

PROMOTING HEART HEALTH: A EUROPEAN CONSENSUS

A HEALTH INITIATIVE DURING IRELAND'S PRESIDENCY OF THE EUROPEAN UNION

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Heart health in Europe

Working in partnership with the European Society of Cardiology (ESC) and the European Heart Network (EHN), the Irish presidency of the European Union (January to June 2004) sought to gain consensus among European Member States on strategies for the prevention of cardiovascular disease (CVD). Towards this end, and with the support of the EU Commission, an expert conference 'Promoting Heart Health: A European Consensus' was held in Cork, 24-26 February 2004. Discussions and consultation relevant to the topic were held both before and after the conference, in order to agree a brief consensus document on promoting heart health in Europe.

It has been recognised for several decades that there is substantial variation in the epidemiology of CVD in different European regions.¹ Populations in the south of Europe have enjoyed relatively low death rates from coronary heart disease (CHD). In contrast, more northerly countries have had high CHD death rates, although rates have been declining in several such countries.² Populations in central Europe continue to have high CHD death rates, although in recent years rates have started to decrease in many of these countries also.³

In general, death rates from stroke have been declining in European populations in recent decades.³ Some countries still experience relatively high death rates and stroke continues to be an important cause of morbidity among older people throughout Europe (see Figures 1 and 2).

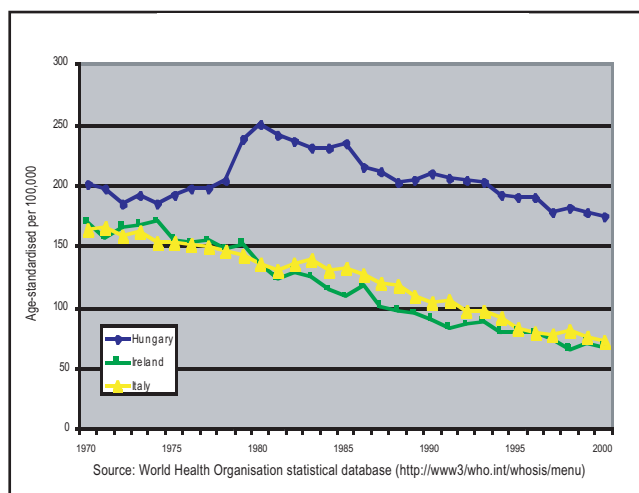


Figure 1. Stroke mortality, men all ages.

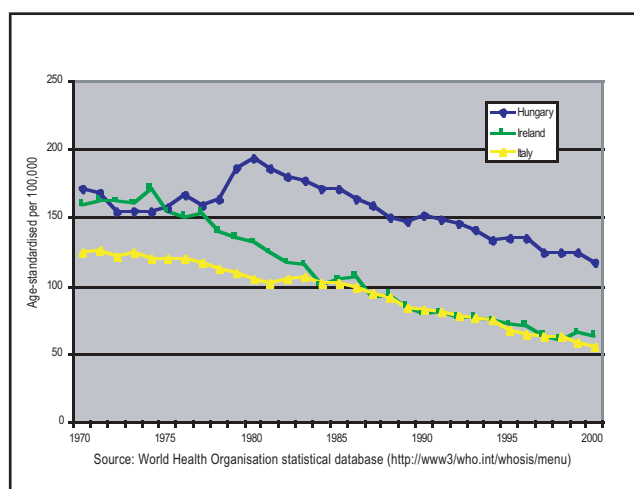


Figure 2. Stroke mortality, women all ages.

Despite the decreasing death rates from CHD and stroke in many European populations, there is no room for complacency. The evidence suggests that in high risk populations, decreasing deaths in younger age groups is associated with an older age at presentation and a longer time course for the disease. The number of people with chronic cardiovascular conditions, such as heart failure, is increasing.

Growing concern

In some countries where death rates were high but are now declining, there is concern about the widening gap in mortality and morbidity between the managerial and professional social classes, and those with lower levels of education and on lower incomes.⁴ There is also concern in many countries about the increased prevalence of physical inactivity, obesity and diabetes, with associated increased risk of vascular disease.⁵

There have been important developments in treatments and interventions for those with symptomatic CHD. The combination of greater numbers of patients alive with chronic cardiovascular conditions and the demand to provide access to evidence-based treatments presents many challenges for health services. The continuing high burden of CVD in many European populations highlights the importance of prevention to reduce mortality, delay disease onset and reduce the risk of recurrent events (see Figure 3).

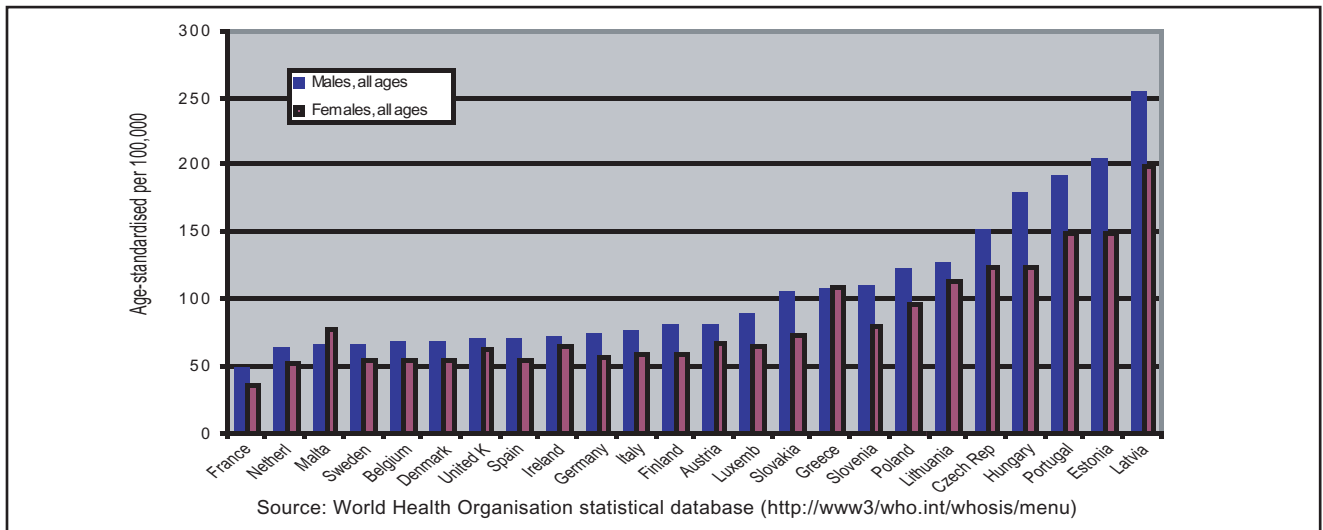


Figure 3. Cerebrovascular disease mortality, all ages

Consensus conference

The expert committee for the conference, chair Professor Lars Ryden, agreed from the outset that population and high risk strategies for CVD prevention are complementary. “In this context, prevention is a continuum and is relevant throughout

life and for the whole of society. It is important in health but is also relevant to rehabilitation and risk reduction with those who are ill.”⁶ Public policies and a physical and socioeconomic environment which support health are essential to facilitate heart healthy lifestyles in the mass of people at relatively low

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anaesthetics, diabetes mellitus, strict fasting, ongoing desensitisation therapy, first degree AV block, Prinzmetal's angina, peripheral arterial occlusive disease, psoriasis, thyrotoxicosis. Allergic reactions may be worsened. **Pregnancy and lactation:** Bisoprolol should not be used during pregnancy unless clearly necessary. Use during breastfeeding is not recommended. **Drug interactions:** Calcium antagonists, clonidine, monoamineoxidase-A inhibitors, class-I and class-III antiarrhythmic drugs, parasympathomimetic drugs, other β -blockers, insulin and oral antidiabetic drugs, anaesthetic agents, digitalis glycosides, prostaglandin synthetase inhibiting drugs, ergotamine derivatives, sympathomimetic agents, tricyclic antidepressants, barbiturates, phenothiazines, other antihypertensive agents, rifampicin, mefloquine. **Side effects:** **Common:** Coldness or numbness in the extremities, tiredness, dizziness, headache, GI disturbances. **Uncommon:** Muscular weakness/cramps, bradycardia, AV-stimulus disturbances, worsening of heart failure, orthostatic hypotension, sleep disturbances, depression, bronchospasm. **Rare:** Nightmares, hallucinations, hypersensitivity reactions, increased liver enzymes, hepatitis, increased triglycerides, potency disorders, hearing impairment, allergic rhinitis, dry eyes, psoriasis-like rash, alopecia. **Presentations:** Cardicor film-coated tablets contain either 1.25mg, 2.5mg, 3.75mg, 5mg, 7.5mg or 10mg bisoprolol fumarate (2:1). Calendar Pack 28 tablets. Price in Republic of Ireland: 1.25mg €8.76; 2.5mg €8.11; 3.75mg €10.01; 5mg €10.51; 7.5mg €12.13; 10mg €13.43. **Product licence no.:** PL 0493/0179-84. **Product authorisation number and holder:** PA 654/71-6; Merck Pharmaceuticals, (A Division of Merck Ltd), Harrier House, High Street, West Drayton, Middlesex UB7 7QG, United Kingdom. **Legal category:** POM. **Date of preparation:** January 2003. Full prescribing information available on request from: Merck Pharmaceuticals, (A Division of Merck Ltd), 2004A Orchard Avenue, Citywest Business Campus, Naas Road, Dublin 24. Tel: 01 466 1900. **Reference 1.** CIBIS II, *Lancet* 1999; 353 (9146): 9-13.



risk who provide most cases of CVD at population level. There are evidence-based risk reduction interventions for secondary prevention in those at high risk but this group also benefits from an environment which supports necessary lifestyle changes.

The conference therefore aimed to reach European agreement on the most effective strategies for the promotion of cardiovascular health, for the majority of the population who are healthy (population strategy), as well as for those known to be at high risk or already diagnosed with a cardiovascular condition (high risk strategy).

The programme for the conference was structured to provide background information on the epidemiology of CVD in the EU and on factors which influence risk, and to provide opportunities for discussion on the following:

- population health, health promotion strategies and the creation of environments which support heart health;
- high risk strategies in those with CVD and in those identified as being at high risk; and
- the potential for a comprehensive cardiovascular health policy at EU level.

All 25 Member and Accession States (full members since 1 May 2004) were represented at the meeting. Most countries


had two representatives – a senior civil servant and a professional with expertise in health promotion, public health or cardiology. Prior to the conference, there had been discussions in many countries between the health ministry and the national cardiac society. In addition, each country completed a questionnaire on health promotion strategies and the implementation of guidelines in clinical practice to reduce CVD risk.

Reports from professional organisations and the recommendations of experts provided the scientific basis for discussion at the conference in Cork.⁶ Reports from the EHN, the World Health Organisation and Food and Agriculture Organisation, and Eurodiet and ESC reports provide specific expert recommendations on health promotion in relation to diet and physical activity, as well as on prevention in clinical practice. Given the authoritative nature of these reports and the consistency and coherence of the experts' recommendations, there was relatively little discussion at the meeting in Cork on the scientific basis for the recommendations for health promotion and disease prevention actions.

In their responses to the questionnaire and in discussion at the conference, countries reported interventions across the action areas of the Ottawa Charter to support heart healthy

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lifestyles. In addition, at least two-thirds of countries have adopted national guidelines for CVD prevention in clinical practice. While most countries have already implemented some strategies for CVD prevention, the discussion indicated support for additional health promotion and disease prevention actions, and a desire to achieve EU added value where possible.

The EU context

Discussions on health promotion and disease prevention aiming to reach agreement on actions at either EU or Member State levels must stay within the scope of the Treaty on European Union. The Programme of Action in the Field of Public Health 2003-2008 includes the general objective to promote health and prevent disease through addressing health determinants across all policies and activities. However, caution is required to ensure that any proposals on CVD prevention do not stray into areas of national jurisdiction, i.e. that proposals are consistent with the 'principle of subsidiarity' whereby Member States are responsible for the delivery of their own health services.

The draft proposals for council conclusions which were tabled at the conference needed to achieve a balance between the need for action and the extent to which the 24 other countries might be expected to support specific proposals. In turn, each national delegation had to judge whether or not the proposals would be supported by their health ministry. The discussion could build on advances already made by the EU, for example in tobacco control legislation. It was also helpful that council conclusions on related topics had been agreed during recent presidencies, for example on obesity and healthy lifestyles.

Conference outcomes

Overall, the discussion at the conference was very supportive of the draft proposals for consideration by Member States and by the Commission. Some of the proposals are fundamental to heart health promotion, for example, the further development and application of health impact assessment to measure the impact of national and European policies. Other proposals seek to gain added value through action at EU level, for example, the encouragement of networking and the exchange of information between stakeholders, including professional, non-governmental and consumer organisations.

Of interest to cardiovascular researchers, epidemiologists and health service planners is the proposal to study the implementation of standardised procedures and methods for the monitoring and surveillance of CVD mortality, morbidity and risk factor data across Member States.

The 'Proposal for Draft Council Conclusions on Promoting Heart Health' which emerged from Cork has been further discussed by Member States via their permanent representatives to the EU based in Brussels. The draft which emerged was tabled during an informal meeting of the Council of Health Ministers in Cork in May. The document will go forward to the health ministers' meeting in Dublin in June for adoption as council conclusions on promoting heart health. These conclusions will be widely disseminated, to inform as wide an audience as possible of the agreement on further consideration and action to promote heart health and to prevent CVD in the EU.

The Consensus Conference in Cork was a landmark in the prevention of CVD, recognising that there is sufficient evidence for action, for both population and high risk strategies. It was evident that Member States share challenges and concerns in relation to the prevention of CVD. The conference extended discussions beyond community-based public health, into clinical practice, though focussing on prevention. The initiative demonstrated the benefits of partnership between the presidency and European professional and non-governmental organisations.

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