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He Ako Hiringa
Learning Always

Cardiovascular disease – a risky business

Cardiovascular disease is the leading cause of death in New Zealand, accounting for 35 per cent of mortality in 2019. Yet it's preventable and treatable.[1]

The risk of CVD is a continuum – everyone has some – and reducing risk via lifestyle changes is recommended. However, once an intermediate five-year risk level (5–15 per cent) is identified, blood-pressure and lipid-lowering medicines should be discussed and initiation considered. Primary preventive therapy usually comprises monotherapy with a statin or dual therapy with a statin and ACE inhibitor;[2] strong evidence supports the reduction of five-year event rates by 25–30 per cent with individual use of each medicine.[3]

These medicines are also recommended in people with higher risk, with aspirin added if indicated; management would generally be the same as in people with established CVD.[2,3]

Risk is disproportionately higher among people with severe mental illness, and among Māori, Pacific and South Asian peoples compared with people not of these ethnicities. Therefore, CVD risk assessments in these ethnicities should begin at age 30 in males and 40 in females, and from age 25 in people with severe mental illness.[2]

Inequity persists

CVD medicines are generally required long term so need to be prescribed, dispensed and taken regularly; however, differences in dispensing data exist between ethnicities.

Although Māori have a higher risk of CVD and premature mortality relative to non-Māori, non-Pacific peoples, 2019 data show a lower proportion of Māori are dispensed preventive CVD medicines (36 per cent), compared with non-Māori, non-Pacific peoples (43 per cent).[4] This gap is larger for men than women.

Conversely, more Pacific peoples were dispensed CVD preventive medicines (48 per cent) than non-Māori, non-Pacific peoples, although access remains insufficient for those who need these medicines.[4]

Barriers contributing to inequities include prescribing bias, cost, and inadequate access to medicines and healthcare.

References are available with the online bulletin

Medicine persistence and possession

Dispensing data reveal whether a person has had access to medicines, to enable regular administration. Dispensing can be measured using indicators: persistence – the proportion of people who have accessed preventive medicine in a specified time period; possession (adherence) – the proportion who have had sufficient medicine dispensed to cover that period; and regular dispensing – persistence and possession combined. People with regular dispensing have adequate medicine to prevent or treat their condition.

These definitions are helpful when exploring primary prevention of CVD. Of all people previously dispensed preventive medicine to reduce cardiovascular risk, about half do not continue to receive it regularly.[5]