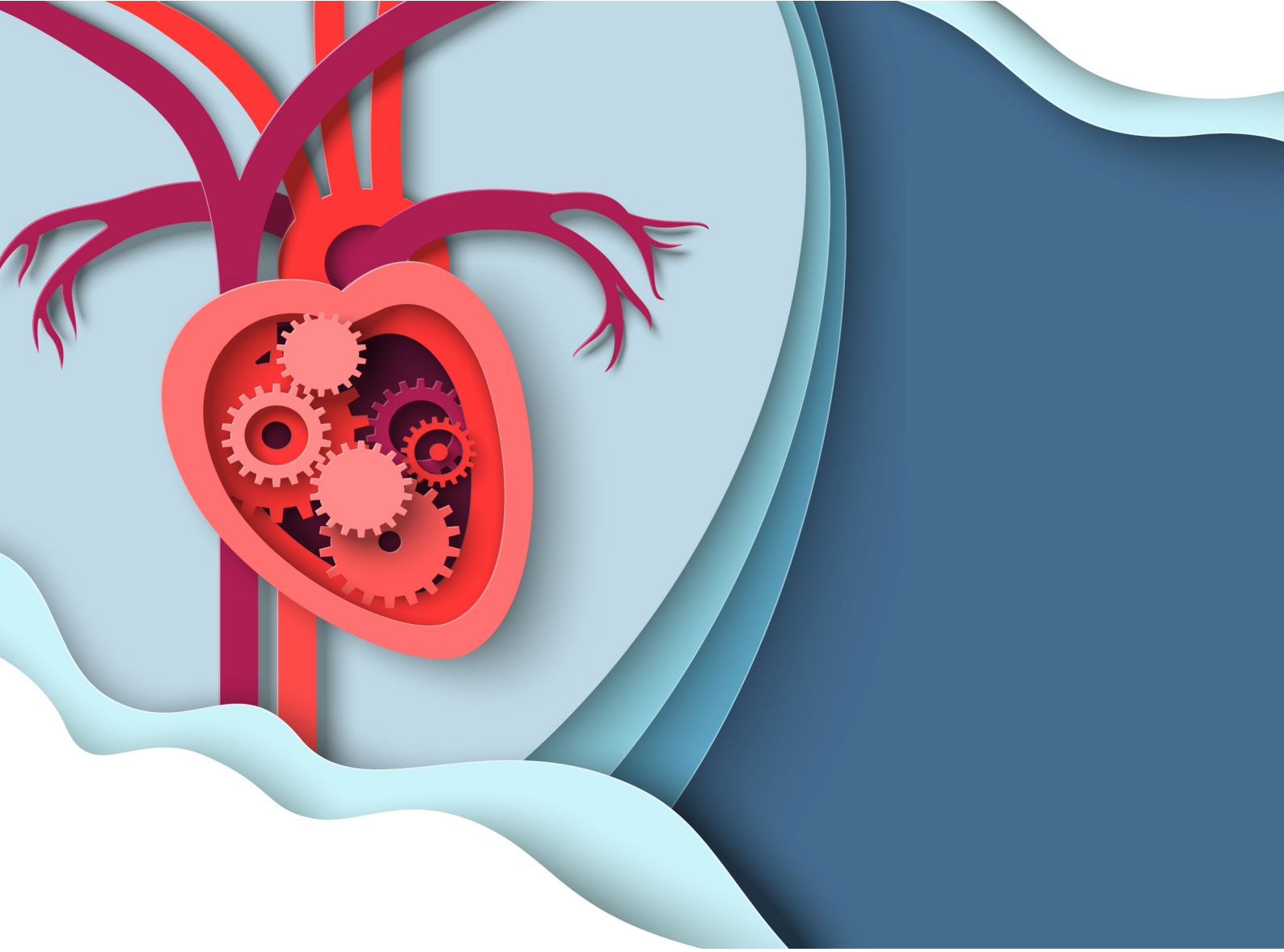


ABHI & LCP HEALTH ANALYTICS: FINDING TANGIBLE SOLUTIONS TO ADDRESSING HEALTH INEQUALITIES IN CARDIOVASCULAR DISEASE

ABHI CARDIOVASCULAR

LCP powering possibility

CONTENTS

EXECUTIVE SUMMARY

On 18 January 2024, ABHI and LCP Health Analytics convened a roundtable, addressing health inequalities in Cardiovascular Disease (CVD) within the UK.

CVD remains a significant public health challenge, being the leading cause of mortality and disability in the country. The roundtable, attended by a diverse group of stakeholders from the HealthTech industry, government, and healthcare providers, focused on understanding the context of CVD inequalities, identifying barriers to change, and proposing actionable solutions. Key discussions included the absence of a national CVD strategy, systemic inequities leading to poor access and outcomes, and the need to move beyond data analysis paralysis.

Proposed actions for ABHI members, referred to as the '4 Ps' – Prioritise, Podiums, Playbook, and Policymakers – involve establishing a strategic working group to tackle health inequalities, using industry platforms to raise awareness about CVD inequalities, creating a playbook of best practices for addressing health inequalities in CVD, and engaging policymakers to advocate for meaningful change.

The roundtable concluded with a commitment to leveraging industry and NHS collaborations to address the root causes of CVD disparities, emphasising the importance of a unified strategy, targeted stakeholder engagement, and the utilisation of detailed data to drive equitable health outcomes for all affected by CVD.

WHY DO WE NEED TO FIND TANGIBLE SOLUTIONS TO TACKLE HEALTH INEQUALITIES IN CVD?

Cardiovascular diseases, or CVD, are the leading cause of death and disability in the UK. It is estimated that around 7 million people in the UK are living with CVD[1] and this is costing both our healthcare system and the wider economy billions each year. Research shows us that across CVD[1] diseases there remain inequalities in health and healthcare, including variations of access and uptake to care across genders, ethnicities, and socioeconomic groups. This has contributed to stark disparities:

- CVD accounts for the largest gap in health life expectancy in England. Those in the most deprived 10% of the population are almost twice as likely to die as a result of CVD than those in the least deprived 10% of the population.[2]

- When it comes to major cardiovascular events, women are 50% more likely to receive the wrong initial diagnosis when presenting with a myocardial infarction (a heart attack) than men, thus leading to worse outcomes; women also have a worse survival
- rate at 30 days and years later.[3]

  Older people and women wait longer for a diagnosis of heart failure compared with younger people and men, and less frequently receive evidence-based pharmacological therapies for heart failure and atrial fibrillation.[4]

In addition, the current impact of CVD on mortality has been exacerbated by the pandemic. In the post-Covid-19 era excess deaths have remained high due to the direct effects of Covid-19 infection, acute NHS pressures, disruption to chronic disease detection and management. Across clinical areas excess deaths due to CVD is 12% higher than expected. Within CVD deaths of middle-aged people, excess deaths have been 33% higher than expected, while for specific conditions, deaths involving ischaemic health disease were 44% high than expected.[5]

In response to these stark disparities, several policies have been introduced by Government and NHS in recent years, including CORE20Plus5, the Major Conditions Strategy and the Women's Health Strategy. Beyond health outcomes, governments recognise that addressing inequalities also makes good economic sense. For every $1 invested in women's health globally, there is a $3 return of economic growth.[6]

What is becoming increasingly apparent is that the life sciences sector has a key role to play as system partners and the creators of innovation that can help close the health gap in CVD. What is needed now, and why the roundtable was convened, is to identify the meaningful actions industry can take within their sphere of agency to drive efforts to address health inequalities. A key first step is to use existing data to gain a detailed understanding of where and how pronounced inequalities are across CVD, different demographics and different geographies, and then help design, implementing and monitoring solutions to address them.

WHAT IS HOLDING BACK CHANGE?

A cross cutting theme and a fundamental priority discussed at the roundtable was the need to build and strengthen relationships, communication channels and collaborative efforts in the CVD space between industry and NHS. Industry shares the same ambition as the NHS in reducing health and healthcare inequalities. Furthermore, industry have additional resources and expertise to help drive initiatives that can make a difference when paired with NHS knowledge.

Lack of National CVD Strategy

National policies present an invaluable opportunity for all stakeholders, ranging from the NHS to industry, to align their efforts towards shared objectives. Despite CVD standing as the foremost cause of mortality in the UK, the absence of a dedicated national strategy to address it exacerbates existing disparities in access and outcomes as well as the wider determinants of health.

Recent national policy documents and strategies acknowledge the significant burden imposed by CVD on the UK populace, yet they lack the granularity needed for effective intervention. For instance, the Major Conditions Strategy identifies CVD, along with conditions like stroke and diabetes, as one of the six primary contributors to poor health and premature death. Similarly, the NHS Core20Plus5 strategy outlines measures to mitigate healthcare disparities at both national and systemic levels, highlighting hypertension and lipid management as one of its five clinical focal points but falling short of encompassing CVD comprehensively.

While initiatives such as the Major Conditions Strategy and Core20Plus5 signify progress in recognising CVD and its associated inequities as NHS priorities, the absence of more targeted policies hampers the guidance required for cohesive action among the NHS, industry, and other stakeholders.

A singular strategy for improving CVD health could ensure coherence of delivery across Government Departments and clear asks and priorities to local and system leaders as well as opportunities for industry to support and partner.

Inequities in Healthcare Driving Poor Access and Outcomes

Systemic inequities are driving poorer access to CVD care which leads to poorer health outcomes. Early detection and intervention is the golden ticket in preventing mortality caused by CVD, but currently is an opportunity that is not maximised, especially amongst female sufferers.

Many of the roundtable attendees agreed that CVD has traditionally been seen as a male 'disease' leading to inequalities in early access for female patients. One such example is in abdominal aortic aneurysm (AAA) screening, which has traditionally not been seen to be cost-effective in England to offer to women. Screening is, however, offered to men during the year they turn 65[7]. We know a third of deaths from ruptured AAA occur in women and this has certainly been compounded with a lack of research to really understand full benefits and harms of introducing a screening programme for women.

There is also currently no screening for CVD for women who have had pre-eclampsia, despite this group known to have elevated risk of stroke, cardiac atherosclerotic events, peripheral events, heart failure, atrial fibrillation, and cardiovascular related deaths.[8] Gender, ethnicity and deprivation related inequalities in access to care have also been noted for those requiring aortic valve replacement.[9]

Moving Away from 'Paralysis by Analysis'

Understanding CVD inequalities demands a nuanced understanding of its drivers facilitated by granular patient-level data and thorough analyses. Both the NHS and industry possess highly detailed patient level datasets that can highlight CVD inequalities in granular detail and enable solutions focussed resource allocation.

However, as the roundtable discussion progressed it became clear that the full potential of such data to unveil disparities within the CVD patient pathway and move to meaningful action for remediating inequalities remains untapped.

Discussions surrounding inequity often adopt a geographical lens, focusing primarily on Integrated Care Systems (ICS).

While this perspective is crucial, it represents just one aspect of a multifaceted issue. It is imperative that we broaden our scope and pose diverse questions to the data, exploring how inequities present themselves across various demographics including gender, ethnicity, and age.

Insight and action are often limited by a fragmented data landscape. The NHS holds highly detailed patient-level information across primary and secondary care settings, whilst industry also holds valuable data regarding unmet need for patient populations. Limited accessibility and collaboration across stakeholders hinders progress in health inequalities. If we want to drive change, bridging the gap between stakeholders and fostering channels of communication that can increase collaborative opportunities is paramount to crafting targeted strategies that address the root causes of CVD inequalities.

ABHI MEMBERS' ROLE

Attendees discussed the '**4 Ps**' – **Prioritise**, **Podiums**, **Playbook** and **Policymakers** – as key activities and actions industry could drive and within their sphere of influence.

PRIORITISE

An immediate activity for ABHI members is to create an internal strategic working group with the aim to combine industry efforts to tackle health inequalities. This group would align on priorities and act as a unifying voice for wider advocacy and engagement efforts. This working group would also agree on the measures of success. As became clear during the roundtable, data and insight to drive action is the cornerstone to meaningful change. The working group should make better use of data across ABHI members to articulate the challenges with CVD inequalities and advocate for change.

PODIUMS

Industry have a key role to play in raising awareness of the ongoing issues in inequalities in CVD and can shine a light on it via speaking opportunities and campaigns. Particularly powerful campaigns often include the third sector who can bring an important patient perspective. For example, in France Axa Prévention, a non-profit association, paired the findings of a study around CVD and women's health with an emotive advertising campaign to raise awareness about CVD prevention specifically targeting women.[10] Similar campaigns working with the third sector and using powerful and compelling statistics could be supported by industry in England.

Campaigns and raising awareness can empower individuals with the knowledge and tools to manage their CVD health effectively and can lead to improved self-care practices, better health outcomes, and reduced healthcare disparities.

PLAYBOOK

What became clear during the roundtable discussion is that there are plenty of examples of local led best practice for addressing health inequalities in CVD. For example, we heard how there are good examples of successful community-based care. Successful community approaches have recognised the environment in which people live and used this context to design ways to better engage. For example, young black men are less likely to present to their GPs with hypertension. Instead, successful community approaches have focused on working with pastors and churches to increase awareness and engagement about symptoms of the disease with this group of individuals.

Attendees also discussed how there are opportunities to learn from other disease areas to address some of the issues we see in early diagnosis. The Lung Health Check programme, for example, is a useful pilot of targeted screening programs to learn from. This uses data to identify people with certain risk factors, such as age and smoking status, to then invite to screening in a targeted and personalised manner.

Attendees agreed that healthcare stakeholders are not always successful in sharing this best practice both across industry and the wider ecosystem. A playbook should be created that a) focuses on learning best practice for CVD from other clinical areas and b) aggregate resources across stakeholders into single resource, for example, compiling key lessons from the numerous community pilots that take place across the NHS and industry.

POLICY MAKERS

Meaningful change on a wide scale requires engaging decision makers. Industry can help the NHS to reduce CVD inequalities by influencing decision makers in collaboration. However, the NHS is complex with many different programs and systems working on this issue and identifying the right person or group to engage with to move the needle can be challenging. The ABHI working group established to address inequalities in CVD should continue to utilise its stakeholder mapping to identify who out of relevant groups and stakeholders at a national, system and local level, are a priority to engage with to ensure their advocacy efforts are targeted and effective going forward.

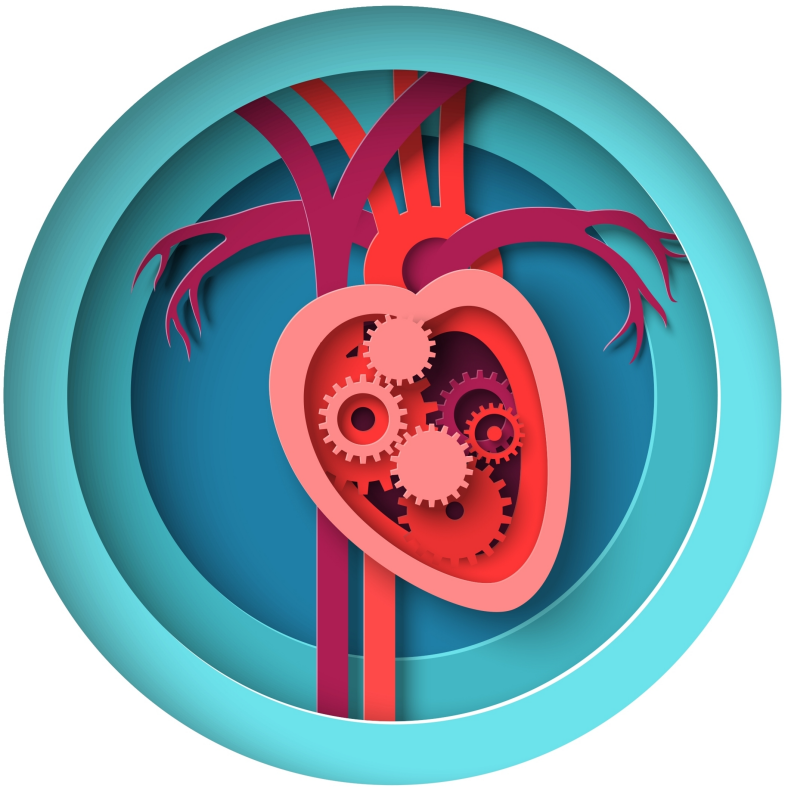
A tried-and tested method of influencing care provided by the NHS is to bring routine measurement into play. This was done with hospital mortality statistics and is the basis for 'QOF'[11] in primary care, the 'RightCare'[12] programme and other examples. Introducing routine data collection about procedures for CVD and disaggregating this into sex/ethnicity, could begin the process of closing the gaps in inequitable care. Industry can provide impetus for this and support the adoption of meaningful data and measurement to show what is working and what could be improved.

CONCLUSION

Addressing health inequalities in CVD is a multi-faceted issue. However, attendees concluded the roundtable with a sense of hope and collaboration about what they can do to drive change. Aligning on a strategy, identifying key stakeholders and making better use of data should be the first key first steps to enabling better CVD health for all.

Have Your Say & Get Involved

Do the reflections within this report resonate with you and your business? We would love to hear from you. Equally, if you are an ABHI member or stakeholder, and would like to contribute to work on this agenda, please get in touch at **enquiries@abhi.org.uk.**



ABHI & LCP HEALTH ANALYTICS

ABHI

ABHI is the UK's leading industry association for health technology (HealthTech).

ABHI supports the HealthTech community to save and enhance lives. Members, including both multinationals and small and medium sized enterprises (SMEs), supply products from syringes and wound dressings to surgical robots, diagnostics and digitally enhanced technologies. We represent the industry to stakeholders, such as the government, NHS and regulators. HealthTech plays a key role in supporting delivery of healthcare and is a significant contributor to the UK's economic growth. HealthTech is the largest employer in the broader Life Sciences sector, employing 154,000 people in 4,465 companies, with a combined turnover of £34.3bn. The industry has enjoyed growth of around 5% in recent years. ABHI's 400 members account for approximately 80% of the sector by value.

LCP HEALTH ANALYTICS

LCP is an 80-year-old partnership consultancy with over 1200 employees based in the UK and France. The health analytics practice includes over 45 Masters/PhD qualified health data scientists, epidemiologists, statisticians, medical doctors, bioinformaticians and health economists supporting clients in the pharmaceutical, med tech and biotech industries. Our multi-disciplinary analytics team at LCP work across the life-sciences sector to provide actionable insights and shift healthcare systems from importers of illness to exporters of health.

Specifically, we work with our clients in the life sciences and healthcare industries, combining our strategic vision with innovative and market leading analytics to:

- Unmask increasingly complex multimorbid unmet patient needs to inform targeted action and improve health equity.
- Help to redress the misalignment of how Health Technology Assessment bodies and governments value medicines and interventions and the value of health to patients, populations, and economies.

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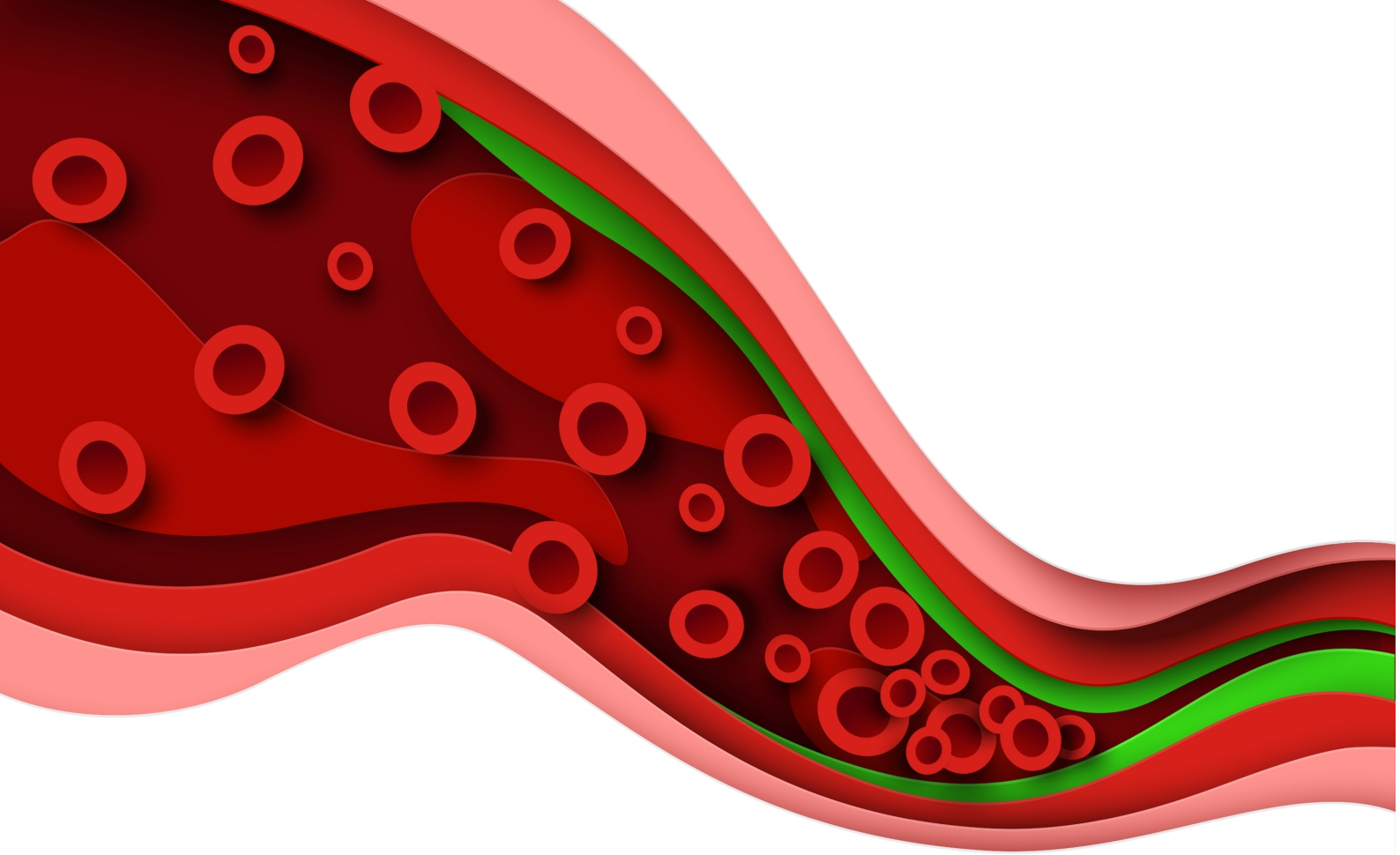

March 2024

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