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Global disparities in prescription of guideline-recommended drugs for heart failure with reduced ejection fraction

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Abstract

Background

Heart failure (HF) is a global challenge, with lower- and middle-income countries (LMICs) carrying a large share of the burden. Treatment for HF with reduced ejection fraction (HFrEF) improves survival but is often underused. Economic factors might have an important effect on the use of medicines.

Methods and results

This analysis assessed prescription rates and doses of renin-angiotensin system (RAS) inhibitors, β-blockers, and mineralocorticoid receptor antagonists at discharge and 6-month follow-up in 8669 patients with HFrEF (1458 from low-, 3363 from middle-, and 3848 from high-income countries) hospitalized for acute HF in 44 countries in the prospective REPORT-HF study. We investigated determinants of guideline-recommended treatments and their association with 1-year mortality, correcting for treatment indication bias.

Only 37% of patients at discharge and 34% of survivors at 6 months were on all three medication classes, with lower proportions in LMICs than high-income countries (19 vs. 41% at discharge and 15 vs. 37% at 6 months). Women and patients without health insurance, or from LMICs, or without a scheduled medical follow-up within 6 months of discharge were least likely to be on guideline-recommended medical therapy at target doses, independent of confounders. Being on ≥50% of guideline-recommended doses of RAS inhibitors, and β-blockers were independently associated with better 1-year survival, regardless of country income level.

Conclusion

Patients with HFrEF in LMICs are less likely to receive guideline-recommended drugs at target doses. Improved access to medications and medical care could reduce international disparities in outcome.

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Introduction

Despite advances in care, patients recently hospitalized for acute heart failure (HF) still have a high mortality.1–4 Evidence-based practice guidelines5,6 recommend that patients with HF with reduced ejection fraction (HFrEF) are treated with angiotensin-converting enzyme inhibitors (ACEi)7,8 or angiotensin receptor blockers (ARBs),9,10 β-blockers,11 and mineralocorticoid receptor antagonists (MRAs).12–14 Early initiation of these guideline-recommended medications following hospitalization for HF improves outcomes.15 Unfortunately, many patients with HFrEF do not receive these lifesaving medications at all or only on less than guideline-recommended target doses (GRTD).16–19

We previously showed that post-discharge mortality was substantially worse in patients with HFrEF from low- or middle-income countries (LMICs) in the prospective REPORT-HF registry.4 It is unclear whether this finding reflects differences in patient characteristics, quality of discharge care, or access to guideline-recommended medical therapy. Reports from Western Europe and the United States suggest <20% of patients with HFrEF are on guideline-recommended doses of ACEi/ARBs, β-blockers, and MRAs.16–18 Furthermore, in LMICs in Asia, substantial underutilization of guideline-recommended medical therapy exists.18

This analysis aimed to assess (i) the prescription patterns of guideline-recommended therapy at discharge and 6-month follow-up for patients with AHF; (ii) factors associated with use in countries at different economic levels; and (iii) the association of medication prescribing with 12-month mortality.
Materials and methods

Study design, setting, participants, and study procedures

Design, methods, and 1-year outcomes of the REPORT-HF study have been published. In summary, REPORT-HF was a prospective, observational, global cohort study with patients prospectively enrolled from 6 continents, 44 countries, and 358 sites. This study was conducted according to the Declaration of Helsinki, and the protocol received Institutional Review Board and/or ethics committee approval at each participating centre. Participants were hospitalized with a primary diagnosis of acute HF, according to the treating physician. Written informed consent was obtained from all the patients or a legal representative. Potential participants unwilling or unable to provide informed consent were excluded. Patients were also excluded when they concurrently participated in a clinical trial with any investigational treatment.

Data were collected on patient’s demographics, medical history, vital signs, laboratory values, acute therapies, procedures, hospital course, length of stay, and mortality in a central electronic database using the same case report form at all sites. Data were reviewed by central data management and queries were resolved by local study monitors. Heart failure with reduced ejection fraction was defined as a left ventricular ejection fraction <40%, in keeping with current guidelines. Coronary artery disease was defined as having a history of coronary artery bypass grafting, percutaneous coronary intervention, acute coronary syndrome, or myocardial infarction. Anaemia was defined as having a history of anaemia or having a haemoglobin <12 g/dL in women and <13 g/dL in men. Valvular heart disease was defined as a history of valvular heart disease or having valvular heart disease as an aetiology. There were programmed database edit checks and manual data review with queries if no information was filled in or in cases of data conflicts.

Collection of data on medication

Data on medication at discharge and 6 months after discharge were collected. Medication and doses at discharge were captured by investigators from medical records at or around the time of discharge during the index hospitalization. Medication information during follow-up was acquired from the treating physician or patients during a regular follow-up visit. If patients had no scheduled follow-up visit with the hospital where the initial index hospitalization took place, prescribing data were obtained by telephone from the primary care provider and/or patient at 6 months. There were programmed database edit checks and manual data review with queries if no medications were recorded or doses(units) were out of range for any of the cardiovascular (CV) drugs. Additional data quality checks were performed using the records provided at the analysis stage. The fractionated target dose of ACEi/ARB/angiotensin receptor–neprilysin inhibitor (ARNi), β-blockers and MRAs was calculated based on GRTD according to the European Society of Cardiology and American Heart Association guidelines (see Supplementary material online, Table S1). When no medications were recorded at discharge or follow-up visits, it was assumed that these data were missing, because it is unlikely that a patient would not be taking any medication. When one or more medications were recorded (e.g. a diuretic or hypoglycaemic agent), this did not include one or more guideline-recommended treatments for HF (ACEi/ARB/ARNi, β-blockers, MRAs), it was assumed that these agents had not been prescribed. In total, paired medication data were available in 6827 patients with HFrEF at both discharge and follow-up; and analyses involving medication at follow-up are restricted to these patients.

Outcomes

Follow-up information from study participants was collected via a telephone interview at 6 and 12 months unless a regular follow-up visit was planned at the investigator’s site for routine care. Vital status was supplemented by national reporting databases where available. Local investigators ascertained the cause of death and classified as CV, non-CV, or unknown.

Statistical analysis

We report differences in patient characteristics, medication use, and dose achieved according to country income levels. Countries were grouped by income level, based on the World Bank classification (see Supplementary material online, Table S2) using gross national income in 2017. The 44 participating countries were grouped into seven geographic regions based on a modification of the World Health Organization classification (see Supplementary material online, Table S2). We showed medication use and doses according to regional income level and to geographic region ordered according to mean regional income level. In secondary analyses, we studied the effect of income inequality on medication use using the Gini coefficient, with zero (0%) representing absolute income equality and one (100%) indicating significant income inequality. For most countries, the Gini coefficients were obtained from the UN Development Programme, as described previously. Data from the year closest to 2003 were used, allowing for a potential lag effect. For comparisons between groups, we used the one-way analysis of variance, χ²-test, or Mann–Whitney U-test for normally distributed continuous variables, categorical variables, and non-normally distributed continuous variables, respectively. Multivariable logistic regression analyses were performed to investigate variables associated with being on medication. Variables were selected based on clinical significance and expert opinion. Because the aim of REPORT-HF was to compare quality and usual care globally, measurement of N-terminal pro-B-type natriuretic peptide or B-type natriuretic peptide was not mandated and only reported if measured by treating physicians. We classified natriuretic peptides in tertiles and included a missing category for patients who did not have natriuretic peptides measured, to correct for any measurement bias. To test whether country income level modified the association of sex with medication use, we performed a test of interaction between sex and country income level for medication use. To correct for treatment indication bias in outcome analyses, the reported hazard ratios (HRs) from Cox proportional hazards regression analyses were weighted by the inverse probability of receiving the given treatment (ACEi/ARB/ARNi, β-blockers, or MRAs) at ≥50% of GRTD. The probability of receiving ≥50% of GRTD for a particular treatment in each patient was modelled using logistic regression with LASSO penalization based on a comprehensive list of 58 variables (see Supplementary material online, Table S3). The optimal penalty parameter was
Results

Baseline characteristics

During the study period between July 23, 2014, and March 24, 2017, 18,553 patients were enrolled including 8904 with HFREF of whom 8669 survived to discharge. The population’s median age was 64 (25th and 75th percentile 55–74) years, and 72% were men. Compared with patients from high-income countries, patients from low-income countries were younger (median age of 60 vs. 67 years), more often of non-White ethnicity, and more often had new-onset HF than patients from high-income countries (Table 1). In total, 12% of patients from low-income countries were in NYHA Class III/IV at discharge compared with 15% of patients in high-income countries. Patients from low-income countries had a lower known comorbidity burden, except for diabetes, which was more prevalent in low-income countries (44%) than high-income countries (37%).

Among patients from low-income countries, 24% did not have health insurance compared with only 3% in high-income countries. Furthermore, patients from low-income countries were less likely to see a doctor after discharge (47 vs. 69% in high-income countries); either a general practitioner (2 vs. 15% in high-income countries) or cardiologist (44 vs. 60% in high-income countries). This difference remained after correcting for health insurance differences (P < 0.001 for all).

Medication at discharge and 6-month follow-up

At discharge, 3189 patients (37%) were on all three medications, 29 patients (<1%) had missing data on medication. In low-income countries, 271 patients (19%) were on all three medications compared with 1566 (41%) in high-income countries. Patients from low-income countries were less likely on any of three classes of medicines, including ACEi/ARB/ARNi (57 vs. 71% in high-income countries), β-blockers (52 vs. 84% in high-income countries), and MRAs (45 vs. 59% in high-income countries, Figure 1A). Furthermore, patients from low-income countries were less likely on ≥50% of GRTD for ACEi/ARB/ARNi (22 vs. 28% in high-income countries) and β-blockers (7 vs. 32% in high-income countries) but were more often on GRTD for MRA (14 vs. 9% in high-income countries, Figure 1A).

At 6 months, data were missing on medication for 625 (8%) of patients. Among the 6827 patients with medication data available at both discharge and 6 months, 5% of patients from low-income countries compared with 10% of patients in high-income countries for ACEi/ARB/ARNi were up-titrated (Figure 1B). For β-blockers, 6% of patients from low-income countries were up-titrated to GRTD compared with 12% of high-income countries. For MRAs, patients from low-income countries were equally likely to be up-titrated at 6 months (4%) than patients from high-income countries (4%).

Patients without health insurance were less likely on ACEi/ARB/ARNi (57 vs. 68%), β-blockers (52 vs. 78%) and MRAs (46 vs. 62%) compared with patients with public insurance (Figure 1C). They were less likely on GRTD for ACEi/ARB/ARNi (28%), β-blockers (11%), and MRAs (10%) compared with patients with public insurance (28, 27, and 15% for ACEi/ARB/ARNi, β-blockers, and MRAs, respectively, Figure 1C). Only 51% of patients from low-income countries without insurance were on ACEi/ARB/ARNi, 41% on β-blockers, and 37% on MRAs compared with 70, 83, and 59% of patients with public insurance in high-income countries for ACEi/ARB/ARNi, β-blockers and MRA, respectively (see Supplementary material online, Figure S1). Patients without insurance were less likely up-titrated to GRTD compared with patients with private or public insurance for any medication class (Figure 1D). When stratified according to regions ordered by mean country income level, medication use was lowest in southeast Asia for all three classes and highest in Western Europe (see Supplementary material online, Figure S2). There was considerable heterogeneity among countries within regions (see Supplementary material online, Figure S3) as well. Figure 2 shows that medication dosages were considerably lower in Southeast Asia for most medication classes.

Factors associated with medication use

In multivariable analyses, women, older patients, patients with new-onset HF, patients with chronic kidney disease, patients from low-income countries, and patients without insurance were less likely to be on ACEi/ARBs/ARNi, β-blockers, and MRAs at discharge (Figure 3) and 6 months (see Supplementary material online, Figure S4). At 6-month follow-up, 22% of women from low-income countries were not on any medication than 5% of men from high-income countries. In sensitivity analyses, we replaced history of hypertension with systolic blood pressure. Results remained similar (see Supplementary material online, Figure S5). We did not observe a significant interaction P-value between sex and country income level for any of the three medication groups. Supplementary material online, Figure S6 shows secondary analyses including country income disparity (Gini coefficient). Patients from countries with higher-income disparity were less likely to be prescribed ACEi/ARB/ARNi or β-blockers at discharge than patients from countries with low-income disparity. Income disparity did not have a consistent effect on the likelihood of receiving an MRA at discharge.

Association with survival

In total, 1819 (22%) patients died within 1 year. Mortality rates at 1 year were higher among patients from low-income countries (25%) compared with high-income countries (19%, P < 0.001). Patients not on any of the three guideline-recommended classes of medicines at discharge were more likely to die (31%) compared with patients on
### Table 1  Baseline characteristics of 8669 patients with heart failure with reduced ejection fraction in the REPORT-HF study

<table>
<thead>
<tr>
<th>Income classification</th>
<th>Low-income (n = 1458)</th>
<th>Middle-income (n = 3363)</th>
<th>High-income (n = 3848)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>60 (52–68)</td>
<td>63 (54–72)</td>
<td>67 (57–77)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Men, n (%)</td>
<td>1058 (73)</td>
<td>2419 (72)</td>
<td>2781 (72)</td>
<td>0.89</td>
</tr>
<tr>
<td>Race, n (%)</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Caucasian</td>
<td>161 (11)</td>
<td>1451 (43)</td>
<td>2587 (67)</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>2 (&lt;1)</td>
<td>75 (2)</td>
<td>434 (11)</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>1224 (84)</td>
<td>1003 (30)</td>
<td>553 (14)</td>
<td></td>
</tr>
<tr>
<td>Native American</td>
<td>0 (0)</td>
<td>134 (4)</td>
<td>42 (1)</td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>4 (&lt;1)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>71 (5)</td>
<td>700 (21)</td>
<td>228 (6)</td>
<td></td>
</tr>
<tr>
<td><strong>New-onset HF, n (%)</strong></td>
<td>995 (68)</td>
<td>1077 (32)</td>
<td>1309 (34)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>NYHA Class at discharge, n (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>I</td>
<td>200 (14)</td>
<td>392 (12)</td>
<td>310 (8)</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>492 (34)</td>
<td>1381 (41)</td>
<td>877 (23)</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>114 (8)</td>
<td>880 (26)</td>
<td>465 (12)</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>53 (4)</td>
<td>180 (5)</td>
<td>121 (3)</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>599 (41)</td>
<td>530 (16)</td>
<td>2075 (54)</td>
<td></td>
</tr>
<tr>
<td><strong>Heart rate (b.p.m.)</strong></td>
<td>93 (80–108)</td>
<td>86 (73–100)</td>
<td>90 (75–106)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Systolic blood pressure (mmHg)</strong></td>
<td>120 (110–140)</td>
<td>120 (108–140)</td>
<td>128 (110–147)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Diastolic blood pressure (mmHg)</strong></td>
<td>80 (70–90)</td>
<td>78 (68–86)</td>
<td>79 (68–91)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Aetiology, n (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Ischaemic</td>
<td>563 (39)</td>
<td>1403 (42)</td>
<td>1302 (34)</td>
<td></td>
</tr>
<tr>
<td>Hypertensive</td>
<td>208 (14)</td>
<td>264 (8)</td>
<td>338 (9)</td>
<td></td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>367 (25)</td>
<td>773 (23)</td>
<td>957 (25)</td>
<td></td>
</tr>
<tr>
<td>Valvular</td>
<td>45 (3)</td>
<td>249 (7)</td>
<td>254 (7)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>73 (5)</td>
<td>197 (6)</td>
<td>281 (7)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>202 (14)</td>
<td>477 (14)</td>
<td>716 (19)</td>
<td></td>
</tr>
<tr>
<td><strong>Signs and symptoms, n (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspnea at rest</td>
<td>1096 (87)</td>
<td>2681 (86)</td>
<td>2505 (78)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Orthopnea</td>
<td>841 (71)</td>
<td>2477 (83)</td>
<td>2091 (75)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Peripheral enema</td>
<td>619 (52)</td>
<td>2246 (70)</td>
<td>2225 (68)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Pulmonary rales</td>
<td>730 (67)</td>
<td>2161 (70)</td>
<td>1601 (58)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Comorbidities, n (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of hypertension</td>
<td>614 (42)</td>
<td>1909 (57)</td>
<td>2315 (60)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Atrial fibrillation/flutter</td>
<td>85 (6)</td>
<td>853 (25)</td>
<td>1274 (33)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>COPD/asthma</td>
<td>101 (7)</td>
<td>417 (12)</td>
<td>591 (15)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Anaemia</td>
<td>755 (52)</td>
<td>1211 (36)</td>
<td>1880 (49)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Valvular heart disease</td>
<td>73 (5)</td>
<td>519 (15)</td>
<td>717 (19)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Continued
at least one medication (21%). After adjusting for indication bias, pa-

tients up-titrated to ≥50% of GRTD had lower mortality compared with

other patients, even after adjusting for treatment indication bias for

ACEi/ARB/ARNi (HR 0.70; 95% CI 0.64–0.76), β-blockers (HR 0.68; 95% CI 0.63–0.75), and MRAs (HR 0.88; 95% CI 0.81–0.96) (see Supplementary material online, Table S4 and Figure S7).

Results at 6 months were similar for all classes, except for MRAs (see Supplementary material online, Table S4).

**Discussion**

Pharmacological treatment is the cornerstone in the management of HFrEF. Yet, effective guideline-recommended medications for HF are underused and underdosed globally.16,17,24 Our analysis adds to this evidence by demonstrating three principal findings and highlights the need for enhanced implementation of evidence-based medication for patients with HF globally. First, there is more under-
treatment of patients with HF in low-income countries than patients from high-income countries. Second, underuse and sub-target dosing are particularly common in women and patients without health in-
surance. Six months after discharge—an appropriate time frame to

ensure stability and initiate and up-titrate ACEi/ARB/ARNi, β-blockers, and MRAs to target dose or the maximally tolerated dose—almost 9% of patients did not receive any recommended pharmacological agents despite the clear guideline recommenda-
tions. Third, underuse of medications and target dosages were asso-
ciated with increased mortality (Structured Graphical Abstract).

In REPORT-HF, one-fifth of women in low-income countries were not on any of the three essential disease-modifying medicines at 6 months after discharge, compared with <1 in 20 men from high-

income countries. The findings highlight broad implications beyond health policy since health and social exposures are closely inter-
twined. To address disparities in prescribing, we suggest that broader

changes in policy (i.e. social, economic, and health policy) are neces-
sary to close the gap.

Our findings add to prior regional studies by evaluating medication prescribing and up-titration across multiple regions simultaneously. Despite clear survival benefits,15 various studies have shown sub-

optimal prescribing of guideline-recommended medication in pa-
tients with HFrEF.16,18,26–28 However, these studies were from single

countries,16,28 regions,17,18 or exclusively from higher-income coun-

tries. Our results extend these earlier findings in several important

ways, by including (i) global contemporaneous representation of a

large number of countries, including many categorized as low in-

come, (ii) data on medication and titration at different time points, and

(iii) in-depth patient data on planned follow-up visits and insur-

ance coverage. In Western Europe, only about half of patients with

HFrEF were on ≥50% of GRTD for ACEi/ARBs and 40% for

β-blockers.17 In the United States, 23% of patients were on ≥50% of

GRTD for ACEi/ARBs and 36% for β-blockers in the CHAMP-HF regist-

ry.16,24 In the recent QUALIFY registry, prescription rates of ACEi/ARB (87%) and β-blockers (87%) were higher than prior research. However, this study predominantly included patients from high-income countries. Furthermore, patients with a HF hospitalization in the previous 6 months were excluded.19 Trends of prescription rates in REPORT-HF parallel findings from these previ-

ous studies: only 36 and 44% of patients from Western Europe were on

GRTD for ACEi/ARBs and β-blockers, respectively; in North

America, 28% of patients were on ≥50% of GRTD at 6 months for

ACEi/ARBs and 39% for β-blockers. Notably, the use and doses of

MRA were higher in many lower-income regions, possibly driven by

the low cost of spironolactone and policies encouraging its use. For

example, the use of MRAs in China was particularly high in our

study, confirming earlier results.18 This might be attributed to a na-

tionwide quality assessment evaluation programme evaluating spi-

ronolactone use during hospitalization20 or treatment of co-existing

hypertension.31 Furthermore, seeing a general practitioner or

| Table 1 Continued |

<table>
<thead>
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<th>P-value</th>
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</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>637 (44)</td>
<td>1149 (34)</td>
<td>1436 (37)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>147 (10)</td>
<td>540 (16)</td>
<td>967 (25)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

1-year outcomes, n (%)

<table>
<thead>
<tr>
<th></th>
<th>Low-income (n = 1458)</th>
<th>Middle-income (n = 3363)</th>
<th>High-income (n = 3848)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dead at 1 year</td>
<td>350 (24)</td>
<td>774 (24)</td>
<td>695 (19)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospitalized within 1 year</td>
<td>234 (16)</td>
<td>1259 (38)</td>
<td>1726 (46)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospitalized for HF within 1 year</td>
<td>158 (11)</td>
<td>868 (27)</td>
<td>1059 (28)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Length of stay (days)</td>
<td>6 (4–9)</td>
<td>9 (6–14)</td>
<td>8 (5–12)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Follow-up visits within 6 months

<table>
<thead>
<tr>
<th></th>
<th>Low-income (n = 1458)</th>
<th>Middle-income (n = 3363)</th>
<th>High-income (n = 3848)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any</td>
<td>677 (47)</td>
<td>1698 (52)</td>
<td>2591 (69)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>General practitioner</td>
<td>35 (2)</td>
<td>321 (10)</td>
<td>566 (15)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>634 (44)</td>
<td>1423 (43)</td>
<td>2245 (60)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

COPD, chronic obstructive pulmonary disease; HF, heart failure; NYHA, New York Heart Association.

*a*Using patients alive at 1-year as the denominator.
cardiologist after discharge was an independent predictor of being on medication at 6 months after discharge, highlighting the vital role that healthcare practitioners outside of cardiology can play in initiating HF medication. Beyond country income level, there was considerable geographic heterogeneity. For example, medication use and dosages of most pharmacotherapeutic classes were lower in Southeast Asian and Western Pacific countries when compared with countries in Western Europe or North America. The ESC Heart Failure Association Atlas recently highlighted the important regional heterogeneity of medication use and uptake, even within Europe. Higher-income regions in Europe had more dedicated HF centres and more complete reimbursement of guideline-directed medical therapy (GDMT), particularly ARNi, than middle-income regions. These previous data suggested that reimbursement might be an important factor in determining the utilization of GDMT. Our findings extend on this by further highlighting the importance of reimbursement: GDMT utilization was lower in patients without health insurance and in lower-income regions, where patients often have higher out-of-pocket costs. Country income disparity showed an independent association with being prescribed ACEi/ARB/ARNi or β-blockers at discharge. This suggests an important part of the variance of medication use and doses may be explained by other factors such as local/regional practices and standards and income inequality, rather than country income level alone. Future clinical

**Figure 1** Stacked bar chart depicting the proportion of patients at discharge on guideline-recommended medical therapy and ≥50% of target dose at discharge stratified by country income level (A); up-titration of patients between discharge and 6-month follow-up stratified by country income level (B); the proportion of patients at discharge on guideline-recommended medical therapy and ≥50% of target dose at discharge stratified by insurance status (C); up-titration of patients between discharge and 6-month follow-up stratified by insurance status (D).
Figure 2 World maps for average dosages of guideline-recommended medical therapy at discharge among patients on medication for angiotensin-converting enzyme inhibitors/angiotensin receptor blockers/ARNi, β-blockers, and mineralocorticoid receptor antagonist.
trials in (acute) HF might benefit from examining the consistency of results by classifying countries not only by geography but also by income and income disparity.

Previous data from Asia suggest stark regional differences in guideline-recommended medicines. China had the lowest prescription rate of ACEi/ARBs (60%) but the highest prescription rate of MRA (78%) in the ASIAN-HF registry,\(^1\) which is similar to REPORT-HF (57 and 86% ACEi/ARBs and MRAs, respectively). Besides, patients from lower-income countries in ASIAN-HF were more often on sub-target, similar to REPORT-HF. Taken together, data from REPORT-HF are consistent with previous country-based or regional reports. Our results extend upon these earlier findings in several important ways, by including (i) global representation of low-income countries, (ii) data on medication and titration at different time points, and (iii) in-depth patient data on planned follow-up visits and insurance coverage.

Patients from low-income countries, those without health insurance, and women were least likely to be on guideline-recommended medical therapies and below GRTD. To the authors’ knowledge, this is the first study showing underuse and sub-target dosing of lifesaving HF medications in low-income countries in a global registry with broad representation and highlights the need for targeted public health interventions to increase the quality of care and prescription of guideline-recommended therapy in HF. Individual patient factors like renal function, age, blood pressure, and heart rate might determine the prescription and dosing of pharmacotherapy for HFrEF. These factors, however, likely do not explain the observed regional differences—patients in lower-income countries were almost a decade younger in REPORT-HF and had a lower prevalence of relevant risk factors, including renal dysfunction and chronic obstructive pulmonary disease.\(^6\) Another explanation might be a patient’s perception and familiarity with HF therapy. A recent survey in the US highlighted that a significant proportion of patients with HF were not familiar with GDMT and questioned their effectiveness.\(^3\) Our results show that economic factors might play a role.\(^4\) In the Prospective Urban Rural Epidemiological study, secondary preventative medicines for CV disease were underused globally, particularly in low-income countries.\(^35\)–\(^38\) Importantly, β-blockers and ACEi were considered unaffordable even for participants in the highest household wealth groups in low-income countries.\(^37\) While we did not investigate ARNi or sodium–glucose cotransporter 2 inhibitors separately, uptake will likely be even lower for these more expensive but lifesaving treatment options.\(^39\) Together, our data suggest the underuse of ACEi/ARBs, MRAs, and β-blockers in patients without health insurance, indicating that insurance coverage and medication costs might be a possible governing factor determining access.

Our results suggest a survival benefit for achieving ≥50% of GRTD for ACEi/ARB/ARNi and β-blockers, after accounting for treatment indication bias, and regardless of region or economic status. We tried to correct for confounding factors as much as possible. However, REPORT-HF was not a randomized trial and, therefore, our results should be interpreted with caution. For example, we did not observe a survival benefit for MRAs. Patients with a worse New York Heart Association class and longer length of stay were more likely to be prescribed an MRA. Therefore, the absence of a clear association with survival of MRAs might be driven by (residual) confounding, despite the use of inverse probability weighting. The benefits of MRAs for patients with HFrEF are well established in randomized trials.\(^14,22\) Thus, the analyses of REPORT-HF should not be used to determine treatment decisions for individual patients. Observational data can be used to assess outcomes associated with a treatment, but randomized trials are required to determine the response to treatment; these are very different concepts.\(^40\) However, our results highlight the window of opportunity to initiate HF medication before

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**Figure 3** Forest plots for multivariable logistic regression with factors associated with being on (A) angiotensin-converting enzyme inhibitors/angiotensin receptor blockers, (B) β-blockers, and (C) mineralocorticoid receptor antagonists at discharge.
Strengths and limitations of the study

Strengths of this study include the prospective design and the global representation of patients with different ethnicities from countries at different economic levels. The study limitations include non-random sampling of centres and countries, done for practical reasons and lack of establishment on causality or drug efficacy. Therefore, these results likely represent a best-case scenario—centres serving more rural populations are probably not well represented. While we have performed inverse probability weighting to account for confounding in outcome analyses, residual confounding can unfortunately not be measured. Furthermore, no reasons for sub-target dosing, contraindications, or adverse events were captured in the database. Likewise, it is unclear if patients not receiving target doses were on maximally tolerated doses or not, and we did not assess adherence. Besides, it is possible that some patients not receiving medications or receiving low doses have previously tried the medication but did not tolerate it. However, given the more favourable risk profile of patients from low-income countries, including a lower prevalence of hypotension and renal dysfunction, differences in contraindications likely do not explain the differences in prescription patterns between income regions but are possibly the consequence of economic limitations or clinical inertia. Given the need for patients to consent to participate in REPORT-HF, selection bias might have taken place. Furthermore, fractions of GRTD might be confounded by individual patient characteristics (weight of the patient, frailty, blood pressure, renal function) and decisions of individual healthcare practitioners, which might have introduced bias. If updated prescribing information was not available from the participants’ medical records, it was obtained by telephone from the primary care provider or patient. Finally, patients in REPORT-HF were hospitalized, and a relatively higher risk population. However, given the lack of data on prescription rates and dosages of HF medications, especially in LMICs, the present study is the best available evidence to date for these patients.

Supplementary material

Supplementary material is available at Brain Communications online.


