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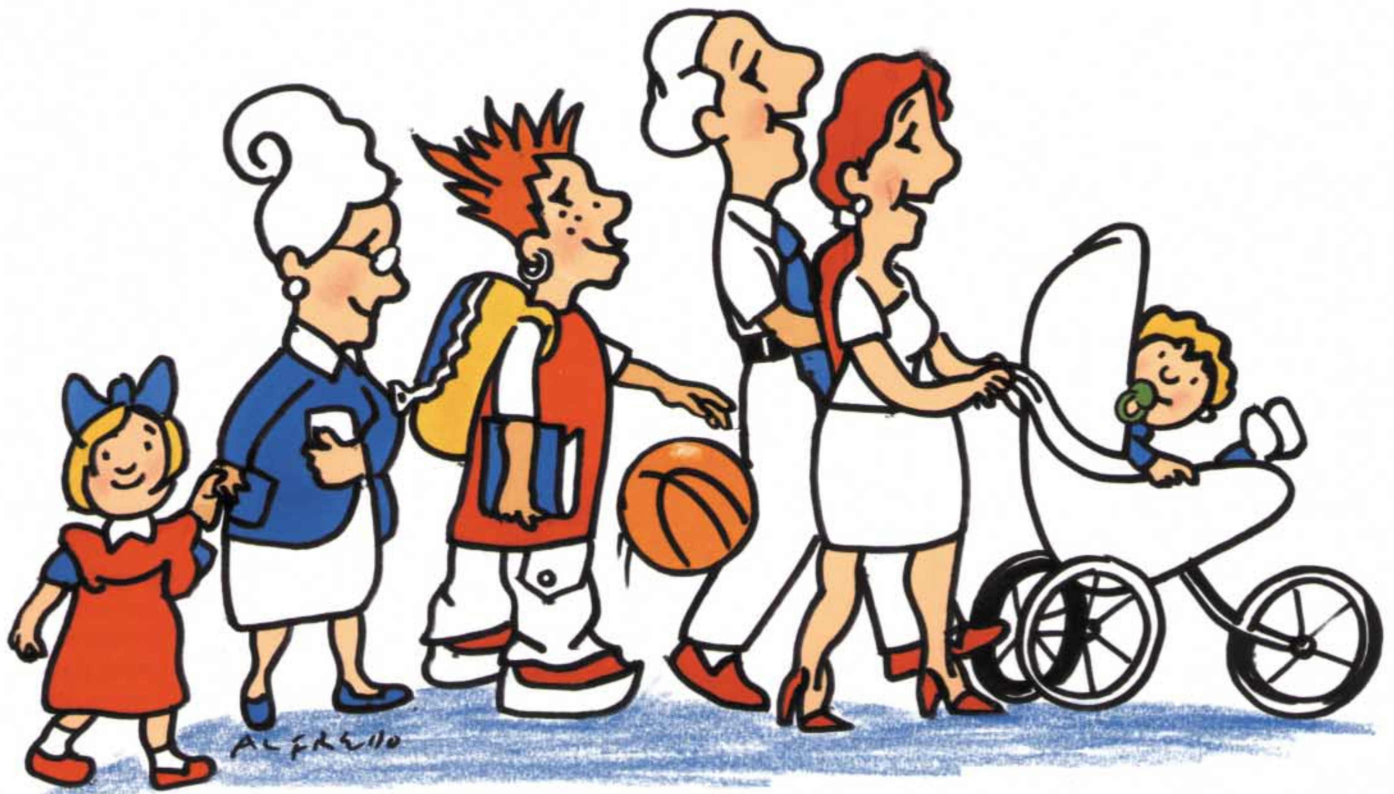

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1 editorial

The biggest killer – and how to kill it off!

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As stated in the "European cardiovascular disease statistics" report published in 2000 by the British Heart Foundation and the European Heart Network, cardiovascular diseases (CVD) are responsible for over four million deaths each year in Europe. This is almost half of all deaths. Coronary heart disease (CHD) and stroke account for the majority of these deaths. For example, CHD by itself accounts for nearly two million deaths each year in Europe. Not only is CVD the leading cause of death in Europe, it also represents the first cause of the disease burden expressed in DALYs (disability adjusted life years), according to the World Health Organization's "European Health Report 2002".

This is the bad news. The good news is that CVD is largely preventable – indeed there is good evidence to suggest that at least 75% of new cases of CHD can be explained by the major risk factors, namely poor diet, physical inactivity and tobacco use.

Therefore, the key to reducing early death and suffering from CVD is to reduce the risk factors. This has been set out very clearly in the World Health Organization 2002 World Health Report "Reducing Risks, Promoting Healthy Life" (see article on page 3).

Nobody disagrees. CVD, and other non-communicable diseases, are the major disease burdens in Europe. Everybody agrees that CVD must be a focus for attention in particular since the underlying risk factors or health determinants are much the same as for other non-communicable diseases. The problem is, though, that not everybody agrees on how to tackle CVD. Many believe that combating CVD is a medical issue and are persuaded that in fact great strides have already been made in terms of treating heart disease. Medical advances have certainly helped people not only survive but also achieve a reasonable quality of life after having suffered heart attacks or strokes. But prevention remains a better way forward than cure, and improving the risk profile of an entire population as opposed to focusing on an individual approach will yield much better results. One of the ingredients in a population-wide approach to promoting health and preventing disease is the use of government measures. Often such measures must be in the form of binding legislation in order to be sufficiently effective in shifting behaviour. And this is where the motherhood and apple pie agreement that health is good for you and disease is bad for you starts falling apart. Politicians do not want to take measures in the field of food products, when they make

> 'Even small changes in a population's risk factors have significant and positive results on death rates.'

them unpopular. Because such legislation includes measures on: Taxation, pricing health damaging products at a high level to discourage consumption. Labelling, clearly indicating contents on the product including warnings about health damaging effects of consuming it. Advertising, banning advertising of certain products and to certain particularly vulnerable groups. Subsidies, abolish or re-direct subsidies for primary production and promotion of produce which counteracts health strategies.

But if decision makers are genuinely interested in combating CVD, they should not hesitate to put in place what might appear to be unpopular measures or measures that could label them as leaders of "Nanny States". Because even small changes in a population's risk factors have significant and positive effects on death rates. Just look at the report from the National Heart Forum on "Estimating the impact of changes in risk factors" (see article page 7). A little goes a long way, and if there are moderate changes to each risk factor, the authors of this report predict a 30% reduction in CVD in ten years in the UK. Even though the results of the modelling carried out in the UK cannot necessarily be extended to the rest of Europe without modifications, it is fair to conclude that a focus on policies that will help bring about even moderate changes in cholesterol, blood pressure, smoking rates and obesity are worth a go.

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Heart Matters, focusing on cardiovascular disease prevention, is a publication relevant to policy makers, public health experts and organisations involved in health promotion, disease prevention and public health research.

Reducing the risk of cardiovascular disease worldwide: the untapped potential

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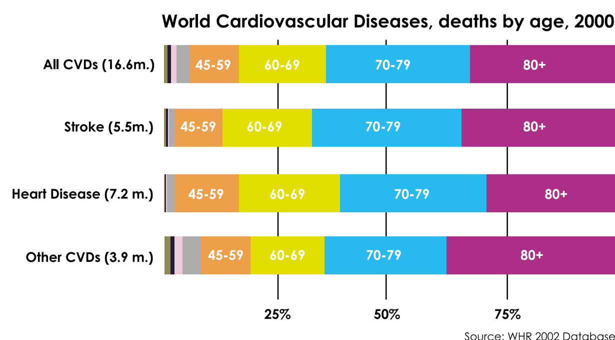
Global cardiovascular disease epidemic and its consequences

Cardiovascular disease (CVD) was responsible for 16.5 million deaths worldwide in 2002 and three fourths of them were in low and middle income countries.[1] Except in very low income countries and those countries in the African region affected by AIDS, in all other regions in the world cardiovascular disease is already a leading cause of ill health and premature death (figure 1, 2).

Figure 1: Global mortality due to cardiovascular disease



Projected figures indicate that by 2020 there will be 25 million deaths due to CVD, 19 million of them from low and middle income countries.[2]
Every year about 32 million individuals suffer heart attacks and strokes and 12.6 million succumb to these events. Chronic ill health due to these life threatening conditions overloads the already strained health systems in developing countries. Furthermore the epidemic affects a large number of productive middle-aged adults (figure 1) in these regions, causing serious social and economic consequences for families and communities and a negative impact on sustainable development.

Few risk factors responsible for a major epidemic

Against this background it is pertinent that the premier publication of the World Health Organization (WHO), World Health Report 2002 (WHR) on "Reducing risks, promoting healthy life", focuses on the risk factors of cardiovascular and other major noncommunicable diseases (NCD). It carries the first ever global analysis of disease, death and disability attributed to 26 selected risk factors. The analysis includes major cardiovascular risk factors: high blood pressure, high cholesterol, tobacco, low fruit and vegetable intake, physical inactivity and obesity. Risk factors analysed in this report as shown in figure 3 are responsible for a substantial proportion of the leading causes of death and disability worldwide.

Figure 2: Cardiovascular disease is already a leading cause of premature death in all regions except in the African Region.

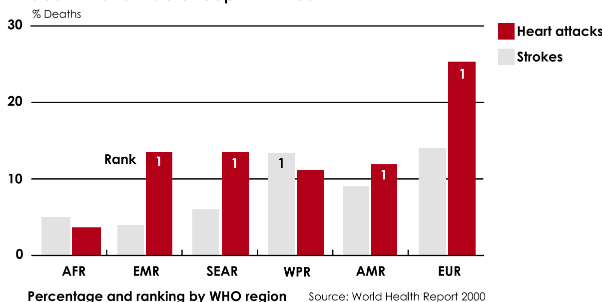
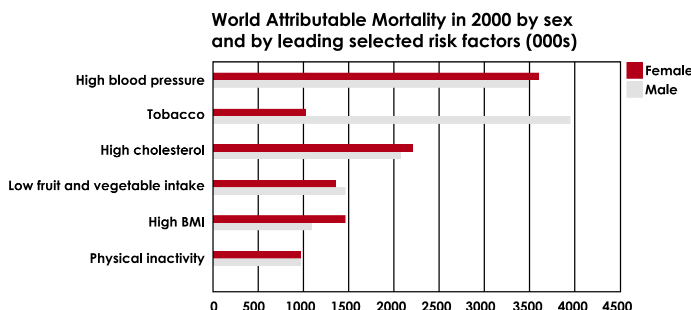


Figure 3: Global mortality attributable to cardiovascular risk factors in 2000



Not only does the report describe the amount of CVD, disability and death attributable to these risk factors, it also estimates the amount of the present burden that could be avoided in the foreseeable future if bold and meaningful action is taken to reduce them from now onwards. Even more importantly, the data it provides highlights the fact that such gains are within the grasp of all countries, including the poorer countries, provided they take immediate bold steps to utilise a range of affordable, time-tested and efficacious CV interventions.

The WHR 2002 also points out that poverty, violence, rapid social and economic changes, lack of education, inadequate health services and urbanisation contribute as much to the increasing cases of NCD including CVD as they do to AIDS, malaria and tuberculosis. Rapid and unplanned urbanisation for example increases exposure to risks associated with NCD due to change in traditional diets, promotion of physical inactivity, unregulated marketing and availability of health-damaging foods and tobacco products.

As the report demonstrates, in developed countries NCD risk factors constitute seven of the ten leading risk factors contributing to the burden of disease, compared to six of ten among low mortality developing countries, and three of ten in high mortality developing countries (Table 1). Trends for most NCD risk factors in many developing countries over the last decade foreshadow a major increase in the occurrence of CVD and other major NCD over the next two decades.

However the impact of major, established risks has been under-estimated and under-appreciated as a significant cause of the global disease burden. For example, more than three quarters of cardiovascular disease – the world's leading cause of death – is due to only three risk factors: tobacco, high blood pressure, high cholesterol or a combination of the three. Overall, high blood pressure causes 7.1 million, tobacco causes 5 million and elevated cholesterol causes more than 4.4 million premature deaths per year respectively. Tobacco is responsible for 22% of CVD worldwide. About 62% of global cerebrovascular disease and 49% of global ischaemic heart disease are attributable to suboptimal blood pressure. High cholesterol is estimated to cause 18% of cerebrovascular disease and 36% of ischaemic heart disease. Low intake of fruit and vegetables is estimated to cause about 11% of cerebrovascular disease and 31% of ischaemic heart disease worldwide. A further 21% of ischaemic heart disease is attributable to a BMI above 21. Physical inactivity, which is estimated to cause 1.9 million deaths worldwide, causes 22% of ischaemic heart disease.

As a large proportion of the world's people live in developing countries and background disease rates and risk factor levels in these regions have risen over the last decade, the disease burden attributable to each of these risk factors is greater in developing countries (figure 4). For example in the 1990s more tobacco deaths occurred in the developed than the developing world, whereas currently the tobacco-related disease burden is predominantly in the developing regions of the world.

While disease-related interventions would help to restrain the global CVD epidemic, it can be prevented only if meaningful action is taken against the major CVD risk factors and their determinants. As the WHR reiterates, major health gains can be achieved worldwide if the population distribution of these risk factors can be reduced across the board through a combination of population and high-risk approaches.

Population-wide and high-risk approaches for risk reduction

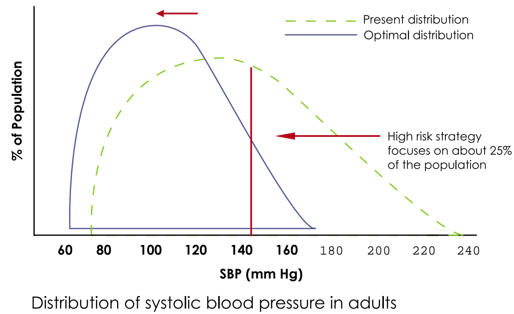
Major cardiovascular risk factors such as blood pressure and cholesterol are widely distributed in the population, with individuals differing in the extent of their risk rather than whether they are at risk or not. Use of dichotomous labels such as hypertensive/normotensive, hyper-cholesterolemic/nomocholesterolemic do not do justice to normal distribution of these risk factors in the population but are for operational convenience.[3] People with borderline or slightly raised blood pressure or cholesterol suffer more cardiovascular events than those with moderate to severe levels of these risk factors. While population-wide interventions are not sufficient to address the risk levels of those at high cardiovascular risk, high-risk approaches will neglect the vast majority of people at borderline/mild cardiovascular risk (figure 4). Therefore without creating false antagonism between these two approaches, as sometimes happens, population-wide and high-risk strategies need to be implemented in a complementary manner to achieve maximum health gains.

Table 1. Ten leading selected risk factors as causes of disease burden

	Developing countries		Developed countries
Rank	High mortality	Low mortality	
1	Underweight	Alcohol	Tobacco
2	Unsafe sex	Underweight	Blood pressure
3	Unsafe water	Blood pressure	Alcohol
4	Indoor smoke	Tobacco	Cholesterol
5	Zinc deficiency	Body mass index	Body mass index
6	Iron deficiency	Cholesterol	Low fruit and vegetable intake
7	Vitamin A deficiency	Iron deficiency	Physical inactivity
8	Blood pressure	Low fruit and vegetable intake	Illicit drugs
9	Tobacco	Indoor smoke from solid fuels	Underweight
10	Cholesterol	Unsafe water	Iron deficiency

Source: World Health report 2002. CVD risk factors are shown in red

Figure 4: Strategies aimed at diet and physical activity of the population shift the BP distribution of the whole population to the left



Distribution of systolic blood pressure in adults

Developed countries such as Finland have implemented such a combined approach to control cardiovascular risk factors; Finland has demonstrated a precipitous decline in cardiovascular disease over the last two decades.[4] It is pertinent to note that in the 1970s when these programs were initiated in North Karelia only modest resources were available in Finland for their implementation. Similar two-pronged approaches, appropriately tailored to match available resources, are applicable in the majority of developing countries. Upstream policy interventions such as regulation of food prices and food availability can have population-wide impacts. For example, the reduction in consumption of animal fat and increase in the availability and consumption of fruits and vegetables is considered to be at least partly responsible for the dramatic decline in mortality from ischaemic heart disease seen in Poland in the early 1990s.[5,6] Such interventions are relatively inexpensive and should be particularly appealing to countries with limited resources.

Need for a paradigm shift from single-risk factor to multiple-risk factor interventions

Cardiovascular risk factors often cluster together. As the WHR 2002 illustrates, even modest changes in blood pressure, cholesterol, tobacco use and obesity could bring about large benefits if intervention strategies are population-wide and clusters of related major risks are addressed simultaneously. Therefore it is essential that comprehensive high-risk approaches that focus on the margin of these risk factors be complemented with population-wide risk reduction approaches targeting several risk factors that shift risk factor distributions to low cardiovascular disease risk profiles for the whole population.

In order to implement this in low resource settings with inadequate infrastructure it is necessary to carry out risk assessment solely on the basis of simple indicators such as age, sex, smoking status and body mass index measurable in most low resource settings. In order to facilitate this absolute risk approach to cardiovascular risk management, WHO recently convened a meeting of experts to address the integrated management of CVD in low resource settings[7] and has now developed a user-friendly CVD risk assessment and management package[8] that enables settings with limited resources to implement the absolute risk approach.

Prevention and control of the CVD epidemic with available resources

A range of cost effective interventions are available for reducing the cardiovascular risks alluded to above and as the WHR 2002 demonstrates, in all countries at least one type of intervention to reduce risks associated with CVD, is cost effective. When resources are very limited, priority should be give to population-wide prevention and promotion strategies combined with less intense high-risk approaches, for instance, treating individuals whose overall cardiovascular risk is over 35% in ten years. Policy makers may decide to lower the threshold to include individuals with 15% risk of a cardiovascular event over ten years when additional resources permit. As the threshold for intervention is lowered the health benefits increase but the costs also escalate. The optimal mix of interventions to control the CVD epidemic depends on the political, economic and social realities of specific countries.

With regard to cost-effectiveness of health interventions, the recent report of the Commission on Macroeconomics and Health suggested that interventions costing less than three times GDP per capita for each DALY (disability adjusted life year) averted represent good value for money and that if a country could not afford to undertake this intervention through its own sources the international community should find ways of supporting them.[9] The interventions classified as very cost-effective in the WHR 2002 are those which avert each additional DALY at cost less than GDP per capita, and those categorised as cost effective interventions are those which avert each additional DALY at a cost of between one and three times GDP per capita. The Commission on Macroeconomics and Health identifies tobacco control as being one of the most cost effective interventions that would benefit the poor.

The WHR 2002 presents a wealth of regional data related to the cost effectiveness of a variety of interventions for prevention and control of the CVD epidemic. Population-wide strategies for control of blood pressure and cholesterol through reduction of salt intake and health education through mass media were found to be very cost-effective in all regions. Population-wide salt reduction through cooperation between government and the food industry or through legislative action has been shown to achieve a 15% and 30% reduction in salt intake respectively with corresponding reductions in mean population blood pressure.

With regard to tobacco, while taxation of tobacco products was the most cost-effective intervention in all regions, comprehensive bans on advertising and information dissemination activities were found to be affordable and cost-effective for most regions. Countries such as Brazil, South Africa and Thailand have already registered substantial public health gains through such interventions. The world's first public health treaty, the Framework Convention on Tobacco Control,

currently under negotiation among WHO's member states, will facilitate the implementation of these cost-effective interventions for tobacco control.[10]

Taking action to prevent and control the CVD epidemic

It is encouraging to see the growing national and international recognition of the need for urgent action to control the CVD epidemic through risk reduction. During the World Health Assembly in Geneva in May 2002 WHO's member states took part in organised round table discussions on risks to health. Ministers of Health or their representatives who took part in these discussions demonstrated their knowledge of risk factor trends worldwide and in their own countries and their willingness to take action.[11,12]

Despite strong evidence of the magnitude of the CVD epidemic and the availability of cost effective interventions for its prevention and control, overall the CVD epidemic has been neglected by policy makers, international health donors and the scientific community. For example the WHO global capacity assessment survey shows that 57% of countries do not even have a national CVD/NCD policy yet.[13]

In many countries high technology curative interventions for CVD are made available without due consideration of their cost effectiveness and affordability and prevention is not given due priority. There are many reasons for this scenario, including societal demand for immediate care of the sick, lack of a proactive attitude of health professionals to prevention, influence of the commercial sectors which fear that regulatory action by government may reduce their profits, and the inability of health professionals to facilitate intersectoral collaboration. These impediments can be at least partly overcome if there is strong national and global commitment to integrated primary and secondary prevention, to introducing health-sensitive food, transport and school policies at all levels, and to forging alliances to promote healthy lifestyles.[14] WHO has stepped up its activities for prevention and control of cardiovascular diseases. It is targeting the main risk factors of cardiovascular disease through global action such as the Framework Convention on Tobacco Control and the development of the global strategy on diet and physical activity. National surveillance systems for key risk factors have been strengthened through standardised approaches. In addition regional networks are being established to strengthen capacity and advocacy for prevention and control of non-communicable diseases at country level. Further, WHO has also initiated a multi-country programme to scale-up secondary prevention of major cardiovascular diseases[15] and is in the process of piloting a cost effective cardiovascular risk-management package in low resource settings.[16]
leash the full preventive potential that the WHR 2002 alludes to, the vital messages in the WHR 2002 have to be effectively communicated to all stakeholders, including the global community, governments, policy makers, health care providers, media, and the public at large, so that all of them can make an effective contribution to reducing the global disease burden.

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Estimating the impact of risk factors and determining public health strategies

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Despite recent improvements, the death rate from coronary heart disease (CHD) in the UK is amongst the highest in the world, and in Western Europe only Finland and Ireland have higher rates. In recent years, the UK government has set targets to reduce CHD rates and tackle major risk factors such as smoking. For policy makers and health planners, a major challenge is to predict the likely effect of policies aimed at tackling the established CHD risk factors. A report from the National Heart Forum (NHF) published in 2002 is an important addition to the evidence base and its findings have informed a recent Treasury review of long-term health trends and expenditure.

According to the NHF report, "Coronary heart disease: Estimating the impact of changes in risk factors",[1] public health strategies to reduce the risk of coronary heart disease coupled with better, more available treatments could see deaths in England from the leading single cause of death halved in a decade. The publication – which is the NHF's first technical report on epidemiology rather than policy – examines the epidemiological evidence for the main risk factors that affect CHD rates: cholesterol, physical activity, blood pressure, smoking, alcohol and obesity. For the first time, it also estimates the relative impact that changes to these risk factors may have on the CHD cases and deaths in England. The report considers the data in the light of targets set in the health strategy for England (see below); it does not include Scotland, Wales and Northern Ireland within its scope.

The authors examined time trends for the risk factors, whether observed, expected or anticipated in England, and translated these to consequent trends in CHD incidence using standard epidemiological techniques for calculating attributable risk proportions. These calculations assume a causal relationship for the relative risk estimates used and represent an approximate measure of proportional changes in risk, were a change in prevalence of risk factors to occur. These changes are considered "avoidable" CHD events. Where possible these calculations have been performed on a social class specific basis within age and sex groups and the results amalgamated.

The public health strategy for England, "Saving Lives: Our healthier nation", published in July 1999, set a target to reduce deaths from cardiovascular diseases in people under 75 years of age by at least 40% by 2010 – saving up to 200,000 lives. According to Professor Klim McPherson, co-author of the report and vice chairman of the NHF, based on current trends this target will be easily achieved, even though the prevalence of CHD remains stable. "The message for UK policy makers is that we should now be looking towards more ambitious targets and focusing prevention efforts on coordinated dietary and physical activity strategies where there is clear potential to make further important reductions in both CHD cases and mortality." During consultations on the draft health strategy, the NHF strongly advocated a more ambitious target of a 50% reduction in mortality that would demand improvements not accounted for by prevailing trends. While UK morbidity trends are difficult to discern, illness caused by CHD seems to be increasing substantially in people over 75 years of age.[2] Targets to reduce mortality must be complemented by targets to reduce the incidence of CHD if we are to see progress in health expectancy as well as life expectancy.

Key estimates from the report are:

- A sustained reduction in serum (blood) cholesterol levels to less than 6.5mmol/l across the population, would achieve a reduction in CHD of around 11%.
- Changes in physical activity could result in an overall 10% reduction in CHD risk if people who now have lightly active or sedentary lifestyles changed to a moderate level of activity.
- A reduction in diastolic blood pressure to a level below 76mmHg across the population would result in a 15% reduction in CHD for men and 12% for women.
- If all those who currently smoke more than ten cigarettes a day cut down to fewer than ten a day, there could be a 5% drop in CHD. The risk attributable to all smoking, including recent quitters, is 20% for men and 17% for women. Therefore, if everyone quit, CHD would be reduced by 20% among men and 17% among women. If all social class V men quit, CHD among them would be reduced by 24%.
- Changes in the prevalence of obesity could be responsible for a 3% change in CHD if the prevalence of BMI (body mass index) over 30 were reduced to 6% among men and 8% among women.
- A moderately optimistic summation of plausible improvements in these risk factors could predict a change in incidence of CHD of around 30% in ten years. The reductions predicted are consistent with current trends and represent specific examples of reductions suggested in "Saving Lives: Our healthier nation".

Some of the epidemiology presented in the report may be seen as problematic in policy terms, for example the inclusion of data for cutting down smoking, where

the epidemiological data is sparse. It should be remembered that the report is concerned with population risk and estimates of relative risk reduction from various changes in smoking rates. It does not suggest, for example, that cutting down smoking should be set as a policy objective when there is consensus that quitting is far better for the individual smoker.

In the UK, as in other European countries, imperatives to treat the sick and cut waiting lists too often eclipse the need to invest in disease prevention and health promotion. Added to this, the difficulties in obtaining reliable evidence on which to base public health spending mean that securing resources for population prevention strategies is a perennial struggle.

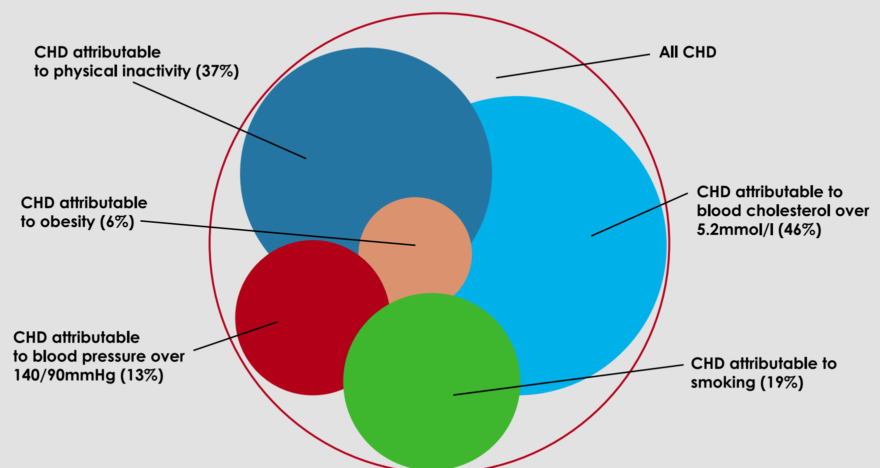
In April 2002, the UK Treasury published a review of long term health trends[3] (known as the Wanless report) in which it was estimated that with a public that is "fully engaged" in maintaining good health, with lower smoking and obesity rates, improved diets and more physical activity, the NHS would, by 2022, be spending £30 billion (45.2 billion euros) per year less than if today's scenario of mainly curative spending were maintained and current public health targets met. What this figure does not take into account is the social and economic benefits – aside from health service costs – that would accrue from such a scenario. The Wanless report's most conservative resource model has since been adopted by the government to work towards achieving the "fully engaged" scenario described above.

One of the obstacles encountered in the Wanless report was a dearth of evidence based policy information on public health, and the review questioned why public health has received so little attention in terms of research and development investment.

With alarming predictions of future disease burdens such as those described in the World Health Report 2002, there is clearly a much wider need for new health forecasting models as a basis for long term health and health service planning. A group of public health specialists and organisations, including the National Heart Forum, the UK Public Health Association and the Faculty of Public Health Medicine, is seeking to take forward the agenda for public health investment which builds on the foundations of the Wanless report and the opportunities for long term thinking.

The UK government's policy of shifting budgeting responsibility from the centre to local level means that three quarters of the total National Health Service budget will be allocated by primary care organisations from this year. Other considerations for the group will be how to identify the best options for public health investment at local level, turning the "fully engaged" scenario into a practical agenda for locally determined prevention strategies.

Proportion of all CHD attributable to five different risk factors



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9 European policy developments

The European Convention

With the upcoming enlargement of the European Union to include ten more countries, new structures have to be developed to keep the EU a workable instrument. In order to prepare these new structures the European Convention was set up in February 2002 under the chairmanship of former French president Valéry Giscard d'Estaing. The European Convention brings together representatives of governments and national parliaments of both EU and applicant countries, the European Parliament and the European Commission.

The ultimate goal of the Convention is to come forward with a new treaty for the European Union, outlining its competences on the one hand, and its decision making powers on the other hand.

In the framework of the Convention, several working groups have been set up to deal with a host of different issues. One of these working groups deals with social issues under the chairmanship of the Greek Member of Parliament Mr Katiforis. Called the Working Group on Social Europe, it was set up in November 2002, and is also responsible for the subject of public health. In February 2003, it presented the outcome of its deliberations at the plenary meeting in which it stated that "a high level of public health" should be one of the objectives of the European Union to be included in Article 3 of the new treaty.

A draft of the first 16 articles of the new treaty was presented by the Convention's Praesidium in February as well. In this draft, public health was maintained as a "shared competence", upgraded from a "supporting measure" in the Praesidium's initial draft skeleton treaty.

More information on the Convention can be found on the following website: *http://european-convention.eu.int*

European Union Public Health Action Programme

In September 2002, the new Programme for Community Action in the Field of Public Health was adopted (Decision 1789/2002/EC of 23 September 2002). This programme outlines public health actions of the European Union for 2003-2008 and is a follow-up from the previous programme, which expired in 2002.

In its general outline, the programme states that "the Community is committed to promoting and improving health, preventing disease and countering potential threats to health, with a view to reducing avoidable morbidity and premature mortality and activity-impairing disability." Health is accordingly considered a priority in the general EU policy, which therefore makes it possible to have a high level of health protection in the definition and implementation of all Community policies and activities.

Amongst the major health challenges referred to in the "Health Strategy" accompanying the programme are the high levels of premature death mainly due to lifestyle-related diseases, notably cardiovascular diseases, cancer and accidents. The Health Strategy also refers to social conditions: wide variations and inequalities in health status (both morbidity and mortality) with substantial evidence that poorer people, disadvantaged and socially excluded groups have significantly higher health risks and mortality.

The programme proposes to tackle these challenges via three major strands:

- improving information for the development of public health;
- reacting rapidly to threats to health;
- tackling health determinants through health promotion and disease prevention.

The new Public Health Programme will have a considerable impact on the new accession countries, where the health situation is worse than in the existing EU Member States. The accession countries have a lower life expectancy and poorer health status as well as fewer resources to improve this situation.

The programme acknowledges the five major burdens of disease in Europe (in disability-adjusted life years) listed in the World Health Organization's World Health Report 2000, where cardiovascular diseases are ranked second only to neuropsychiatric disorders, followed by malignant neoplasms, unintentional injuries and respiratory diseases. In the World Health Organization's European Health Report 2002, cardiovascular diseases represent the first cause of disease burden expressed in disability-adjusted life years.

The full text of the Commission's Public Health programme can be found on *http://europa.eu.int/comm/health/ph/eu_action/eu_action01_en.html*

EU Health Policy Forum

In November 2001, the European Commission launched the European Health Forum. It is a three-tier structure, consisting of:

- the EU Health Policy Forum;
- an open forum;
- a virtual forum.

The EU Health Policy Forum has a permanent membership of 35-40 organisations representing four main groups:

- non-governmental organisations in the health field representing patients and citizens' views;
- organisations representing health professionals and trade unions active in the health field;
- organisations representing health care providers and different health and social services;
- organisations representing industry in areas of key relevance to health (e.g. pharmaceuticals, medical devices).

The EU Health Policy Forum has met three times since its inauguration and has discussed a wide range of issues ranging from health and social policy to re-use of single-use medical devices.

The members of the EU Health Policy Forum have produced two papers. One concerns health and the enlargement, with a set of recommendations to strengthen the accession countries' health situation, and the other calls for health to be firmly established as one of the objectives in the new Treaty on the European Union.

http://europa.eu.int/comm/health/ph/health_forum/index_en.html

European Health Forum - Gastein

The 2002 European Health Forum – Gastein topics included:

- A Europe of Patients? European Health Systems in a Changing Environment

- Improving the Environment for Health Care Quality in Europe
- Health Inequalities and Social Policy
- Health Determinants – Nutrition and Food Policy
- Public Health Research for European Community Policies

It also offered an additional session on the Common Agricultural Policy, analysing its impact on health.
In his keynote speech, Health and Consumer Affairs Commissioner Byrne asserted that obesity is a key issue for the European Commission and that he is determined to bring together agendas in public health, food law and agriculture. The Commissioner also stated that he is committed to creating a European Centre of Disease Control by 2005.

More information on the Gastein forum can be found at : http://www.ehfg.org/

Website link to the Commissioner's speech:
http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=SPEECH/02/426|0|RAPID&lg=EN&display=

Status report on the European Commission's work in the field of nutrition in Europe

In October 2002 the European Commission published its "Status Report on the European Commission's work in the Field of Nutrition in Europe". This report sets out the direct link between good nutrition and health in general and the reduction of cardiovascular diseases as well as cancer, diabetes, obesity and osteoporosis in particular.

The report examines the current nutrition-related activities within the framework of public health and consumer protection as well as nutrition-related actions in other relevant policy areas. Such areas include:

- the Common Agriculture Policy (CAP) and the Common Fish Policy. The CAP includes provisions for assisting Member States in the distribution to vulnerable members of the population of certain agricultural products (such as milk and diary products, beef, fruits and vegetables) held in intervention stocks;
- developments with regard to the internal market and hence the free movement of food;
- EU-funded research programmes, including activities in safety and quality control of food and feed, and research programmes on nutrition (food production, food safety and health and nutrition). Understanding the role of nutrition in health and well-being is for example one of the objectives of this part of the research programmes. The objective is to improve understanding and awareness of the role of nutrition, diet and lifestyle in promoting and sustaining health and preventing disease, to support consumer choices for foods of high nutritional value, and to facilitate the development and understanding of health promoting products and diets. Food quality is one of the major issues under the EU 6th Research Framework Programme;
- social policy and nutrition. This aspect focuses on themes such as policy relating to pregnant women and breastfeeding women;
- educational policy. Public information and education about nutrition and the composition of healthy diets should be more prevalent, especially in the educational systems;
- audio-visual communication policy. Actions have included the promotion of a regulatory framework allowing the realisation of an effective single market for broadcasting and aiming at protection of minors from access to harmful audio-visual content. Proposals to restrict certain types of food advertising to children have been discussed in the Consumer Committee.

The nutrition challenges in the European Community listed in the report include:

- low intake of fruit and vegetables, especially in the northern part of the Community and in most socio-economically disadvantaged groups;
- high dietary intake of fat, and especially saturated fats;
- fall in cereal consumption;
- increased meat consumption;
- increase in the prevalence of obesity.

The full report can be found at:
http://europa.eu.int/comm/health/ph/programmes/health/reports/nutrition-report_en.pdf

Council Conclusions on Obesity

In December 2002, the Employment, Social Policy, Health and Consumer Affairs Council agreed Council Conclusions on obesity. The Council asks the Commission to reinforce its efforts to prevent and combat obesity and to support Member States in their efforts to prevent and manage obesity.

The full text of the conclusions can be found on this website under "European Council" and then "Social Affairs and Health Council":
http://ue.eu.int/newsroom/newmain.asp?lang=1

Health status in the European Union – narrowing the gap

In 2001 the European Commission published the report "Health Status in the European Union". This report provides information on life expectancy in the EU Member States, on morbidity and mortality. It includes a chapter on the health status of specific population groups.

A separate chapter discusses health determinants, including the major determinants such as tobacco use, alcohol abuse, inadequate diets, drug addiction, physical inactivity and the socio-economic determinants of health status.

According to the report's conclusions, well thought out policies supported by appropriate strategies and tools will have an impact resulting in further improvements in the health status of the EU Member States.

The full report can be found on this website:
http://europa.eu.int/comm/health/ph/programmes/monitor/fp_monitoring_1998_exs_10_en.pdf

Combating the rise in heart disease

While mortality from cardiovascular disease (CVD) has been falling at an annual rate of 2% in Western Europe, it has been increasing by as much as 6% each year in the Eastern and Central European countries. In Yugoslavia and in the Republic of Srpska (Entity in Bosnia and Herzegovina), after decreasing between 1980 and 1990, by 1996 the trend had reversed and CVD mortality was up and increasing. Reversing this disturbing trend is the prime goal of Bosnia and Herzegovina Foundation of Health and Heart.

Plan to stop CVD at national and local level

Entity Srpska-Bosnia and Herzogovina's Strategy of Health Protection Development has set stopping the increase in mortality from CVD as one of its priorities. In early 1999 the Cardiovascular Diseases Prevention Programme was drafted, amended by the Sector for Reform and Reconstruction of the Health Ministry and the Health Insurance Fund, and promotion began. The relevant ministries are both defining and tackling the problems, while also seeking outside funding, including European Union funding, to help meet the challenges.

An advisory body called the National Committee for Cardiovascular Diseases was formed in 2000 to give advice to the Ministry of Health and Social Protection. The committee will conduct inter-sector analyses of activities already carried out and define guidelines and recommendations for future work.

A pilot project drafted by the committee proposes a unique programme for monitoring CVD. Initial results show that patients suffering from coronary diseases present modifiable risks. Of the 430 patients studied, 40.5% were smokers, 74.3% suffered from hypertension, 28.4% had hyperlipidaemia, while 25.7% were obese. Nearly one-quarter of the patients were diabetic. These figures confirmed the direction that CVD prevention should take in Bosnia-Herzegovina.

One of the first goals locally is to improve the training that physicians receive in primary health care. European recommendations have been translated into the local language, printed and are being distributed to practising physicians. Doctors are coming together for training in the latest recommended treatments in seminars, while learning about the importance of advising their patients on CVD prevention. In August 2002, for example, 180 physicians were trained in regional seminars, and then delivered public speeches, lectures in schools and programmes in the local media to educate the general public.

Smoking is being attacked at the national level, with a special programme and the enactment of legal regulations restricting smoking in public places.

The Diabetes Development Project started in 2002. It established the Health and Diabetes Foundation whose aim is to review the diagnosis and the treatment of patients suffering from diabetes with a view to reducing cardiovascular complications.

The Ministry of Health and Social Protection formed a National Committee which is in charge of drafting a food and nutrition policy including a food and nutrition action plan in accordance with the World Health Organization's European action plan for food and nutrition.

Cooperation at a European level

The Bosnia and Herzegovina Foundation of Health and Heart observes the activities that take place in the framework of the EU-supported European Heart Health Initiative and has subscribed to the Winning Hearts' declaration in a slightly adapted version, that every child born in the 21st century should not suffer from cardiovascular diseases before the age of 70.

International activities

International cooperation is crucial to the work on CVD prevention in Bosnia-Herzegovina. Heart and Health has participated in World Heart Day for the last several years. In 2000 the goal of encouraging regular physical activity and recreation was chosen as the particular focus. A project called "Health Path" was promoted especially in the city of Banjaluka. In 2001 the target was schools, where children in primary and secondary school were informed about the importance of changing their lifestyle to prevent CVD. A pamphlet was printed and distributed in all the schools. In 2002 again a pamphlet printed by the World Heart Federation for the occasion was translated and distributed in the school.

A World Health Organization questionnaire was implemented in 2001 to determine the levels of CVD risk factors in a demonstration area in Banjaluka. This investigation concerned people between the ages of 15 and 64.

For more information, please contact Drusco Vulic, author of the article, at dule@blic.net

The heart at work

Action plan for 2002-2005

In its ambitious action plan, the Danish Heart Foundation prioritises the areas of improving treatment and rehabilitation for heart patients and reducing the incidence of Cardiovascular Disease. The organisation hopes to extend strategic alliances, back up local work with more local committees, and increase cooperation with local authorities and the business community.

In line with a commitment to preventing CVD, counselling on diet and exercise is an ongoing concern which will be further strengthened under the action plan. One focus area is the workplace.

CVD prevention in the workplace

Thanks to a strong Work Environment Act in Denmark, the physical framework in most Danish workplaces is now very good. But the health of the staff, the company's most valuable resource, often requires a closer look. The Danish Heart Foundation has therefore put in place a cooperation programme whereby companies offer their employees a maintenance check in Danish workplaces. A company that efficiently and thoroughly integrates health into its personnel policy will find it easier to attract and maintain vital young staff members. And there are other advantages. A lower incidence of absence due to illness should be one of the results of a healthy personnel policy. Around 2,250 Danish people in the active employment age range die every year as a result of a heart disease, while 450,000 Danes live with a cardiovascular disease. Compared to the other Western European countries, the incidence of death due to heart attack is high.

There is much the individual can do to prevent cardiovascular diseases: give up tobacco, walk the dog, eat plenty of greens and a low-fat diet. It is up to individuals to make good choices and change their lifestyle. But making the healthy choice is more easily accomplished in the company of others. Chances that good habits will persist are greater when a group of people – work colleagues, for example – support each other. This is the basis on which the Danish Heart Foundation now offers Danish companies company membership.

Precard® for companies

With support from the Danish Heart Foundation among others, physician Troels Thomsen from the Centre for Disease Prevention at Glostrup County Hospital has developed a computer programme, Precard ® (prevention of cardiovascular diseases), that is designed to make prevention of heart disease more efficient. Among other things it can draw up health profiles for a company's staff members.

Using very few questions and answers and a blood test, the program can assess the individual employee's risk of heart attack within the next ten years. Most importantly, the investigation shows what each employee himself or herself can do here and now to reduce the risk of cardiovascular diseases. The measurements and analyses are always carried out by one of the Heart Foundation's specially trained nurses, who then talks with the employee about the possibility of changing lifestyle. After a couple of months, the Danish Heart Foundation has another talk with staff members about how they are progressing with the new lifestyle.

When the individual staff members have been investigated and advised, the Danish Heart Foundation follows up with carefully prepared suggestions as to what the workplace as a whole can do.

It may be that smoking should be banned, or at least clear rules should be drawn up as to where and when staff members may be allowed to smoke. Maybe the canteen needs to make changes, or perhaps the elevator should be turned off every other day. Results are achieved little by little through small daily changes - on this basis the Danish Heart Foundation has drawn up its guide to health promotion for companies.

Information materials include

- the Heart Foundation's membership magazine, Heart News (Hjertenyt);
- information pamphlets about heart health and heart disease;
- recipes;
- special offers for cookbooks, cycling clothes and other goods specially manufactured for the Danish Heart Foundation;
- link to the Danish Heart Foundation's Web site with offers;
- information about exercise offers for athletes, exercisers and families;
- news from the local Heart Centres;
- particularly favourable prices for services in the area of health promotion.

The Heart Foundation's offers to the individual staff member in member companies cover

- health profile with PRECARD®, test;
- total cholesterol measurement;
- blood pressure and total cholesterol measurement;
- one-hour discussion of diet with nutrition consultant;
- discussion of diet with nutrition consultant and 5 x 15 min. follow-up;
- fitness test of 30 min. duration and 30 min. follow-up;
- carbon monoxide test of 10 min. duration;
- one-hour stop smoking conversation with instructor;
- stop smoking conversation with instructor and 5 x 15 min. follow-up.

Offers to groups of employees in member companies include presentations and briefings on how to quit smoking, risk factors, exercise and nutrition, and group courses are arrange for weight loss, smoking cessation, and inspiration for the company canteen.

Hard-working hearts deserve attention, and in Heart Foundation member companies they are given their due.

Finnish Heart Association

Heart health promotion in Finland

Action Plan for Promoting Heart Health

As a part of on-going heart health promotion and primary prevention of Cardiovascular Disease in Finland, in 1998 the Finnish Heart Association (FHA) and the Ministry of Social Affairs and Health published a consensus statement, the "Action Plan for Promoting Finnish Heart Health". To produce this document a consensus model was chosen with the aim of involving all relevant heart health promotion organisations and authorities of the country. Free copies of the action plan are available in Swedish, Finnish and English.

Strategies to reduce the risk of CVD coupled with better, more available treatments could see age standardised CVD incidence and mortality rate brought down to the current southern European level.

118 recommendations for action

Crystallising the evidence for the fight against CVD, the action plan makes 118 recommendations for action. The statement is in line with national and EU public health targets, including the "health in other policies" principle. The recommendations involve a broad range of options that are aimed at the various social, economic and environmental determinants acting on the modifiable risk factors of poor diet, sedentary lifestyle and smoking.

Implementation of the action plan

FHA coordinates and implements the action plan, in particular creating and fostering alliances between other organisations and partners which share its goals in heart health promotion as well as coordinating the implementation of the proposals and the recommendations made by the alliances. The main focus of interest was first in nutrition and physical activity. For the last two years special attention has been paid as well to health promotion among children and young people and to planning prevention strategies in tackling psycho-social risk factors.

Leading experts from different areas of heart health promotion participate in the work of the alliances, and FHA works closely together with the universities and other research institutes.

Among the first activities of the alliance:

- a heart symbol is now being awarded to foods that meet strict nutritional requirements;
- canteen catering is improving public health through well-planned healthy meals;
- Health-Enhancing Physical Activity (HEPA) promotes exercise or other sufficient and regular physical activity as part of a stable lifestyle for Finns;
- school health education creates awareness among policy makers, health professionals, teachers, other health and sport organisations and canteen catering personnel of the means to reduce CVD; information is provided to raise people's awareness about risk factors of CVD and reasons and methods for changes in lifestyles.

New alliance activities include:

- Children's Health Forum;
- "A Small Decision per Day" with the Finnish Diabetes Association promotes heart health and works to prevent type 2 diabetes and metabolic syndrome;
- Mental Well Being and Heart Health with the Finnish Mental Health Association focuses on the workplace environment.

Looking forward

Up until now implementation of the action plan has been aimed mainly at nation-wide activities and projects involving the entire population. The next phase could focus more on local actions and more concrete health promotion programmes aimed at individuals.

At the follow-up meeting of the action plan scheduled for March 2003 the national strategy will be further developed. Important new policy areas could be closer cooperation between health system, schools (authorities, European Network of Health Promoting Schools) and international partners (European Heart Network, other heart associations). Purely national measures and campaigns against CVD are no longer sufficient.

National guidelines and recommendations for CVD prevention

Simultaneously with the population dietary guidelines and recommendations for heart health promotion, guidelines and goals in the management of hypertension and hypercholesterolaemia at individual level are crucial. Lifestyles play an indisputable role in the aetiology and prevention of hypertension and high blood cholesterol. Changes in lifestyles usually result in significant lowering in blood pressure and cholesterol and reduce the risk of cardiovascular disease. Although lifestyle changes alone are not sufficient in all people, they can increase the effectiveness of medication.

FHA promotes better eating habits and physical activity

FHA's first nutrition recommendations, primarily aimed at health care personnel, are now available, and physical activity recommendations are being drafted. Both recommendations will be released as one document to emphasise the importance of nutrition and physical activity together and separately.

Best practice guidelines aimed at health professionals give clear, concise and up-to-date information on issues related to CVD prevention. Now in use:

- "Prevention of coronary heart disease in clinical practice" (1999) - European recommendation modified for Finland by the Finnish Medical Association and the Finnish Heart Association.
- Best practice recommendation - "Blood Pressure" (2002) - The Finnish Society of Hypertension.
- Best practice recommendation - "Obesity among Adult Population" (2002).
- Best practice recommendation - "Treatment of Dyslipidaemia" (in progress).

All the guidelines are available in hard copy, in CD format and on the FHA website. Education, training and production of health education materials are always part of the implementation of the recommendation.

Associazione per la Lotta alla Trombosi Onlus ALT

Fondazione italiana per il cuore
Italian heart foundation

Preventing heart disease in Italy

Coronary heart disease (CHD) morbidity and mortality are relatively low in Italy, as in all the Mediterranean countries. Nevertheless, about 3.7 million people between 35 and 74 years of age have > 20% probability of incurring a CHD event over a ten-year period, according to a recent estimate. Campaigns aimed at increasing the general population's awareness of CHD prevention are thus strongly needed in Italy.

In 2002 the Italian Heart Foundation and the Association for the Fight Against Thrombosis implemented several activities aimed at increasing the awareness of doctors, the government and public health officials and the lay public of the necessity of preventing cardiovascular disease (CVD).

Italian Association for the Fight Against Thrombosis - ALT

ALT has developed a successful programme of promoting awareness of CVD in private companies – now this programme is being implemented in the Italian Parliament (the implementation date is still pending). The "healthy month" will be launched with a one-day event organised within the Parliament buildings, including displays of ALT materials. In addition to being informed about the initiative and its purpose, Italian Members of Parliament will be asked to fill in ALT's risk screening questionnaire. Using the information collected, ALT experts will draw up a screening of the overall IMP risk profile. Each policy maker will also receive an individualised "healthy mark".

Day to day, IMPs will then be given advice on taking up a healthier life style (e.g. take the stairs instead of the elevator or cycle to work instead of using a car, etc.). They will also be informed of the cardiovascular emergency in Italy by means of presentations, charts exhibition, presentations of campaigns and ongoing operations. Over the "healthy month" only healthy food (prepared following ALT recipes) will be served at the Parliament restaurant and bars.

The Italian Parliament general risk profile will be presented to the media (print press, television and radio) at a press conference to be held on the last day of the "healthy month".

Lifestyle and CVD

ALT has promoted its health awareness campaign among Italian golfers with the "Golf Trophy" since 1989, gathering a broader consensus and wider consideration among media and sport authorities each year. In 2002 the 14th edition took place. Thanks to the collaboration of a wider number of sponsors, the trophy involved a large number of golf clubs and so thousands of Italian golfers have joined the "healthy" competition.

When enrolling and then throughout the competition participants are provided with ALT material on CVD prevention, healthy nutrition advice, and physical activity recommendations, as well as information on CVD and where to obtain emergency help. In 2002 about two thousand Italian golfers were reached and made aware of the CVD risk.

Another approach to encouraging a healthy lifestyle is the "Healthy Holiday" project promoted by ALT in partnership with a tour operator. The project involved a test group of CVD patients in a healthy experience which was both relaxing and productive. Throughout a week in Sharm el Sheik CVD patients were monitored daily by doctors and encouraged to follow a healthy diet and to take up exercising while enjoying a five star resort. The successful feedback persuaded ALT's board to confirm the project for 2003; subscriptions are expected to be far beyond the 50 reached with the first project.

The Italian Heart Foundation

World Heart Day 2002 was promoted and organised in Italy by the Italian Heart Foundation, the Italian Federation of Cardiology and the Heart Care Foundation, endorsed by the Italian Ministry of Health. The Italian National Olympic Committee, the Italian Red Cross, scientific societies, patients groups and several prominent researchers and clinicians together organised more than 50 events throughout the country. Around 5,600 people were tested (mainly cholesterol and hypertension tests; in some cases also ECG) free of charge, and 200,000 leaflets and 4,000 posters were distributed through a variety of hospital units and research centres.

Among the many activities were a press conference with the Italian League of Football Players. All 40 major soccer teams wore the World Heart Day T-Shirt. Publicity went beyond the events as well, with advertising in daily newspapers and magazines and journals. Media efforts combined are estimated to have reached more than 15 million people.

The Italian National Campaign on Global Cardiovascular Risk Prevention

Global cardiovascular risk, which takes into account the combined effect of all the factors affecting the probability of a cardiovascular event, is accepted world-wide as the primary guideline on which a preventive strategy should be based. It is crucial for a proper and effective use of all the therapeutic options available (diet, lifestyle, drug treatment).

Therefore the Italian Heart Foundation is operating a campaign to teach practising physicians this approach and to inform patients and the general population of the importance of the concept.

The first step in this project was to enrol and prepare 40 "tutors", experts with a relevant medical background willing to transfer both the scientific messages of the campaign and the ability to communicate effectively to the public. By October 2003 the second step of enrolling and preparing 400 "trainers", experts willing to improve their scientific and communications background and skills in order to transfer such knowledge to general practitioners, should be complete. Then at the beginning of 2004 the third phase of local meetings and interactive tools using technologies and standards of e-learning methodology will begin.

This campaign is expected to reach 5,000 to 7,000 general practitioners.

by the Irish Heart Foundation

Building healthier hearts in Ireland

Ireland continues to have the highest rate of death from coronary heart disease before the age of 65 in the European Union and so the publication of the Irish Government's Cardiovascular Health Strategy "Building Healthier Hearts" in 1999 was an important milestone in the fight against heart disease in this country. "Building Healthier Hearts" has resulted in € 54 million being spent over the four years and an additional 800 staff have been employed in the health services.

The Strategy recognises that intensive efforts will be required to prevent cardiovascular disease at a population level and there are 58 recommendations on health promotion. The importance of integration of national, regional and local campaigns, of sustained initiatives and attention to disadvantaged communities is recognised by the Strategy. Specific recommendations address smoking, diet and nutrition, physical activity, alcohol and blood pressure.

In 2001, the Advisory Forum and the National Heart Alliance held a one day workshop to identify for each health promotion recommendation:

- the lead agency to implement the recommendation,
- key tasks required to implement the recommendation, and
- the key stakeholders.

The report of the workshop continues to inform the setting of priorities for implementing the Strategy's health promotion recommendations.

Ireland needs a Change of Heart

A key recommendation refers to the integration of national and regional programmes for maximum effectiveness. As a first step a major information and advertising campaign to increase public awareness of the risk factors associated with heart disease was agreed.

The campaign, entitled "Ireland needs a Change of Heart", comprised advertising on TV, outdoor posters and radio and ran from World Heart Day, 24 September 2000 to the end of Irish Heart Week, 6 November 2000. A 16 page "Handy Guide to a Healthy Heart" was produced in association with the Irish Heart Foundation and distributed to every household in the country. The Guide gave practical tips on how to improve heart health through lifestyle. The Irish Heart Week tied in to the theme of the national campaign with the slogan "Your Heart the Good News". Phase two of "Ireland needs a Change of Heart" concentrated on physical activity.

This campaign was organised jointly with Northern Ireland and included all Ireland national and regional advertising on television and radio and new physical activity and walking leaflets.

Tobacco

Much of the progress in relation to tobacco control in the last four years relates to improved legislation as called for in "Building Healthier Hearts" and which had been sought by submissions both by the National Heart Alliance and ASH (established by the Irish Heart Foundation and the Irish Cancer Society).

In May 2002 the Minister for Health and Children signed the Public Health (Tobacco) Act, 2002, (Commencement) order. The Act provides:

- for a prohibition on the sale of tobacco products to persons under 18 years of age,
- for a provision whereby the Minister can prohibit or restrict smoking in specified places. In January 2003 the Minister indicated that he will restrict smoking completely in all workplaces
- for a new, more comprehensive and strengthened legislative basis for regulating and controlling the sale, marketing and smoking of tobacco products and for enforcing such controls
- for a comprehensive ban on tobacco advertising (with limited exceptions) and on all forms of sponsorship by the tobacco industry
- for a prohibition of certain marketing practices (including the sale of cigarettes in packets of less than 20 cigarettes; the manufacture, supply or sale of oral smokeless tobacco products; the sale of confectioneries, normally intended for children, which resemble a tobacco product and the sale or supply of tobacco products which do not bear a health warning), and
- for the prohibition of certain claims in relation to tobacco products and the sale of tobacco product by means of self service (with a derogation for tobacco vending machines in licensed premises).

In 2001 the Minister for Finance offset the reduction in the VAT rate, so that the price of tobacco will not fall. There has also been much debate about the inclusion of tobacco in the Consumer Price Index and the issue is currently being examined.

All health boards have expanded their smoking cessation service. Additional smoking cessation officers and smoke-free co-ordinators support individuals and groups and provide advice regarding smoking policies and legislation.

Each year the Irish Heart Foundation's Happy Heart Eat Out is part of the Department of Health and Children's National Healthy Eating Campaign. Pictured L - R are Catherine Kane, manager of the Muse Cafe, particpants in Happy Heart Eat Out with Caroline Coen, Irish Heart Foundation and Liz Cummiskey, Kerry Foods.

Nutrition

A "National Healthy Eating Campaign" has been in place for the last ten years. This campaign has been successful in creating and increasing public attention on healthy eating with 60% awareness of key healthy eating messages. The campaign has introduced the food pyramid now acknowledged and accepted as the national guide to healthy eating, and has enhanced public awareness on healthy eating guidelines on fruit and vegetables, fibre, low fat and having a healthy weight. The Irish Heart Foundation's "Happy Heart at Work" Programme and "Happy Heart Eat Out", the healthy food choices programme in restaurants, link in each year to the "National Healthy Eating Campaign".

Additional community dieticians have been recruited. These have formed partnership with community groups to provide nutrition education, cookery programmes and healthy eating projects. Examples include a fruit and vegetable co-operative and a community café in disadvantaged areas and a men's healthy weight programme.

Its all about balance!

Physical activity

All Health Boards have appointed physical activity coordinators or structures to provide advice and support in a number of settings, including schools, workplaces and communities. Many work closely with the Irish Heart Foundation's "Sli na Slainte" walking routes, "Happy Heart at Work" and "Action for Life", a training and resource for teachers to teach physical activity in the classroom.

The Strategy has provided additional funding to "Sli na Slainte" and many physical activity coordinators now act as trainers for walking leaders to promote these walking routes in local areas.

Other projects include "Playground Markings" developed by a regional health board in association with the Irish Heart Foundation. Following a successful pilot, a General Practitioner (GP) exercise referral programme is now being rolled out nationally. The concept is for low risk patients to be referred by their GP to an exercise co-ordinator in a local gym or leisure centre for advice and a programme of exercise appropriate to their condition.

Key settings

Workplace and schools are also identified as key settings with a number of recommendations.

In relation to schools, the Department of Education and Science is the lead agency. A new programme "Social and Personal Health Education" is being phased in to all schools and embraces health promotion. A new curriculum for Physical Education is also planned and it is hoped that this will be introduced to schools over the next few years.

With regard to the workplace, "Building Healthier Hearts" placed an emphasis on inter-sectoral collaboration to provide a healthy work environment. Steps have been taken both at national and regional level to engage different players including trade unions and employer groups. A number of health boards have initiated different heart health programmes for staff and the Health Promoting Hospital Network has undertaken a range of supportive initiatives for both staff and patients.

Best practice

The National Heart Alliance was identified as being responsible for developing a set of guidelines for good practice based on the experience of health promotion projects. It is hoped that funding will be available in 2003 to commence this work.

Other areas

Apart from health promotion the publication of the Strategy has had significant impact on the work of the Irish Heart Foundation in a number of ways. Last year the Irish Heart Foundation hosted two major consultative workshops to prioritise for action 140 recommendations in "Building Healthier Hearts" for Primary Care, Prehospital Care, Hospital Services and Cardiac Rehabilitation. These recommendations were accepted and some of the priorities being progressed include:

- legislation to enable Emergency Medical Technicians (EMTs) to administer cardiac care drugs
- a provision of chest pain clinics in acute hospitals
- a Secondary Care Programme within primary care where GPs will follow up and monitor high-risk patients over one year
- An increased number of cardiologists appointed.

The Irish Heart Foundation's Happy Heart Eat Out each year is part of the Department of Health and Children's National Healthy Eating Campaign. Pictured at the launch of happy Heart Eat Out are Chef Stephane McGlynnn from Caviston's Restaurant with model Deborah Carbtree.

Erik Ruland,[1] Janneke Harting,[2] Patrick van Limpt,[3] Gaby Ronda,[2] Mieke Steenbakkers,[1] Patricia van Assema,[2] Jan van Ree,[3] André Ament,[4] Ton Gorgels[5], Maastricht, The Netherlands

Nederlandse Hartstichting
vrienden van de hartstichting
Raakt je leven

"Hartslag Limburg": A United Approach in Preventive Care Community-based prevention integrated with a high risk group approach in general practices and the hospital

Introduction

In most Western countries the prevention of cardiovascular disease (CVD) is a major concern. Dutch research has shown that the risk of suffering CVD for people with only primary education is twice as high as for those with the highest education. The conclusion of an expert meeting organised by the Netherlands Heart Foundation in 1994 was that a united approach was needed to meet the needs of low socio-economic status (LSES) groups and reduce fragmentation in the preventive health service delivery. To meet this challenge, the stakeholders in the Maastricht region united to create a new approach. The "Hartslag Limburg" project (Heartbeat Limburg) aims:

- to realise a sustainable and affordable format for inter-organisational cooperation between all stakeholders involved in public health and medicine (World Health Organization (WHO) Towards Unity For Health concept (1));
- to reduce cardiovascular disease in the Limburg (Maastricht) region.

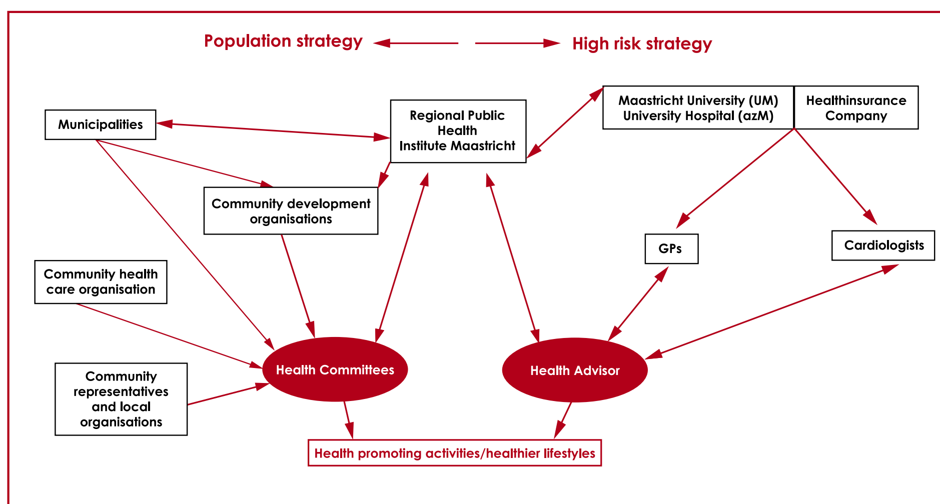
Since June 1998 Hartslag Limburg has carried out cooperative programmes with twelve main partners: the City Council of Maastricht and four adjacent municipalities, the Regional Public Health Institute, community development organisations, Maastricht University in conjunction with the University Hospital and general practitioners (figure 1). Community-based health promotion focussing on healthy eating, physical activity and not smoking, is done by nine local Health Committees; four of these committees are located in low socio-economic status (LSES) areas. Furthermore, 2700 high-risk patients have been selected with the help of general practitioners and cardiologists as part of a controlled study on the effectiveness of health counselling. Patients in the intervention condition receive personal guidance in acquiring a healthier lifestyle through a new employee, a specially trained "health advisor".

Within the health advisor and community approach, special adjustments have been made in order to reach the LSES target group.

For this entire project, extensive scientific evaluation of the process, its effects and cost-effectiveness has been carried out. Focused change management efforts, based on the newly developed "WIZ-model" (Working Group Integrated Care), have been implemented to increase support among stakeholders.

Figure 1: The Hartslag Limburg network: partners and main linkages.

GP= general practitioner; community health care organisation: e.g. dieticians; health advisor = a new professional who guides high risk patients in acquiring a healthier lifestyle; Health Committee = local intersectoral committee of organisations that cooperate in health promotion activities.



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HARTSLAG LIMBURG

Major outcomes

Objective 1: Ongoing cooperation between all partners has led to a significant increase in local health promoting activities (n>500, period June 1998-December 2002).

At post-test in 2001, the number of activities per organisation involved in preventive activities was significantly higher in the Maastricht region than in the control region. Furthermore, the overall post-test percentage of organisations involved in at least one activity relating to physical activity was higher in the Maastricht region than in the control region. It was especially the (para)medical services and civic and social clubs in the Maastricht region which were more often involved in these activities. In addition, (para)medical services in the Maastricht region were also more often involved in activities relating to healthy eating.

Ongoing cooperation has also resulted in the development of several new initiatives (public health and research projects, new partnerships, proposals for organisational reform). By the end of 2001 initial funding by national agencies was replaced by funding through local authorities, which tripled the local budget for CVD health promotion until the end of 2003.
Objective 2: Initial scientific conclusions are expected by the end of 2003.

Conclusion

Hartslag Limburg demonstrates that integration of public health and medicine, as promoted by WHO's TUFH concept, is feasible. Ongoing inter-organisational cooperation has resulted in a significantly higher level of health promotion interventions in local settings. The existence of a smoothly functioning and sustainable regional network has enhanced the adoption and implementation of health promotion interventions. Moreover, this cooperation has also created opportunities for new initiatives, increased political support and increased funding.

Given the outcome of similar community-based health promotion programmes, the short-term effect on CVD risk factors is expected to be modest. Building a healthier environment through sustainable inter-organisational cooperation takes a great deal of time, but should be regarded as an essential link in the chain of conditions needed to change health behaviour.

Literature

Boelen, C. Towards Unity For Health: Challenges and opportunities for partnership in health development; a working paper. Geneva, WHO, Department of OSD, 2000.

Key figures

Target region: city of Maastricht and four adjacent municipalities, ± 250 square kms

Target population: 186,000 inhabitants, of whom 21,000 are living in selected LSES areas

Project funding: app. €500,000 annually

People involved: ± 200 (professionals and volunteers)

More information: www.ggdzzl.nl

Hartslag Limburg is sponsored by The Netherlands Heart Foundation and health insurance company VGZ.

Nasjonalforeningen for folkehelsen

Strategies for a healthier Norway

Norwegian White Paper on health

The Norwegian government recently presented a "recipe for a healthier Norway" in a White Paper about public health policy. Strategies are set to achieve the aims of helping people live longer in good health while reducing health differences between genders, social groups and ethnic groups.

Based on the great challenges associated in particular with physical inactivity, tobacco use and social differences in health, the White Paper presents several high-priority strategies for public health work for the next ten years:

- establish the premises necessary for all individuals to take responsibility for their own good health;
- build alliances and infrastructure for public health;
- orient health services towards preventing more to cure less;
- promote measures based on knowledge and experience;
- focus on women's health.

In this article we briefly summarise some of the efforts to implement these strategies.

Establishing good premises for individual responsibility for health

Focussing on the connection between lifestyles and health, the government wants to affect conditions in the environment that influence our lives and health. An alliance between society and each one of us means that both take responsibility and make their contribution. Besides physical activity, special attention is given to nutrition, tobacco and drugs.

The government points out that the Norwegians have increased their weight in the last few decades (men's weight at age 40 has increased by 9.1 kg in the last 30 years) while our daily physical activity has been reduced to a noticeable extent. The activity level is too low in more than half of the population. The strategy to make us more active includes the following measures:

- prepare for increased use of bicycles, especially in towns and villages, and on roads used by schoolchildren;
- evaluate measures that can increase the level of activity in schools;
- evaluate the quality of school-based physical education, with the intention of motivating children to take part in physical activity, while improving their practical skills, the course contents and the competence of teachers;
- systematically test cooperation efforts in school, following the model of Bunkeflo in Sweden, based on cooperation between school and the local sport organisation. All pupils have at least one hour physical activity a day at school. Swedish research shows positive results, including better concentration and better performance among the pupils;
- make sure that all pre-school personnel know about motor skills, physical activity and health;
- develop a database concerning the connection between lifestyle and health, with an overview of effective efforts to promote physical activity in different arenas.

Building alliances and infrastructure for public health

By developing local and regional partnerships, including alliances between the public sector and voluntary organisations, the government will build up public health work that is local and based on democratic values.

Voluntary organisations will play a role particularly in implementing and organising efforts, and in forming public health policy on behalf of their members as a corrective to purely administrative and political planning. Measures to stimulate cooperation between the two sectors include:

- forums for dialogue in different subject areas between public authorities, professionals and voluntary organisations, aimed at exchanging information, carrying out professional discussions, creating a common understanding in different areas and focussing attention on effective measures;
- annual meetings, like a market day, where voluntary organisations and other actors may present proposals for public health work;
- a review of public health subsidies to ensure that they are well targeted and effective.

Public health advisors, who have been active for several years already, will play an important role, as the counties will be the most important administrative level in this work, cooperating in Norway's five health regions. All governmental efforts will be implemented through regional partnerships. The central authorities will commit themselves to giving economic support corresponding to the needs stated by the local authorities.

Women's health strategy

A report on women's health from 1999 revealed a lack of knowledge and integration of a gender perspective in health policy and practice. It suggested structures, routines and tools for using gender perspective in research, policies, health promotion and health services. One concrete result was a demand that all research in Norway include women in clinical studies, if there are no convincing reasons to omit them.

The current White Paper follows up with proposals to:

- strengthen research on gender differences in the risk for and development of illness, diagnostics, optimal treatment and prevention;
- stimulate studies on gender differences in adverse effects of medicine;
- develop consensus conferences and other forums for discussion of women's health issues;
- strengthen the knowledge of treatment and health services for elderly women, emphasising minority women.

Opinion

Much attention has been focussed on the White Paper on public health, to which a comprehensive range of organisations contributed with opinions and suggestions. The partnership model it proposes is both a great challenge and a very promising approach to health promotion.

The White Paper will now be debated in the Norwegian parliament. If the "recipe" can give us the right medicine, the government has to follow up the strategy with concrete efforts.

As a voluntary organisation the Norwegian Council on CVD welcomes the cooperation model, and hopes it will strengthen non-governmental organisations. The Ministry of Health has appointed a group, headed by a representative from our organisation, to implement the model of partnership between the public sector and non-governmental organisations.

by the Spanish Heart Foundation

Cooperative activities promote healthy hearts in Spain

Working together with schools and a variety of public and private organisations, the Spanish Heart Foundation operates a number of projects aimed at informing Spaniards of all ages and both genders of how to stay healthy and avoid cardiovascular diseases (CVD). Some of the focal points in their recent work have been promoting more physical exercise among the young, making women more aware of their specific risks, and drawing attention to the importance of hypertension and stroke.

More active children

Reaching children with healthy messages is best done through entertainment and play, which the Spanish Heart Foundation again put into practice with "the healthiest afternoon" (La tarde más saludable) in October 2002. This sports-centred event brings together around 500 children for gymnastics, hockey and swimming. Special games teach about nutrition, emphasising fruit consumption, and about avoiding tobacco and alcohol.

The Madrid Sports Council has joined this initiative with a decision to keep sports facilities open Saturdays from the afternoon until 3.00 a.m. so young people have a healthy and sociable alternative to the pubs on the weekends.

Focus on women

Efforts to make women aware that they too are at risk of CVD, and not just men, are being made under the heading of the "Direct to the Heart" campaign (Directa al Corazon). Participation has surpassed the expectations of the organisers. Events were organised in several major cities, and at each of these occasions, more than 200 women attended talks by Spanish cardiologists.

Among the messages being passed on are that CVD is now the major cause of death for Spanish women. Up until now women have had a longer life expectancy, so more women than men suffer from hypertension, and women over 65 are more likely than men of the same age to be affected. Women are more likely than men to die after their first myocardial attack. Female hormones play a role in the risk of CVD that is still being researched, but it is clear that smoking is even more dangerous for women than for men, and that smoking combined with oral contraceptives increases the risk still more significantly. Since 50% of young people smoke, with more women than men taking up the habit, the facts must be communicated more widely to the Spanish public, especially young people.

Diabetic women have a risk of CVD that is four times higher than that of non-diabetic women. Women diabetics must be made aware of their increased risk, and must control their glucose levels strictly.

Obesity is also a very significant risk factor, with obese women 60% more likely to develop CVD. Because the Spanish population is very sedentary, the Spanish Heart Foundation especially promotes physical activity to combat obesity; a weight loss of even 10% can significantly lower cardiovascular risk.

Hypertension and stroke

Stroke is the main cause of death for Spanish women and the second highest cause of death for Spanish men. Therefore the Spanish Heart Foundation has a campaign under way ("take hypertension seriously") to raise awareness of the risks. A coalition including the Spanish Society of Cardiology and a large variety of organisations including supermarkets, hospitals, housewives associations, and journalists associations hold presentations in supermarkets, hospitals, housewives association meetings and so on. In each case a free blood pressure reading is done for each attendee.

The message is that monitoring blood pressure regularly and keeping it under control substantially reduces the risk of suffering a stroke. Of each three people who have a stroke, attendees at these events learn, one will suffer lifetime consequences, one will be disabled to the point of lifelong dependency, and one will die. The campaign has been going on for several months now and can be called a huge success. A final report will be drafted in June 2003, with a press conference to enhance the message of the campaign and broadcasting the data collected during the past months of activity.

CPR lessons

In cooperation with the Subway of Madrid, the Spanish Heart Foundation gave two days of practical CPR lessons in central metro stations where there is very high traffic. "Learn to save a life" was very successful, and the Samur-Civil protection representatives and the cardiologists present with the Spanish Heart Foundation not only passed on these life-saving skills, but also distributed brochures and graphics.

Other activities

Healthy nutrition and physical activity were promoted in partnership with numerous organisations at such events as the annual Heart Week in the centre of Madrid, a cardio-healthy circuit for groups of schoolchildren, and cooking classes offered through housewives associations.

Encouraging heart health in Sweden

Although cardiovascular disease (CVD) remains the foremost cause of death in Sweden, progress has been made, and mortality from CVD has been reduced by 20% in the last decade. While there are no official national guidelines on CVD care or prevention, support has been high for a number of public health and education campaigns. A current challenge is that resources have been cut, and prevention is generally first on the agenda for budget reductions.

Five important points

Prevention work in Sweden emphasises five principles:

- Start early: several primary-prevention measures aimed at children and teenagers show positive results.
- "Exercise on prescription": Sweden is the first country in Europe to specifically prescribe exercise for CVD prevention. At many of the country's medical centres the staff have received special training and help in forming a network including sports associations, and offer customised gymnastics and activities for various groups of patients.
- Healthier eating habits: Food is a stimulant, a form of solace for many people in the present rather hard times, so changing eating habits poses a particular problem. However, small but consistent changes in diet can lead to major long-term effects.
- Stress management: Fairly new on the heart prevention agenda, this is a very hot issue in Sweden. In both primary and secondary prevention, people can take part in stress management, in groups or individually. When able to handle their daily stress, they often have more strength and motivation to change their diet, increase their physical activity and stop smoking.
- Individually adapted prevention: Both primary and secondary prevention need to be individually adapted to the patient's circumstances, with personalised information and advice. Doctors also need to improve their communication with patients.

Emphasis on exercise

Doctors in Sweden generally find that convincing their patients to add physical activity to their lifestyle is one of the easier changes they can induce. In a questionnaire study with one thousand participants, 90% stated that if the benefits were equal, they would prefer a prescription of exercise over medicine. Regular physical exercise helps people reduce their weight, which also reduces high blood pressure and the risk of developing Type 2 diabetes, significant CVD risk factors in themselves.

Recent studies have shown that the more dangerous pattern in overweight people is an accumulation of fat in the abdomen. This pattern is increasing among Swedish people, including among women, who traditionally have tended to accumulate their extra weight on the hips. Approximately half the Swedish population over 60, male and female, have abdominal fat. Exercise, combined with eating less and healthier food, can solve this problem.

Physical activity also helps to reduce stress, another specific risk factor for CVD. Walking is a particularly effective form of exercise, so the Swedish Heart-Lung Foundation has supported the establishment of "Keep Fit Paths" in various locations. Generally in especially beautiful environments, these paths are marked every kilometre. People who want to walk can start and end where they wish, or follow their doctor's prescription.

An on-going Swedish Heart-Lung Foundation project tailored to children's needs is "Pelle Pump", entertaining and easily comprehensible information about lifestyle changes that is distributed through the schools. An additional benefit is that children then take the materials home to their parents.

Motivation through physicians

Because doctors can play a key role in motivating people to improve their lifestyle to avoid CVD, efforts are aimed at training them to be better communicators. In Gothenburg, for example, medical students practise communication under supervision and with the aid of video technology. A traditional reluctance to become involved in preventive work has changed into enthusiasm in the young health care generation.

Stress management

Behavioural specialists find that of the lifestyle changes that people need to make to lower their risk of CVD, stress management seems to be the most difficult. A vicious circle of "not enough time to manage stress leading to more stress" is not easy to break. Behaviourists have found, though, that when people handle their stress better day by day, they are better able to determine how they want to live, and make decisions about positive changes in diet, physical activity and smoking.

The role of the health care provider is to empower people to make their own decisions, through open-ended questions that help people reflect. This principle is true of all lifestyle changes.

Visible results

Particularly in northern Sweden, there has been a dramatic decline in CVD. Blood fat levels and blood pressure are better at population level. At the same time, though, people's weight is increasing, with all the risk that entails. Continued work is needed on primary and secondary prevention, and policy makers must be convinced that prevention is a priority that requires investment now, to prevent an unreasonably large population of CVD sufferers later, when they will require modern and very costly treatment.

Preventing heart disease in Turkey

In many respects heart disease in Turkey presents the same picture as in Western Europe: cardiovascular disease is the major cause of death, and as the population ages its incidence is expected to rise accordingly. Improving treatment and prevention through lifestyle changes are major focal points for the Turkish Heart Foundation (THF). However, THF operates in an environment that is different from its counterparts in Western Europe in some important respects. Rheumatic fever and rheumatic heart disease, are still significant health threats. Paediatric cardiology is in its developing stages, and efforts to educate the general public sometimes present different challenges.

Current status

The most comprehensive information on coronary heart disease (CHD) in Turkey results from a broad-based study issued by TEKHARF (Turkish adult coronary risk map and coronary heart disease). A team led by Prof.Dr. Altan Onat has estimated the incidence of CHD among the population aged 35-64 as 58 per 1000 for men and 50 per 1000 for women. Extrapolated figures place the estimate for people living with CHD at two million currently. Comparable data for England, Germany, France and Italy show that the rate of CHD in Turkey is similar to the rate for Europe. Because of the dramatic increase in the older population of Turkey, the incidence of CHD is estimated at 3.4 million by 2010.

Preventing CHD

Proposals for combating the scourge of CHD include:

- educate the general public
- persuade people to quit or not to start smoking, to follow the Mediterranean-style diet, take physical exercise, control their weight and have their blood pressure checked regularly;
- for people with a family history of heart disease, emphasise screening and preventive measure;
- closely monitor diabetics;
- integrate primary and secondary prevention of heart disease into medical school curricula;
- increase government financing for health care, and include CVD prevention in national health policy;
- draw media attention to CVD to make use of their potential for educating the public.

Rheumatic heart diseases

Rheumatic fever and the rheumatic heart disease that results from it are now so rare in Western Europe that it is considered a 19th century phenomenon. However, it is still a significant problem in the world as a whole. The World Health Organization (WHO), states that it is the most common acquired heart disease, and the most common heart disease in children and young adults. Although its incidence is decreasing in Turkey, there are an estimated 135,000 Turkish people over the age of 20 who have rheumatic heart disease, with an estimated 155,000 by 2010.

Rheumatic fever starts with a streptococcal infection that is not or not adequately treated. The standard treatment is with penicillin, and if the streptococcal infection is detected and treated early all is well. If it develops into rheumatic fever, it carries a lifelong risk of congestive heart failure. People who have had the disease must be treated monthly or even daily with penicillin or other antibiotics for the rest of their lives.

Continuing to reduce the incidence of rheumatic fever involves confronting the forces that favour its spread. Poor sanitation, food hygiene, and poor nutrition are major problems in Turkey, particularly where large numbers of people migrate from the countryside into overcrowded cities. Improved health care and improved cultural and economic conditions will play a role in bringing down the numbers.

Ultimately, though, in order to eliminate rheumatic fever the A Beta haemolytic streptococcus bacteria that causes it will have to be eradicated. Throat infections that could be streptococcal must be diagnosed and treated. Families and teachers play a key role here, and they must be educated to recognise the dangers, so they can take precautions and see that treatment starts early.

People who have had rheumatic fever must be educated to continue regular treatment with antibiotics. Society in general must also be made aware of the disease and its prevention. High-risk settings such as schools, factories and medical barracks should undergo periodic surveillance. THF also advocates free health care for those who need it.

Congenital heart disease

With a birth rate of 2.2% according to 1999 figures (ie. 1.5 million babies), about 11,500 babies are born each year with congenital heart disease. A significant percentage of such babies need invasive procedures to correct damage. Especially in the last ten years the specialised care that is needed is increasingly available; paediatric cardiology and cardiac surgery units are being established.
Early diagnosis is also improving. However, much more needs to be done in the area of medical and surgical treatment for newborns and infants.

At the same time, several efforts are necessary to reduce the incidence of congenital heart disease through primary prevention. Among the important steps are:

- spread the use of rubella vaccine;
- educate people to choose marriage partners who are not close relatives;
- encourage women to have their children between the age of 18 and 35;
- improve prenatal care to monitor for conditions such as diabetes, encourage proper nutrition, and persuade pregnant women to avoid alcohol, tobacco and other drugs;
- monitor for conditions that respond to early treatment.

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The mission of the European Heart Network is to play a leading role through networking, collaboration and advocacy in the prevention and reduction of cardiovascular disease so that it will no longer be a major cause of premature death and disability throughout Europe.

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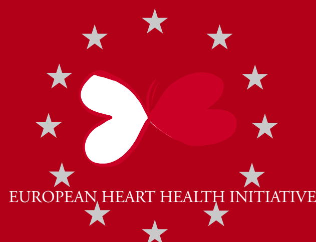

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