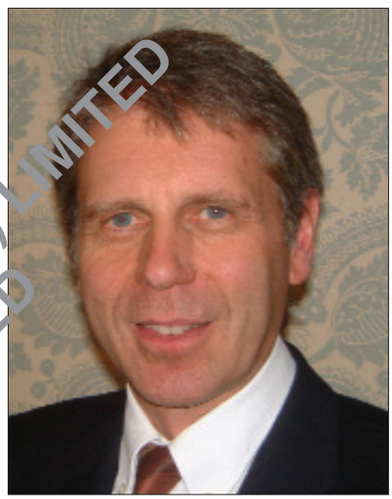
Cardiac services in the UK: are some areas more equal than others?



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The Department of Health has supported the standards and targets set in the National Service Framework (NSF) for coronary heart disease (CHD) with a programme of investment and reorganisation. This has stimulated a substantial expansion of facilities and increased the implementation of evidence-based treatments for patients in England, but cardiologists elsewhere in the United Kingdom repeatedly expressed concern that this progress has not been reflected in their own countries. In response, the British Cardiac Society set up a working group to investigate variations in services and clinical activity and to explore their origins. The report is published in this edition of the Journal.[1]

Notwithstanding methodological difficulties such as the comparability of data from different sources, cross-border activity, separating NHS and private provision and the limited scope of the comparisons, the report discloses compelling evidence of major differences in service provision, activity and aspirations between the devolved nations. These differences bear no relation to the burden of coronary disease in their populations. The pattern is neither consistent nor exclusively in favour of England. Wales and Scotland fare badly in terms of access to coronary angiography and Wales has the lowest overall rates of revascularisation. Scotland lags far behind in the introduction of new technologies – implantable cardioverter defibrillators (ICD) and drug-eluting coronary stents (DES) – but, intriguingly, achieves the highest overall rate of revascularisation despite low rates of angiography. Northern Ireland has the fewest cardiac surgeons in relation to its population and the lowest rate of coronary artery bypass grafting (CABG), but the highest number of cardiologists and the highest rate of coronary angiography and percutaneous coronary intervention (PCI).

Whilst an overall concordance appears to exist between the availability of personnel and facilities with clinical activity, the report concludes that different organisational and commissioning structures and approaches to guidelines account for the observed differences, as much as variations in staffing and facilities, particularly in the uptake of new technologies. It is tempting to regard the English system, based on NICE (National Institute for Clinical Excellence) appraisals, as the ideal paradigm for the introduction of new drugs and devices but it is noteworthy that Northern Ireland, which is not beholden to NICE and has a process considered by cardiologists to be clumsy and unsustainable, far outperforms the other nations in the introduction of DESs and ICDs.

Inequalities in provision

It might be (and indeed it has been) argued that the whole point of devolution is to enable elected representatives to plan and implement services in accordance with local requirements. Whereas some aspects of health service planning, for example reperfusion strategies for patients with acute myocardial infarction, might vary advantageously according to geographical considerations, none of the services examined in this report can legitimately be regarded as being more or less appropriate for patients according to where they live. Moreover, few would argue in support of what has come to be known as postcode prescribing, and the citizens of England, Wales, Scotland and Northern Ireland are, equally, citizens of the United Kingdom.

The report did not set out to criticise the alternative approaches to service provision, but rather to make comparisons in order to encourage discussion and consultation on how access might be improved for patients everywhere. In much the same way, comparative audits of clinical activity have demonstrably improved individual trusts' adherence to guidelines and targets, as exemplified by the Myocardial Infarction National Audit Project.[2] We do not advocate identi-

cal systems of governance but we do argue for equality of provision according to need.

Survey limitations

It must also be acknowledged that the 'snapshot' of data from a single year might reflect different rates of progress rather than inability to provide for the population or an intention to limit services in favour of other priorities. We are aware that significant progress has been achieved since the data for the report were collected. The Society intends to continue to monitor the situation by means of a more detailed survey that will, where the data are sufficiently robust, include both indications of progress and scrutiny of a wider spectrum of services.

Catching up with Europe

Discussion of these substantial variations should not, however, overshadow the uncomfortable fact that personnel, facilities and clinical activity throughout the United Kingdom still fall far below those in comparable Western European countries, despite their lower burdens of heart disease.[3,4] Concern exists, moreover, that the NSF, by focusing attention on CHD targets, has had the adverse consequence of marginalising management of other types of heart disease. The recently published NSF for arrhythmias will, it is hoped, help to redress the balance in this area. Without defined targets and a commitment to fund them, however, it is unlikely to achieve the priority that it, as well as other services that have not been the subject of national service frameworks, require to bring cardiac services in the United Kingdom up to the standards enjoyed by our European neighbours.

References

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