

HEALTH AND SOCIAL WELLBEING: CORONARY HEART DISEASE

Issue/Problem

The prevalence of Coronary Heart Disease in Northern Ireland

Evidence Base (Equality & Inequalities Report)

Coronary Heart Disease (CHD) can result in angina, a heart attack and heart failure and is one of the main causes of death in Northern Ireland. It accounts for 1 in 3 deaths in males and 1 in 4 deaths in females and is responsible for almost 20% of all potential years lost.

Ref: Report of the Chief Medical Officer (1999) cited in "Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:97).

Coronary Heart Disease & Deprivation

Electoral wards with the highest death rates in Northern Ireland are also those with the highest levels of deprivation.

Ref: McWhirter (2002) cited in "Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:86).

Angina

In the 2001 Health and Social Wellbeing Survey the most frequent condition mentioned was angina followed by heart attack.

The prevalence of angina was similar amongst males and females. However, angina was more prevalent with age. Less than 5% of 45-54 year olds were diagnosed with angina in comparison with 23% of people over 75. In the 75+ age band angina was more prevalent amongst females.

Those in the least skilled occupations experienced the highest prevalence of angina. In 2001, 4% of skilled non-manual workers had been diagnosed with angina in comparison with 8% in unskilled occupations.

Ref: 2001 Health and Social Wellbeing Survey cited in "Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:87).

Heart Attack

The prevalence of heart attack is significantly higher amongst males than females. In 2001, more than 4% of males had suffered a heart

attack in comparison with 2% of females.

People in older age bands are more likely to experience a heart attack. In 2001, males in the 65-74 age group had the highest rate of heart attacks at 17%, while amongst females those over 75 were most at risk (9%).

Ref: 2001 Health and Social Wellbeing Survey cited in “Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:87).

Evidence Base (Literature Review)

Some people have a genetic disposition towards coronary heart disease, however for the vast majority the risk of coronary heart disease is largely determined throughout life by diet, physical inactivity and smoking¹.

Women & Coronary Heart Disease

There is often a widespread misconception that heart disease is mostly a male disease. A joint report by the European Heart Network and the European Health Management Association advocates that most people, including women themselves, are unaware of the importance of heart disease in women². The report argues that low awareness amongst women is matched by low awareness within the medical profession in general, regarding the prevalence and manifestations of heart disease in females. The report further maintains that most of the previous Cardiovascular Disease (CVD) research has been conducted on men, leaving a dearth of data on how prevention and treatment may differ for women.

The report highlights that clinical and epidemiological studies have shown that women are different from men with CVD and that women’s physiology, disease processes, clinical presentation and outcomes all differ³.

Men & Coronary Heart Disease

The Men’s Health Forum state that the vast majority of health promotion work currently taking place in regard to Coronary Heart Disease is “gender” neutral and, as such, are likely to be less effective for men. The Forum recommends that strategic plans for addressing the issue of Coronary Heart Disease must be more gender-sensitive in their approach⁴.

The Forum express particular concerns for men from lower socio-economic groups and black and minority ethnic men. White (2001) suggests that awareness of Coronary Heart Disease is still not as good as one would expect from such as major health concern, regardless of whatever group of men one looks at⁵.

Children & Coronary Heart Disease

The National Heart Forum state that heart attacks and illness from coronary heart disease may seem remote from children’s lives, but the key risk factors for developing coronary heart disease (e.g. raised blood cholesterol, high blood pressure, diabetes and smoking) all develop during the life course, many originating during childhood and adolescence⁶. Studies have show that the early signs of coronary heart disease are already apparent in some children and adolescents. The rising levels of obesity amongst children and young people mean that they are likely to be at an increased risk of developing coronary heart disease in adulthood⁷.

Ethnicity & Coronary Heart Disease

Coronary Heart Disease is prevalent amongst certain minority ethnic groups, particularly South Asians. South Asian people born in India, Bangladesh, Pakistan or Sri Lanka are approximately 50% more likely to die prematurely from coronary heart disease than the general population. A joint report by the NHS and British Heart Foundation states that whilst it is not completely understood why South Asians suffer more heart disease than other groups a number of explanations have been offered.

For example, South Asians may be genetically more susceptible to developing CHD and their disadvantaged socio-economic position may also place them at greater risk. Other risk factors common amongst South Asians include high levels of smoking (particularly amongst Bangladeshi men), low rates of exercise, and diets high in fat and low in fruit and vegetables.

In addition to suffering high levels of heart disease, there is evidence to suggest that Asian communities tend to be diagnosed at a more advanced stage of the disease and have poorer survival rates⁸.

Deprivation and Coronary Heart Disease

The key risk factors associated with coronary heart disease such as smoking, unhealthy diets, physical inactivity and obesity are more prevalent amongst people in lower socio-economic groups. Poor nutrition and other factors such exposure to tobacco smoke and increased stress levels places children in lower socio-economic groups at a greater risk of developing coronary heart disease as adults.

Evidence further suggests that people in lower socio-economic groups, particularly men, are not as quick to recognise the symptoms of coronary heart disease or may not fully realise the full significance of appropriate rehabilitation and lifestyle changes⁹.

Is the issue/problem being addressed by current or proposed strategies and policies? On what level?

Provided below and overleaf are a *few* examples of strategies and policies aimed at addressing coronary heart disease and the risk factors associated with the disease.

Investing for Health

Investing for Health provides a cross-Departmental and multi-agency approach to tackling health inequalities. One of the principle objects of [Investing for Health](#) is to enable people to make healthier choices. Through a number of associated strategies and initiatives many of the risk factors associated with coronary heart disease such as smoking, obesity and poor diet, and physical inactivity are currently being addressed.

Investing for Health Partnerships

[Investing for Health Partnerships](#) bring together key statutory, community and voluntary agencies at local level. The aim of each Partnership is to address the social, cultural, economic and environmental determinants of health. All four partnerships have published [Health Improvement Plans](#) (HIPs) outlining how the health and wellbeing needs of their local populations are to be met. Addressing the underlying causes of heart disease (e.g. physical inactivity, poor food and nutritional intake) is a major component of the HIPs.

Physical Activity Strategy and Action Plan

The aim of the proposed new [Physical Activity Strategy and Action Plan](#) is to promote the benefits of regular physical activity, particularly amongst those who are inactive. The key objectives of the proposed new strategy including raising awareness of the physical and mental benefits of physical activity. The strategy aims to see a reduction in ill-health, including a reduction in preventable deaths and diseases.

Other important developments already underway or planned which have a relevance to physical activity (and which are also relevant to weight management) include - CREST's work on diabetes and obesity, the [Workplace Health Strategy](#), the impending Food and Nutrition Strategy and Action Plan, the [Northern Ireland Cycling Strategy](#), the [Northern Ireland Walking Action Plan](#), and the [Community Sports Programme](#).

Tobacco Action Plan & Smoking Cessation Services

The [Five Year Tobacco Action Plan 2003-2008](#) recognises that smoking is a major risk factor for coronary heart disease, strokes and other disease of the circulatory system. The key objectives of the strategy are to prevent people from starting to smoke, to help smokers to quit and to protect non-smokers from tobacco smoke. The Plan whilst aimed at the population as a whole have identified children and young people, disadvantaged adults who smoke and pregnant women who smoke, as key target groups. The strategy strives to achieve these targets through, for example, public information campaigns, education programmes and other such initiatives.

Boards, Trusts and others such as the Health Promotion Agency have taken numerous steps to tackle to issue of smoking including the implementation of various smoking cessation services. Multi-agency, multi-disciplinary [Tobacco Control Groups](#) have been also established in each of the four HSS Board areas to plan and support smoking cessation initiatives.

Food and Nutrition Strategy

A multi-sector working group has been established to develop a new food and nutrition strategy for Northern Ireland. A review of the first food and nutrition strategy was completed in 2003 and recommended the development of a new food and nutrition strategy and action plan. The working group comprises of representatives from statutory, voluntary and private sectors¹⁰.

Addressing the Problem of Obesity

Initiatives aimed at addressing the problem of obesity and poor diets include, for example, the [Fit Futures: Taskforce on Childhood Obesity](#) and the [Health Promoting Schools Initiative](#). The Food Standards Agency Northern Ireland are also currently in the process of considering ways of encouraging children and young people to eat a healthier and more balanced diet. The problem is also being tackled on a number of levels by HSS Boards, Trusts and LHSCGs and by the Health Promotion Agency (often in co-operation with local voluntary and community groups).

Regional Strategy

The new twenty year [Vision for Health and Wellbeing in Northern Ireland](#) outlines that seven major service-wide [Chronic Condition Management \(CCM\)](#) Programmes will be established to promote chronic condition management across the HPSS. One of these programmes will focus on the enhanced management of coronary

heart disease. A key feature of the strategy is the implementation of a [public consultation](#) on smoking in public places in Northern Ireland.

Other Key Developments

A review of [cardiology services](#) was completed in 1999, the aim of which was to outline the strategic direction of future cardiology services in Northern Ireland (including standards of care in treatment, location of facilities and maximising professional skills). The [cardiac surgery review](#) was completed in 2001 the outcome of which has already informed developments in the areas of cardiology intervention.

In 2001 the DHSSPS published a [joint consultation paper](#) which brings together the key outcomes and recommendations of both reviews. This report includes a joint action plan for cardiology and cardiac services in Northern Ireland.

Examples of other key developments relevant to cardiology and cardiac surgery include the [Acute Hospital Review Group Report](#) - which makes recommendations for the future profile of acute hospital services in Northern Ireland; [Developing Better Services](#) - which discusses the outcome of the acute hospitals review and outlines a model for future hospital services in Northern Ireland; [Best Practice – Best Care](#) - which provides a framework for setting standards and improving monitoring and regulation in the HPSS.

Action by Voluntary and Community Bodies.

A wide range of voluntary and community groups in Northern Ireland make a valuable contribution to promoting the prevention and alleviation of coronary heart disease and other related illnesses. An example of recent work in this area includes the NI Chest Heart & Stroke Association’s [Women’s Heart Campaign](#) (which raises awareness of heart disease in women).

Children, Young People & CHD: Interventions

The [National Health Forum](#) acknowledges that there is no one simple solution to reducing children and young people’s risk of coronary heart disease in later life. They have, however, identified key priority actions for improving long term health amongst the young that are aimed at addressing these risk factors. A number of these recommendations are outlined below (however, some of these issues are already being addressed in Northern Ireland through various local strategies and initiatives):

- *Comprehensive National Strategies:* there should be comprehensive national strategies to improve nutrition amongst

Is the problem amenable to further intervention by the DHSSPS or other?

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children and young people; the promotion of healthy eating for pregnant women, the promotion of breastfeeding; increased physical activity for children and young people (particularly girls); tackling the issue of smoking amongst children and young people.

- *End Child and Family Poverty*: reviewing benefits policies to ensure that families can afford the essential prerequisites to give children a healthy start in life.
- *Make Every School a Healthy School*: through health promoting schools policies and raising the quality and uptake of school meals.
- *Building Healthy Communities*: expansion of the Sure Start Programme to cover all children under 4 and their families including a strengthening of the child health components. These should include nutrition and food skills for parents (particularly on breastfeeding and weaning).
- *Strengthening and Expanding Public Health Roles*: public health training, standards and recruitment and retention initiatives should be developed to support those working with children and young people.
- *Secure Corporate Responsibility for Health*: appropriate interventions such as advertising regulations should be introduced for the food and tobacco industries.
- *Give a Voice to Children and Young People*: all policy actions should be developed and implemented with a commitment to involve children and young people.

Women & CHD: Interventions

A [joint report](#) by the European Health Network and the European Health Management Association identifies a range of interventions to address Cardiovascular Disease in women. A number of these are outlined below.

- It is essential that women become better aware of the risks of Cardiovascular disease. Women should be encouraged to discuss possible health risks with their physician. Physicians treating women (e.g. gynaecologists, general practitioners, geriatricians and other specialists) have an essential part to play in ensuring that women are made aware of cardiovascular disease risk factors, symptoms and outcomes.
- Physicians and medical students need training and education on gender and other diversity issues related to research, diagnosis, treatment, prevention and rehabilitation.
- All clinicians should recognise the importance of cardiovascular disease for women and raise awareness of its importance within the medical and social care community.
- All clinicians should be attuned to the differences in pathophysiology in cardiovascular disease between men and women. They should ensure that their female patients receive

gender-sensitive information and are presented with appropriate treatment options.

- Funding agencies may play an important role in making funding of clinical studies conditional on the appropriate recruitment of women.
- Every effort should be made to target public health campaign messages directly at women. It should not be assumed that women will learn from campaigns targeted to men. Effort must be made to involve women in the design and delivery of such campaigns.
- For policy makers and managers – redressing existing inequalities will require dedicated strategies and policies, adequate resources, and significant training and education initiatives.

Men & CHD: Interventions

The Men’s Health Forum¹¹ suggest that strategic plans for heart disease should be more gender-sensitive in their approach and for men they should specifically address:

- *Improving Prevention* – men’s lifestyles put them at particular risk of CHD, therefore there is a clear need for more effective health promotion that encourages men to change their risk behaviours. For example, provision of opportunities to develop projects in the workplace and the community on tackling male weight problems.
- *Encouraging the use of health advice and primary care services* – men are often unaware of the symptoms of heart disease and often delay seeking advice or help. There is a need for innovation in both information and service delivery. Schools will have a particularly important role to play in increasing boy’s knowledge of specific health problems and in increasing the skills and confidence needed for males to access services throughout their lives.
- *Developing appropriate services* – the current structure of primary care often inhibits men’s access to the health care system. Primary care should become more responsive to men (e.g. open hours outside working hours, the provision of services in non-traditional settings such as sports clubs, workplaces, providing men with anonymous and confidential sources of health advice).

Ethnicity & CHD: Interventions

For resources and examples of best practice the prevention, treatment and rehabilitations of South Asians with Coronary Heart Disease see Fox, C. (2004) *Heart Disease and South Asians: Delivery the National Service Framework for Coronary Heart Disease*. London: British Heart Foundation & NHS.
www.dh.gov.uk/assetRoot/04/10/29/18/04102918.pdf. Issues

Inequalities and Unfair Access Issues Emerging from the DHSSPS (2004) “Equality and Inequalities in Health and Social Care: A Statistical Overview” Report

covered in the publication include prevention of coronary heart disease; smoking; obesity, diet and exercise; physical activity; diabetes; treatment; and cardiac rehabilitation.

¹ National Heart Forum. (2002) *Towards a generation free from coronary heart disease: Policy Action for Children’s and Young People’s Health and Well-being*. Introduction and Summary Paper. London: National Health Forum. www.heartforum.org.uk/pdfs/young_at_heart_pley_sum.pdf

² Wait, S. (2004) *A Healthy Heart for Women in Europe*. European Health Network/European Health Management Association/Bristol-Mayers Squibb. www.heartforum.org.uk/pdfs/NHF_Heal_Hart.pdf

³ Ibid

⁴ Information extracted from the Men’s Health Forum Website – www.menshealthforum.org.uk/userpage1.cfm?item_id+756

⁵ White, A. (2001) Report on the Scoping Study on Men’s Health. Leeds: Leeds Metropolitan University. www.menshealthforum.org.uk/uploaded_files/Scopingstudy.pdf

⁶ National Heart Forum. (2002) *Op cit*.

⁷ Ibid

⁸ Fox, C. (2004) *Heart Disease and South Asians: Delivery the National Service Framework for Coronary Heart Disease*. London: British Heart Foundation & NHS. www.dh.gov.uk/assetRoot/04/10/29/18/04102918.pdf

⁹ White, A. (2001) *Op Cit*.

¹⁰ Health Promotion Agency for Northern Ireland. *Inform*. Issue 34. April/May 2004.

¹¹ Information extracted from the Men’s Health Forum Website – www.menshealthforum.org.uk/userpage1.cfm?item_id+756