NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH TECHNOLOGY APPRAISAL PROGRAMME

Equality impact assessment – Guidance development

STA – Semaglutide for reducing the risk of major adverse cardiovascular events in people with cardiovascular disease and overweight or obesity

The impact on equality has been assessed during this appraisal according to the principles of the NICE equality scheme.

Final draft guidance

(when no draft guidance was issued)

1.	Have the potential equality issues identified during the scoping process been addressed by the committee, and, if so, how?
The following potential equality issues were identified at scoping: • Availability of cardiovascular preventative therapies and variable access to specialist weight management services • Elevated cardiovascular risk in people of South Asian or sub-Saharan African ethnic groups • Socioeconomic status influences the incidence and impact of obesity, compounded by the understanding that people living in England's most deprived areas are almost four times more likely to die prematurely from cardiovascular disease than those in the least deprived • Compared with the general population, people with severe mental illness are more likely to develop and die from preventable conditions such as cardiovascular disease	

2.	Have any other potential equality issues been raised in the submissions, expert statements or academic report, and, if so, how has the committee addressed these?

Yes:

Stakeholders further explained that people of South Asian or sub-Saharan African ethnic groups are at higher risk of cardiovascular disease at lower BMI thresholds than the general population. They added that body mass index (BMI)-based criteria for treatment eligibility may not account for ethnic variations in risk. The lead team noted that recommending semaglutide for people with a baseline BMI lower than 27 kg/m2 would fall outside of the marketing authorisation for semaglutide. It also noted there was no evidence of semaglutide's safety or efficacy in a population with a baseline BMI of lower than 27 kg/m2 to justify this. The lead team concluded that making a recommendation for semaglutide in line with the marketing authorisation across all groups would protect patient safety and was a legitimate aim.

Stakeholders highlighted that people with language difficulties may struggle to access, understand or adhere to treatment plans and that people with physical or cognitive impairments may have difficulty with self-injection. The lead team also noted that people with language difficulties or cognitive impairments may have difficulty adhering to treatment plans and may struggle to self-administer semaglutide. But it discussed that this should not be a barrier to treatment and that implementation plans for such groups could help alleviate any inequalities issues. The lead team noted that any lifestyle interventions offered should be accessible to all people, including those with language difficulties and cognitive impairment.

Stakeholders added that people from lower-income backgrounds may face greater barriers to accessing new treatments. The lead team considered that its recommendation does not make it more difficult for people from lower income backgrounds to access treatment.

Stakeholders also highlighted that men are more likely to have heart disease than women, but women may face delays in diagnosis, and the prognosis for women is worse because of this. The remit of this technology appraisal does not cover diagnosis of heart disease, so this could not be covered by the recommendations.

3.	Have any other potential equality issues been identified by the committee, and, if so, how has the committee addressed these?
No other potential equality issues identified by the committee.	

4.	Do the recommendations make it more difficult in practice for a specific group to access the technology compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
As described in sections 1 and 2, people from South Asian or sub-Saharan African ethnic backgrounds are at higher risk for cardiovascular disease (CVD) at lower BMI thresholds than the general population. This means that an individual from this specific group may have the same risk for CVD as someone not in this group but will not be eligible for semaglutide according to the recommendation, as it includes a BMI threshold. The remit for this evaluation is to evaluate semaglutide within its marketing authorisation. The marketing authorisation specifies that semaglutide can be used for people with a BMI of at least 27kg/m^2. The lead team acknowledged that it was not able to make a recommendation outside the marketing authorisation. It also noted that there was no evidence of semaglutide's safety or efficacy in a population with a baseline BMI of lower than 27kg/m^2 as the clinical trials only included people with a baseline BMI of at least 27kg/m^2. The lead team acknowledged that this meant that its recommendation did not provide access for people from specific ethnic groups who have a higher risk of CVD but do not fall within the specified BMI range. But it considered that ensuring drug safety was a legitimate aim, and making its recommendation within the remit of the evaluation (within the marketing authorisation) and within a population for which it had safety and efficacy data was appropriate.	

5.	Is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No

6.	Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access identified in questions 4 or 5, or otherwise fulfil NICE's obligations to promote equality?
Explanations have been provided here and within the final draft guidance. No further recommendations are appropriate.	

7.	Have the committee's considerations of equality issues been described in the final draft guidance, and, if so, where?
Yes – please see final draft guidance section 3.11.	

Approved by Associate Director (name): Ian Watson

Date: 24 March 2026