

EU AT



# Women's Health at Heart

## Promoting Cardiovascular Health and Preventing Cardiovascular Disease

7 March 2006, Brussels  
Résidence Palace

Conference Proceedings

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SOCIETY OF  
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## WELCOME NOTE

### Dear Reader,

On behalf of the European Heart Network and the European Society of Cardiology, we would like to welcome you to the Women's Health at Heart, Promoting Cardiovascular Health and Preventing Cardiovascular Disease Conference Proceedings. We hope that by reading this, you, too, will help prevent cardiovascular disease across Europe.

Cardiovascular disease (CVD) is the number one killer in Europe today and accounts for nearly half of all deaths in Europe. Under the auspices of the Austrian Presidency of the EU, we wanted to bring stakeholders together to address cooperation on creating a framework for better CVD prevention and Cardiovascular Health promotion in Europe.

Participating stakeholders, including Member State Ministry of Health officials, EU institution officials, politicians, leading experts, and patient group representatives, called for a more tangible EU approach in addressing cardiovascular health and combating cardiovascular diseases for all Member States.

In order to achieve the best cardiovascular health and management for all Europeans, we must work together, learning from best practices, and coordinating our efforts. We hope that this conference is a firm step towards this goal.

**European Heart Network**

**European Society of Cardiology**

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## FROM A MEMBER STATE...



**Prof. Zilvinas Padaiga**

Minister of Health for Lithuania

Cardiovascular diseases (CVD) are the main cause of death and permanent disability in women in Lithuania. Cardiovascular mortality in Lithuania is more than twice the European Union (EU) average. Mortality and disability linked to CVD are still rising with a recent increase in stroke mortality in middle-aged women.

The current situation should be addressed properly. There is a clear need for CVD and stroke prevention programmes as well as for educational programmes for patients living with CVD.

Adequate funding to promote cardiovascular health should be allocated both on national as well as on EU level. However, the CVD problem must be addressed further than just by an increase in financing. Other issues that need to be brought forward include highlighting the benefits of sharing experience and evidence-based data, through research and exchange of best practice.

During the conference, Member States were called upon to adopt or review their national public health strategies to include health promotion and cardiovascular health strategies for populations at high risk. In order to ensure that this is achieved most effectively, we should involve the tremendous resources we have in the EU - each other – in order to stimulate inter-regional and international collaboration. The Conference has proved that there is a strong political will to address these issues across the Member States.

Both Member States and the EU play a vital role in creating a strategy to combat CVD across Europe. I am confident that having the EU as the coordinator, minimum standards for CVD prevention and care across all Member States will be promoted via activities such as exchange of experience and best practice.

I am looking forward to addressing these issues, together with my colleagues from other Member States, to ensure better cardiovascular health for all Europeans.

Best wishes,

A handwritten signature in black ink, consisting of a large, stylized 'Z' followed by a series of loops and a long horizontal stroke.

**Zilvinas Padaiga**



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## TO THE HEART OF BRUSSELS



**Dr. Georgs Andrejevs**

Member of the European Parliament

There is a stark contrast in the mortality rate between Central and Eastern Europe and Northern and Western Europe. For example, CVD causes 64 percent of death in women in Lithuania while it accounts for only 34 percent in France. In Latvia, CVD is the main cause of death for women before the age of 65. As a Member of the European Parliament from Latvia, this is of concern for me – especially considering the many lessons we can share between European colleagues.

According to the European Heart Network's 2005 European CVD statistics, CVD incidence and mortality is falling in most Northern, Southern and Western European countries, but Central and Eastern Europe have either maintained the same rate or increased.

The EU's role as a coordinator and facilitator of exchange of views and best practices must be applied. There is a need to promote minimum standards for CVD prevention and care across Europe. The Parliament's role can be exercised by agreeing a Parliamentary Resolution which would call for EU guidelines on screening for CVD, and ultimately call for the European Commission to draft a Communication on a CVD prevention strategy.

In June 2004, the EU Health Council called upon Member States and the Commission to promote cardiovascular health within the context of the national public health strategies and in the framework of the Public Health Action Programme. It is fundamental to the health of all EU citizens to act on this Council agreement; this conference was an important step to achieving a true pan-European consensus on next steps.

There must be continuity within EU legislation. Taking one step for CVD prevention by focusing on healthy eating and smoking cessation must be followed by addressing cardiovascular disease directly, thus tackling all risk factors.

I welcome this report as a first step in achieving European standards for prevention and screening for CVD.

Sincerely,

A handwritten signature in black ink, appearing to read 'G. Andrejevs', written in a cursive style.

**Dr. Georgs Andrejevs, MEP**

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## CONFERENCE CONCLUSIONS

**Participating stakeholders, including Member State Ministry of Health officials, EU institution officials, politicians, patient and professional group representatives, called for a more tangible EU approach to addressing cardiovascular health and combating cardiovascular diseases for all Member States.**

- The European Heart Network (EHN) and the European Society of Cardiology (ESC) called upon EU institutions to act concretely to achieve better cardiovascular health for all Europeans.
- “There must be continuity within EU legislation: taking one step for CVD prevention by focusing on healthy eating and smoking cessation, must be followed by addressing cardiovascular disease directly, tackling all risk factors,” (said Georges Andrejevs, MEP).
- The 7th framework programme for research should ensure sufficient funds for cardiovascular research, including gender specific research.
- “The EU health action programme must make a clear reference to those diseases that constitute the major health burden in the EU, namely cardiovascular diseases, diabetes, mental health, cancer and pulmonary diseases”, (said Susanne Logstrup, Director of EHN).
- In order to enhance cardiovascular health promotion and cardiovascular disease prevention across all Member States, a proposal creating a framework to ensure the best cardiovascular health and management for all Europeans is required to balance the current health inequalities, both between genders and geographically between East and West Europe.
- The European Union needs to mobilise its health community to ensure that cardiovascular health is properly considered in all relevant EU policies. The EU's role as a coordinator and facilitator for the exchange of views and best practices must be applied across all fields.
- There is a need for the European Union to promote minimum standards for cardiovascular disease prevention and care across Europe.
- The European Commission should continue to support activities on cardiovascular health promotion, such as collecting and continuous updating of relevant information, and establishing expert networks.



Conference Delegates

- The European Commission should work together with the European public health and heart communities to draft guidelines on prevention through the existing and future EU public health action programmes.
- Member States were called upon to adopt or review their national public health strategies to include health promotion, population and high risk strategies on cardiovascular health and to develop health impact assessments to measure the burden on national healthcare systems.
- Member States must further develop their action plans on tobacco use, nutrition, and physical activity to promote healthier lifestyles. They should also study ways of promoting better cardiovascular health.
- To ensure cardiovascular health across the EU, the Council of Ministers was called upon to adopt an EU Recommendation on a tangible EU wide prevention strategy developed by the European Commission on cardiovascular disease encompassing:
  - Cardiovascular health promotion,
  - Mechanisms in support of the Member States' strategies and activities,
  - Guidelines on risk assessment, optimal preventive methods, treatment, rehabilitation and screening.

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# THE CONFERENCE

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## **Welcome remarks and introduction by Dr. William Wijns, Vice-President, European Society of Cardiology (ESC), and Ms. Susanne Volqvartz, President, European Heart Network (EHN)**

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Welcoming delegates, ESC Vice-President Dr. William Wijns stressed the importance of gender-related issues in the fight against cardiovascular diseases (CVDs). He noted that there were 58,000 healthcare professionals working in the fields of research, diagnosis, patient care and prevention.

EHN President Mrs. Susanne Volqvartz, said heart disease was the biggest killer of women throughout Europe. One major problem was the lack of awareness in both the female population and the medical profession. Looking to the future, Mrs. Volqvartz argued that the risks of CVD could be reduced by lifestyle changes.

Stressing the important role of both the Commission and the European Parliament, Mrs. Volqvartz stated that as women's heart health was a European issue, a common approach was essential. To this end, the EU should support research in the area and encourage the exchange of best practices. Mrs. Volqvartz therefore welcomed the conference as an important milestone in making heart health a common concern.

Dr. Wijns and Mrs Volqvartz looked forward to a fruitful continuing relationship between the ESC, the EHN, the institutions of the European Union and, indeed, all concerned stakeholders.

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## **Opening address by Ms. Maria Rauch-Kallat, Federal Minister for Health and Women, Austria (over video link)**

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*Dear Mr. President! Dear Ms President! Ladies and Gentlemen!*

*Thank you for the invitation to the conference "Women's Health at Heart" and for the opportunity to present my opening words as a video message.*

*The prevention of Cardiovascular Disease and the examination of the elements needed for a broad CVD strategy are of great importance. Therefore CVD in women is one of the priority issues during the Presidency.*





*In the first half of 2006 during the Austrian Presidency one of the main focuses of the Federal Ministry of Health and Women is women's health, which should thus also gain in significance at an European level. The second priority concerns diabetes, a condition strongly connected with CVD.*

*The first report of the European Commission on the status of women's health was published in 1997. In the meantime many things have changed in the field of medicine, concerning the development of gender-based medicine, as well as women's lifestyle and their conditions of work.*

*At the informal meeting of Health Ministers in April 2006, women's health topics will therefore be the main priority, in particular cardiovascular diseases as well as the increasing number of female smokers and the conjoint increase in cases of lung cancer.*

*In addition there will also be particular emphasis on the diseases of endometriosis and osteoporosis.*

*Cardiovascular diseases have been a central theme in women's health since the beginning of the nineteen-nineties. CVDs are the most frequent cause of death for women and claim more lives than all types of cancer put together. In 2003 more than 21.000 women and about 13.000 men died of cardiovascular diseases in Austria.*

*Women seem to remain largely unaware of their risk of developing cardiovascular disease despite these figures. They remain more concerned about the risks of more widely known conditions such as breast cancer.*

*The Austrian Women's Health Report 2005 showed the main gender-specific questions and included data comparing the developments during the last 10 years. The need for gender-specific prevention, access to care and gender-specific treatment in the field of CVD is highlighted as a main result in this report.*

*Much progress has been achieved in many EU Member states in prevention and treatment of CVD. This can be demonstrated through the decrease of incidence and mortality rates in previous years. Yet, a lot remains to be done.*

*Therefore, I reiterate my call upon the European Commission to publish a concise report on Women's Health in order to provide facts and figures which include our ten new Member States.*

*Another objective of the Report would be to give an overview on instruments and methods that have already been developed and – at least partly implemented.*



Minister Maria Rauch-Kallat

## > THE CONFERENCE

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*For instance, the European guidelines on cardiovascular disease prevention in clinical practice published by the ESC (European Society of Cardiology) include the main objectives of cardiovascular prevention.*

*The objectives of these guidelines are to reduce the incidence of first or recurrent clinical events due to coronary heart disease, ischemic stroke and peripheral artery disease.*

*The focus is on prevention of disability and early deaths. The current guidelines address in detail the role of lifestyle changes, the management of major cardiovascular risk factors and the use of the different prophylactic drug therapies in the prevention of CVD.*

*I can assure you of the full support of the Austrian Presidency for your Initiative of "Women's Health at Heart".*

*According to scientific opinion an individual's three main risk factors for cardiovascular and coronary heart disease are smoking, raised levels of cholesterol in the blood, and raised blood pressure.*

*While these can be related to an individual's lifestyle, particularly their diet and their exercise levels, other factors can also increase the risk of developing cardiovascular disease, most notably the presence of conditions such as diabetes, and genetic factors.*

*Changes in patterns of individual behaviour are necessary in a large majority of patients with established CVD or a high risk of CVD, but recent surveys suggest a serious gap between recommendations for behavioural change and the advice actually provided by physicians in routine clinical practice.*

*The management of behavioural risk factors is similar for patients with CVD and high-risk people, but changing risk behaviours such as unhealthy diet, smoking, sedentary lifestyle and others, which have lasted for many years, needs a professional approach.*

*For many people it can be difficult to change lifestyle according to a physician's advice.*

*This difficulty pertains especially to people and patients who are socially and economically disadvantaged, who exercise little control over a monotonous and unrewarding job, who are in a stressful family situation, or who live alone and lack social support.*

*Besides the ongoing improvements regarding the treatment of existing heart disease namely drug therapies, interventional cardiology and cardiac surgery, increased attention should be paid to strengthen efforts in primary prevention considering the special situation of women.*

*Women's risk factor profiles vary markedly from those of their male counterparts. Women tend to develop heart disease considerably later than men and consequently female risk behaviour maybe different from male behaviour.*

*Risk factors for heart disease and stroke in women are less researched than those for men.*



*Epidemiological studies and clinical trials are biased towards men. So far, women have been grossly under-represented in these studies.*

*Risk factors, drug treatments as well as interventional procedures were evaluated predominantly on male study participants. Further studies focusing especially on preventing cardiovascular disease in women should be encouraged.*

*Recent findings of an Austrian study established Gamma GT as a strong predictor of heart disease and stroke in younger women.*

*The Luxembourg Declaration of June 2005 pointed out that cardiovascular disease is the biggest cause of death of men and women in the European Union. More women die of cardiovascular disease than of all cancers combined. In addition there are significant differences and inequalities in cardiovascular health within and between Member States.*

*Some EU countries are experiencing declining rates of mortality from cardiovascular disease, but increasing numbers of men and women are living with cardiovascular disease, the majority of which is preventable.*

*The EU Health Ministers adopted conclusions on promoting heart health in June 2004 and called on the Member States and the Commission to promote cardiovascular health within the context of the national public health strategies and in the framework of the Public Health Action Programme.*

*With the growth of gender-medicine and the research on important differences in CVD between men and women change of the physician's standard of care for diagnosis and treatment of women has to be achieved.*

*It should be the standard of care to know these differences. We have to pay attention to women, and no longer can we call these atypical feelings 'fuzzy feelings'.*

*It's a very disrespectful term. Women are equal as well as different. The misconception that CVD is a male disease is rife across Europe and the rest of the world.*

*In fact, in Europe, CVD is the main cause of death for both men and women. Medical professionals equally need to improve the screening, diagnosis, treatment and follow up of women with CVD and its underlying risk factors. But women are also different. Women with heart disease are up to ten years older than men and present with much less obvious and stereotypical symptoms. Women tend to get heart disease later than men due to the cardio protective effects of oestrogen that plays an important role up until the menopause. However, after the menopause, the risks increase significantly and need to be delicately managed.*

*This shortage of crucial clinical trial information on women still leads to inappropriate diagnosis and treatment of women with CVD.*

## > THE CONFERENCE

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*Physicians' training is dominated by male data and trends, and guidelines focus on such data in recommending drug doses and procedures. Thus women are being treated as if they are men, despite the notable differences in their disease elements.*

*Summing up, we have to strive for increased awareness, better understanding, increased representation, improved treatment. The change of life style and the reduction of risk factors such as smoking is the responsibility of every individual, male and female.*

*I am very interested in the outcome of today's conference and I am sure that the proceedings will provide a valuable input for the informal meeting of the Health Ministers in April 2006 in Vienna.*

*I wish you all a successful conference and fruitful discussions. Thank you for your attention.*

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### **Keynote address by Mr. Philippe Brunet, Deputy Chef de Cabinet, on behalf of Mr. Markos Kyprianou, Commissioner for Health & Consumer Protection**

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*Ladies and Gentlemen,*

*The European Commission welcomes this conference highlighting the importance of taking action on heart health with a particular focus on women, which provides an opportunity for the many different partners involved in this key area of concern to meet, discuss and agree ways forward towards common action.*

*Chronic diseases such as heart disease, cancer and diabetes inflict a huge health and economic burden on our societies and economies. They should receive our full attention. Cardiovascular disease is the commonest cause of premature death in women in the EU.*

*The good thing about cardiovascular disease is that it is largely preventable. A huge number – perhaps most - of these deaths are avoidable through action on factors such as smoking, diet, lack of exercise, alcohol abuse, stress, and high blood pressure. This is of course not as straightforward as it sounds. Although the main risk factors of cardiovascular disease seem relatively easy to identify, developing effective strategies to bring about changes in behaviours and lifestyles is not an easy task. This is because personal behaviour and lifestyle are heavily influenced by living and working conditions as well as by general socio-economic, cultural and environmental context.*

*European cardiovascular disease statistics show that the death rates of cardiovascular disease have fallen during the last decades. But there are no grounds for complacency: cardiovascular disease still remains the main cause of years of life lost from early death in the EU. One in eight of all men (13%) and one in 17 of all women (6%) die from CVD before the age of 65.*



Moreover, we also see very important gender differences. This is why we welcome the Austrian Presidency approach to increase awareness about the gender aspects of key public health issues, such as cardiovascular health.

In fact, there is a widespread misconception that heart disease mainly affects men. This is wrong. The statistics show that cardiovascular disease is the largest killer of women in Europe. Looking at some of the risk factors we can understand why. Women are now smoking nearly as much as men in many European countries and girls even smoke more than boys. The prevalence of overweight and obesity is increasing while physical activity rates are falling.

Many people are not aware of the importance of heart disease in women and women themselves are often unaware of this threat. Moreover there is also low awareness within the medical profession about the prevalence and manifestation of heart disease in women. Epidemiological studies show that women have a higher risk of death and disability for an equivalent level of disease.



Mr. Philippe Brunet

This is one reason why more gender specific research is needed, as well as prevention activities specifically tailored for women. You will hear more about it today in a special session and I hope there will be new ideas and suggestions coming up to address these unmet needs.

Furthermore there are huge inequalities in deaths from these diseases. Premature death rates from heart disease amongst women from poorer socio-economic backgrounds are at least double those of the better off. There are also remarkable differences between Member States in heart disease death rates.

In this context, the UK Presidency's work highlighted that health inequalities exist in all Member States and that many European citizens do not benefit from the health improvements their countries have achieved in the last decades. The recent reports commissioned by the UK Presidency setting out patterns and trends in health inequalities show that almost all important health problems, including cardiovascular disease, are more common among people with lower levels of education, income and occupational status.

It is important to mainstream health and inequality considerations across the board of public health interventions. We need to make sure that our efforts do not only reach the educated and better off but also the less well off part of the society.

*I want to emphasise the strong economic aspect here as well. Health is a productive factor in a competitive economy. There are clear macroeconomic implications of the disease burden. There are not only the costs of sickness payments, but also less visible costs of absence from work and lower productivity.*

*By tackling the determinants of heart disease and promoting heart health we can reduce the illness and disability caused by cardiovascular diseases and cut work absenteeism and early retirement, thus contributing also to economic growth and sustainable development.*

*Prevention of cardiovascular disease and its determinants has been a priority of several Presidencies. The major Ministerial Conference and the Council Conclusions on heart health promotion during the Irish Presidency from June 2004 helped to firmly place heart health on the EU agenda.*



Conference Delegates

*During the Luxembourg Presidency in 2005, the Commission supported the organisation of an expert meeting to focus on the implementation of these Council Conclusions. In that meeting, the representatives of the Ministries of Health of the Member States, the European Society of Cardiology, National Cardiac Societies, the European Heart Network, and the representatives of the National Heart Foundations agreed upon a Luxembourg Declaration on Cardiovascular Health.*

*This declaration addressed the necessity of a comprehensive action plan in each country; with broad stakeholder participation. It was also decided to develop a consensus document with a preliminary title of "Heart Health Charter" to guide and facilitate the development of national strategies. The concept of the Heart Health Charter will be more explicitly discussed during the third session of today's conference and we welcome the contribution of the European Society of Cardiology and European Heart Network who are taking a lead in this process.*

*A recent survey published by the European Observatory on health care systems shows that EU members use different approaches in their public health strategies.*

*Some countries highlight broader health determinants, focusing on issues such as social inclusion and creating supportive environments. Others put more emphasis on health behaviours, while others again stress disease categories such as cardiovascular disease, cancer, mental illness or diabetes.*

*This is not a contradiction. General health promotion strategies and efforts to prevent disease must go hand in hand. And while some countries will put more emphasis on the one or the*



*other, both routes have to be taken to reduce the burden of cardiovascular disease.*

*The EU's public health approach focuses primarily on the first two categories – tackling broad health determinants through ensuring a high standard of health protection in all policies combined with initiatives on health determinants linked to lifestyles, addictions and social and economic environments. The EU aims to contribute and support national strategies where it can add value.*

*The Commission is preparing a series of Community strategies to tackle the most important health determinants.*

*On nutrition and physical activity, Commissioner Kyprianou has launched a Platform to engage key stakeholders – the food, advertising and retail industry, health professionals, academics and health and consumer organisations – last April. Moreover, the Commission published a Green Paper in December to launch a debate on EU-level action in this field.*

*Regarding alcohol-related harm, a Community strategy document is planned for the second half of this year.*

*As far as tobacco is concerned, an effective mix of legislative measures regulating tobacco products and advertising, public tobacco prevention campaigns and networking activities is in place.*

*Finally, on mental health, a Green Paper was published last autumn to consult about the EU contribution in addressing this major health concern.*

*The Commission's proposal for a new Health and Consumer protection programme puts a strong focus on promotion and prevention and foresees a new action strand on the prevention of diseases with a key public health dimension. This will enable us to contribute further to networking activities, but of course within the limited resources available.*

*I welcome this conference and look forward to hearing about its results. I find the Heart Health Charter an intriguing idea which I hope will be developed bottom up, building on the situations and requirements of the Member States and of those who are working in this field.*

*Through its work tackling the determinants of health, the European Commission is supporting these efforts and more generally your work to develop effective strategies to prevent cardiovascular disease across Europe.*

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## SESSION 1:

### CARDIOVASCULAR DISEASE TODAY – HOW ARE WOMEN DIFFERENT?

The British Heart Foundation's (BHF's) Director-General, Mr. Peter Hollins, chaired the first session, which looked at gender differences within the realm of CVD.

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**Burden of CVD: Prof. Guy de Backer, Chair, Joint European Societies Cardiovascular Prevention Committee; Co-chair of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR) of the ESC**

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Prof. Guy de Backer opened his remarks by looking at the European guidelines on the prevention of CVD in clinical practice (the objectives being to reduce the risk of major cardiovascular events through lifestyle changes, through the management of risk factors and the prophylactic use of certain drugs).

Looking at the causes of death for men and women under 75, Prof. de Backer noted that 38% of such deaths in men were related to CVD, while the corresponding figure for women was 44%. This could be compared to 5% of deaths in women (under 75) being due to breast cancer.

#### **REGIONAL DIFFERENCES AND THE NEED FOR DATA:**

Moving on to regional differences, Prof. de Backer examined death rates due to CVD for both men and women in the same age bracket. The latest data available showed the risks to be four times greater for men living in Eastern Europe compared with those in the Southern and Western countries. For women, the risks were 10 times different by region. WHO data (1968-2001) also showed marked differences by country, with deaths increasing dramatically in the Ukraine throughout the nineties, increasing and then decreasing in Romania in the same timeframe and consistent falls in countries such as the UK and France.

But that was only part of the picture, as Prof. de Backer showed data that indicated that more disability-adjusted life years were lost due to CVD than to either cancer or neuropsychiatric disorders. As for the CVD burden in Europe, Prof. de Backer said that recent EHN / BHF CVD statistics showed the true cost to be €169 billion per annum (or €3724 per capita), made up of direct costs, productivity losses and patient care.

After describing the risk factors impacting coronary heart disease (lifestyles, modifiable risk factors, e.g. elevated blood pressure and non-modifiable, e.g. family history), Prof. de Backer referred to the INTERHEART study that identified nine risk factors (smoking, lipids, hyper-





tension, diabetes, obesity, diet, physical activity, alcohol consumption, and psychosocial factors) that accounted for over 90% of the risk of acute myocardial infarction (AMI). However, in other studies such as the MONICA project the heterogeneity of the dynamics of the CHD epidemic was less well explained through changes in classical risk factors.

The increasing number of patients surviving attacks, together with the changing demographics, means that there are and will be serious cost implications (healthcare needs and costs). He added that for a better understanding of the actual and future transitions in CVD there is a strong need to gather comparable and continuous data on the incidence and lethality of CVD throughout Europe.

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**European Parliament Activities on EU Health and CVD: Dr. Georgs Andrejevs, MEP, European Parliament (ALDE, LV); Professor in Anaesthesiology**

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Dr. Georgs Andrejevs discussed the need for CVD to be properly addressed at both national and European levels. Reminding the audience that CVD (mainly heart disease and stroke) was responsible annually for nearly 2 million deaths in the EU-25, Dr. Andrejevs also highlighted the regional differences. There were increases in Central and Eastern Europe, while CVD was the main cause of death in women in the Baltics, Hungary, Poland and Slovakia. He added that European governments spent more money on CVD than on any other disease.

From the perspective of the European Parliament, Dr. Andrejevs called for additional focus in the Commission Action Programme 2007-13, to maintain the momentum of the Irish Presidency's actions in 2004. The Action Programme spells out the need to act, stating that the EU had a role to "contribute to reducing the incidence of major diseases such as CVD, through specific actions".

However, Dr. Andrejevs regretted that no such specific actions had been really outlined. He wanted to see a definite programme designed to promote cardiovascular health through prevention and screening measures. All risk factors (consisting of high blood pressure and high cholesterol, obesity, alcohol consumption, lack of physical activity and tobacco intake) should be tackled, rather than only placing the focus on the need for healthy eating and a reduction in smoking levels.

With one-in-five deaths from CVD being caused by smoking, Dr. Andrejevs welcomed the Commission's plans to create a "smoke-free Europe", but he wanted all factors to be tackled via a tangible and structured plan to prevent and tackle one of the biggest killers of Europeans – and especially an Eastern European perspective - each year. .

He underscored the need for EU countries to share best practices, and for the EU to set standards and provide an impetus for many Member States, which were falling behind the European average.

Dr. Andrejevs confirmed that he would introduce a Parliamentary Resolution demanding action on CVD prevention and screening at EU level to ensure that minimum standards for CVD prevention and care be created across Europe.

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**Women are not just men in disguise: Dr. Marco Stramba-Badiale, Chair of the Policy Conference on Women of the European Society of Cardiology, Istituto Auxologico Italiano, Milan**

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Dr. Marco Stramba-Badiale showcased how women differed from men in CVD prevention. His first point was that the risk of death from CVD for women was under-estimated, as untreated risk factors were prevalent post-menopause. This meant that a woman of 60 was at the same risk as a man of 50.

Describing the European Society of Cardiology's "Women at heart" programme, Dr. Stramba-Badiale said it aimed to organise initiatives targeted at promoting research and education in the field of CVD in women. The ESC's Policy Conference: Cardiovascular diseases in women, had called for further awareness, and better understanding of the gender differences in managing CVD.



Dr. Marco Stramba-Badiale

He illustrated the gender-differences by describing the effects of aspirin for the primary prevention of myocardial infarction and stroke. Results showed that, in men, aspirin reduced the risk of myocardial infarction with no impact on stroke, whereas the reverse was true for women.

Noting that the majority of drugs were tested for safety and efficacy in male populations, Dr. Stramba-Badiale added that the ESC's Policy Conference also called for clinical trials to be conducted on female groups or on groups with a proportional female population.

Summing up, Dr. Stramba-Badiale recommended implementing a programme to increase the awareness of morbidity and mortality relating to CVD in women, targeting various audiences: healthcare professionals, scientific societies, European institutions and national healthcare authorities, patients' associations and foundations, and the general population.



## KEY QUESTIONS: FIRST SESSION

### *East / West health gap: who can act?*

European Society of Cardiology Chair (Committee for EU Relations) Prof. John Martin welcomed Dr. Andrejevs' call for action but wanted to hear more on the detail. Everyone agreed that the countries in Eastern Europe needed help, but he had noticed a certain reticence in the air. Who would take action?

Dr. Andrejevs agreed that action was urgently needed but he did not want to have only an exchange of best practices. Much more was required, and Dr. Andrejevs likened it to the post World War II necessity for the Marshall Plan. He argued that the Commission was the right vehicle to continue the Irish Presidency's initiative and to be much more active in the field of CVD prevention, including more emphasis on research. The European Parliament's role was to produce a discussion document that would lead to fewer inequalities between East and West Europe.

Prof. Martin agreed that this was a good way forward, and stated that the ESC would work closely with the European Parliament to help secure institutional agreement on these initiatives.



Prof. John Martin

### *Eastern Europe - help needed on the ground*

Dr. Susana Sans, Chronic Diseases Epidemiology Program, Institute of Health and Studies, Barcelona, wanted more practical assistance. She understood that the necessary drugs were not being provided on the ground in Eastern Europe. Dr. Sans therefore wanted a resolution that ensured that drugs be available, otherwise screening programmes would serve no purpose.

Dr. Andrejevs agreed that problems existed, primarily because many governments of the new Member States were in transition. The EU-15 must understand this problem and do its utmost to make positive changes in the economies of Eastern Europe.

Prof. de Backer argued that the real problem was a lack of education (for the medical profession), as even if the drugs were available, they were often not used or prescribed in the wrong doses. Dr. Stramba-Badiale agreed as well, but argued that the role of the ESC was to set guidelines for cardiologists across the EU.

The Slovak Society of Cardiology's Gabriel Kamensky agreed that the root of the problem lay in the differences in the economies of the EU-10 and EU-15. But smoking was cheap in the Eastern European countries, so why didn't the Commission and the Council do something to reach an agreement on a "smoke-free Europe", and be as strong as possible on tobacco control?

### *The need for research and information campaigns*

Mr. Kuzmickas Kestutis, Lithuanian Mission to the EU, asked if there should be separate programmes for men and women or joint activities. Dr. Stramba-Badiale agreed that risk factors were equally important but that the prevalence was not the same. He recommended that the campaigns should be similar with some crossover points. Prof. de Backer commented that the guidelines were 95% the same, but the differences in implementation, required different strategies.



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## SESSION 2:

# ADDRESSING CARDIOVASCULAR HEALTH GAPS IN EUROPE: SHARING GOOD PRACTICES

The second session looked at how best practices could be shared across Europe and was chaired by Dr. Susana Sans, Chronic Diseases Epidemiology Program, Institute of Health and Studies, Barcelona.

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**Looking at Risk Factors: How modification affects CVD Risk, Dr. Julia Critchley, Lecturer in epidemiology and research synthesis, International Health Research Group, Liverpool School of Tropical Medicine**

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Dr. Critchley examined why CHD death rates had declined in some countries (UK, Finland and Italy for example). Was this primarily due to CHD treatments or to reductions in the various risk factors?

To answer the question, Dr. Critchley described an IMPACT Model (table 1) that looked at how modification of risk factors, and improved medical and surgical therapies, affected CVD risk. The model was used to examine why there had been a fall of 50% in CHD deaths (1981 – 2000) in England & Wales – this had meant 68,000 fewer deaths in that timeframe.

This data showed that newer treatments and uptake of treatments had accounted for 40% of the improvements while changes in risk factor levels had accounted for the remaining 60%. However, within the latter figure, data analysis showed that while reductions in smoking, cholesterol levels, and blood pressure had improved the situation, there had been increases in obesity, diabetes and possibly a drop in the level of physical activity.

### TABLE 1 - THE IMPACT MODEL

- **Comprehensive**
- **Data from several sources**
  - Patient numbers (12 groups)
  - Covering 48 treatments
  - Effectiveness and uptake of treatment
  - Trends in major risk factors in whole population

Looking at the numbers of life-years gained (in the UK), Critchley showed that these were mainly in the under-65 population and were due primarily to a reduction in risk factors, especially in men. As for future trends, Dr. Critchley argued that reductions in smoking and in cholesterol levels had the most potential for saving additional lives.

Of great concern was the increasing trend in young women smoking. Increases in smoking in young women may offset future reductions in CHD mortality in Finland and Italy.

Dr. Critchley argued that CHD mortality rates could be halved (in UK, Finland, Ireland and Italy), with dietary improvements and a reduction in smoking levels being the two most obvious areas of focus.

Dr. Critchley called for more research on strategies on how to prevent smoking and facilitate smoking cessation in women of all age groups.

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### Addressing Tobacco: the Canadian experience: Dr. Elinor Wilson, Chief Executive Officer, Canadian Public Health Association

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Dr. Elinor Wilson

Dr. Wilson opened her talk by looking at sex differences (increased CHD among diabetic women, girls' breast development affected by smoking, women gaining more weight after quitting smoking than men, etc.) and gendered influences (poverty and low income, violence, alcohol abuse, etc.).

#### A STEP-BY-STEP APPROACH

Looking at the history of smoking in the Canadian workplace, Dr. Wilson stated that smoking bans had first been introduced in 1985, and have increased ever since. As a result, per capita cigarette consumption had dropped from over 4,000 in 1965 to 1,700 in 2003.

Dr. Wilson reported that there had been great success with vivid picture warnings about smoking and that these had had a major impact (90% of people had noticed the warnings, 44% felt increased motivation to stop smoking, etc.).

The tobacco industry, Dr. Elinor Wilson said, had continually used "smart and creative tactics". To counter such tactics, she called for civil society to develop coherent plans, to organise education programmes and advocate for clearly-written legislation.

### THE DEVIL IS IN THE DETAIL

Despite smoking rates increasing globally, Dr. Wilson reported that in Canada, there had been significant falls in both men's and women's smoking rates (men from 38% to 22%, women from 32% to 17%). However these results masked sub-populations that exhibited persistently high rates of smoking.

#### These included:

- 25% of young women (aged 20-24) were current smokers
- 12% of mothers over 35 smoked during pregnancy whereas the figure for mothers under 20 was 53%
- 7% of mothers aged 25-44 smoked during most recent pregnancy whereas the figure for mothers aged 15-24 was 21%

### A COMPREHENSIVE POLICY IS REQUIRED

According to several studies, Dr. Wilson argued that smoking rates were much higher in those areas with the highest rates of poverty and social hardship.

She also called for a comprehensive gendered tobacco policy that focused on social structural issues, rather than on individual smokers' behaviour. It should be gender-specific, developed with smokers' involvement and be reflective of the diversity of women's and men's experiences. It should also recognise the links to a range of other health, social and economic issues, programs and policies.

In conclusion, Dr. Wilson wanted to extend gender-based analysis, improve research (collaborative models, measurement tools, reporting), develop a holistic approach that took account of all factors (housing, access to child care, social welfare, addictions, etc.) and commit to an ethical framework that reflected social justice principles and linked tobacco policy to a health and human rights agenda.

### CALL FOR CANADA TO

- Implement a comprehensive ban on advertising, sponsorship and promotion
- Prohibit smoking in all federally-regulated indoor workplaces and public places
- Establish sustained funding for global tobacco control
- End deceptive packaging, including the use of misleading terms
- Restore funding to Health Canada's tobacco program
- Re-establish a meaningful Federal mass media anti-smoking campaign
- Increase Federal tobacco taxes by \$10 a carton
- End the sale of reduced-duty tobacco in duty-free stores

**Reducing Blood Cholesterol – Reducing CVD: Prof. David Wood, Professor of Cardiovascular Medicine, National Heart and Lung Institute, Imperial College, London, Charing Cross Hospital**

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### **EPIDEMIOLOGY OF CHOLESTEROL AND CVD**

Using the 52 country INTERHEART study, based on 15,000 heart attack cases and a similar number of healthy controls, Prof. Wood showed that the ratio of good / bad cholesterol in the blood was continuously related to the risk of a heart attack. As the ratio of good/bad cholesterol increased so did the risk of a heart attack, and this was as true for women as for men.

### **REDUCING CHOLESTEROL IN WOMEN**

Conversely the Cholesterol Trialists Collaboration, which overviewed the results of all the major statin trials, showed that reducing blood cholesterol with a drug reduced the risk of heart attack and stroke. By reducing cholesterol by 1.0 mmol/l over 5 years reduced the risk of heart attacks and stroke by about a fifth. The same reduction in CVD risk was seen for both women and men.

### **TREATING CHOLESTEROL IN WOMEN**

The 15 country EUROASPIRE study of the care of people with heart attacks showed that women and men are being treated differently. Although women are less likely to be cigarette smokers they are more obese and have poorer control of blood pressure and blood cholesterol and more diabetes. As a consequence they are at higher risk of recurrent cardiovascular disease. Medical treatment of all risk factors in women, including blood cholesterol, will reduce their risk of developing or having recurrent CVD. However, a medical strategy alone is not sufficient. What is required is a population strategy to reduce the burden of CVD.



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**What Women Need: Ms. Peggy Maguire, Director General, European Institute of Women's Health**

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Ms. Peggy Maguire emphasised that CVD was the number one killer of women in Europe, responsible for more deaths than all types of cancer combined. She reported that more than one-third of women aged between 55 and 64, suffering from CVD, were disabled with the figure being at over 50% for women over 75. With this having economic repercussions, as well as a reduction in the quality of life, the changing European demographics were a cause for concern.

Looking at the barriers to prevention of CVD, Ms. Maguire highlighted the fact that the majority of research had been conducted on men and that there was a resulting lack of data on women. This left many questions (such as the effect of cholesterol on female hormones, effectiveness of aspirin for women, which blood pressure medicines should be prescribed, etc.) unanswered.



Ms. Peggy Maguire

As women have different symptoms and are less likely to have cardiac tests for symptoms suggesting heart problems, there is a serious gap in diagnosis. They were simply not aware of the risks. However that was not all, as Maguire argued that women tended to minimise their symptoms as they were often juggling careers and looking after families.

Moving on to risks, Ms. Maguire said that they were similar for both men and women (cholesterol, smoking, high blood pressure, stress, diabetes, obesity). However, oestrogen did confer a level of protection on pre-menopausal women. She added that women's heart health was linked to income, education, location and the amount of care received. Obesity also played a role, with obese women being 12 times more likely to develop type 2 diabetes.

Ms. Maguire called for a new framework that involved a multisectoral approach, with input from women, medical & healthcare professionals, researchers, public health authorities and policymakers at both national and EU levels.

In conclusion, Ms. Maguire called for a continued focus on women and CVD post Austrian presidency, progress on the European Charter of Heart Health with a strong focus on women. She called for a Council Recommendation on CVD and for the Commission to produce a report on the state of women's health.

## KEY QUESTIONS: SECOND SESSION

### *Smoking bans*

Dr. Stramba-Badiale appreciated Dr. Wilson's approach. He added that in Italy a strict law had been introduced but the main problem had been in having it correctly applied. Nevertheless, Italy had seen a reduction in smoking of 5% and Dr. Stramba-Badiale wanted to know if a similar success might be seen in other countries.

Dr. Wilson agreed that strict application of the law is essential for it to be effective. People had to be educated about the reasons for prohibiting smoking in public places as well as workplaces. She had noted that smoking was still allowed in the European Parliament!

#### WHAT WOMEN NEED – A FRAMEWORK THAT INVOLVES

- **Women:** as they must be involved in the design and delivery of the information
  - via a coherent and clear message
  - as not all women have the same education and access to written literature
  - and women must be trained in asking the right questions of medical professionals
- **Medical and healthcare professionals:** gender-sensitive information has to be provided and symptoms (in women) need to be recognised
- **Research:** more women are needed in clinical trials and more gender emphasis required in FP7 funding
- **Public health authorities:** must communicate more effectively to women about the risks of CVD by involving women and producing good information
- **Policymakers – EU:** the key is to develop a solid information base, so standards can be set and best practices shared
- **Policymakers – national:** programmes must be implemented, monitored and evaluated – national best practices to be consolidated at the EU level



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## SESSION 3:

### EU PUBLIC POLICY ON CVD: EUROPEAN INSTITUTIONS AND STAKEHOLDERS

The final session looked at public policy on CVD and was moderated by EuroHealthNet Director Mr. Clive Needle.

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**Mr. Michael Hübel, Head of Unit, Commission, DG SANCO, Health Determinants**

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Mr. Michael Hübel spoke on the EU role in support of work on cardiovascular health and the prevention of CVD. He explained that the Treaty put the focus on health promotion and prevention (early intervention & healthy lifestyles), while leaving the delivery and financing of health care largely for the Member States. The EU could however facilitate the cooperation of health systems and exchanges of best practices.

**Looking at the actions already taken by the EU, Mr. Hübel highlighted:**

- Developing indicators, collecting and disseminating information
- Research actions under the RTD Framework programmes
- Work on the underlying factors behind CVD, such as nutrition and physical activity, tobacco and alcohol, bringing together EU competences into common strategies

#### **THE HEART HEALTH CHARTER**

Mr Hübel welcomed the European Heart Health Charter initiative which is being taken forward by both the ESC and the EHN with support from the Commission. The aim was to make the Charter the starting point for collaboration between the various players.

Mr. Hübel finished with a review of the funding prospects for public health in the new financial perspectives. Although money was not everything, the budget available for health during 2007 to 2013 will be limited and will make it necessary to take difficult decisions about prioritisation.

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**Dr. Ines Stamm, Expert on Women's Health Affairs, Austrian Ministry for Health and Women, Austrian Presidency of the European Union**

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Dr. Ines Stamm

Prefacing her remarks, Dr. Ines Stamm stated that the Austrian Presidency was emphasising the importance of women's health issues, including the prevention of Type-2 Diabetes and the development of women's health indicators based on the Beijing Action Platform. Focusing on the report – "Women's Health in Europe: Facts & Figures across the EU", produced by the European Institute of Women's Health (EIWH), Dr. Stamm added that she supported Ms. Maguire's call for a new report to be issued by the Commission.

- **CVD:** With CVD being the primary cause of death in European women (at 55%), the female population was severely under-represented in clinical trials and often received an inappropriate diagnosis and treatment
- **Smoking and lung cancer:** Smoking increased the risks of a heart attack three-fold in women; the Austrian Women's Health Report showed that lung cancer had increased by 25% (age standardised rate) since 2001
- **Endometriosis:** the "unrecognised gynaecological disease", affecting 14 million women – a major impact on the quality of life and (due to absence from work) on economic well-being
- **Osteoporosis:** the "silent epidemic", affecting over 600,000 people in Austria alone

Stressing the intention of Austria to follow on from the Luxembourg and Irish initiatives, Dr. Stamm described the various events that would occur under the Austrian Presidency. Looking to the future, she added that the results of the Type 2 Diabetes meeting (February 2006, Vienna) would soon be announced and there would be an informal meeting of Health Ministers in Vienna (25-26 April, 2006), which would focus on the main topics listed above. In addition, Dr. Stamm referred to the proposed action plan of "Improving Heart Health in Women - an EHN/ESC initiative" and stressed that the ESC initiative Women at Heart will be a good base for Austria and that the common goals (definition of common targets, collection, and discussion) are very important for the improvement of CVD of women

**The action plan would include:**

- The definition of common targets
- The collection of EU-wide information on CVD
- A discussion about an EU-wide prevention programme to improve "Heart Health in Women"

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**Ms. Linda McAvan, MEP, European Parliament (PES, UK)**

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Looking to define the EU's vision, Ms. Linda McAvan said that access to proper health care, regardless of status or income, is a key component of the European social model. Today, however, the EU could certainly facilitate the exchange of best practices and assist Member States in the fight against pandemics.

**Ms. McAvan called upon the EU to:**

- Raise awareness on CVD
- Introduce new, relevant legislation (that improves food labelling, helps in the fight against obesity and protects children)
- Emphasise research on heart-health related matters in FP7

And even though there were financial problems within the EU, Ms. McAvan called for the Union to defend the health budget, as it was a priority for all EU citizens.

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**Ms. Susanne Løgstrup, Director, European Heart Network**

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Referring to the Treaty of the Union, Ms. Susanne Løgstrup reminded delegates that the EU had a powerful competence in protecting and promoting health through the obligation to consider a high level of health in all of the EU's policies. The principle of health impact assessment needed to be implemented across the board, for example, the Common Agricultural Policy (CAP) could be used to improve dietary intake and consumption across Europe. But it needs political will.



Ms. Susanne Løgstrup

Ms. Løgstrup expressed concern about the European Parliament's position on the health action programme. The leading Committee had decided not to make reference to CVD and other major diseases in the relevant sections of the programme. She stressed that it was very important in communication to link health determinants to the actual disease outcomes. When political support was needed for specific legislative measures, for example, it was valuable to talk about heart disease and not just 'major disease burdens'. Therefore, it was essential to make it clear in the EU health programme that the EU's main challenges are heart disease, stroke, cancer and mental health. She concluded that the question is not whether to pick a health determinant approach versus a disease-specific approach but to have both.

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### > SESSION 3: EU PUBLIC POLICY ON CVD: EUROPEAN INSTITUTIONS AND STAKEHOLDERS

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To further strengthen efforts to promote cardiovascular health and prevent CVD in the member states, an EU strategy is necessary. She said that EHN was actively engaged in developing the aforementioned Heart Health Charter as a means to gather a large number of stakeholders together and agree to work in specific areas to address the burden and risks of CVD. However, to underpin an EU strategy and grass-roots work, a top-level political commitment is crucial and Ms Løgstrup underlined the need for an EU Council Recommendation on the prevention of CVD.

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#### **Dr. William Wijns, Vice-President, European Society of Cardiology**

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Dr. William Wijns and Ms. Susanne Volqvartz

On behalf of the ESC, Dr. William Wijns gave a strong commitment to the prevention of CVD. The structures and science were in place (together with advocacy) and it was necessary to consider implementation. Dr. Wijns described the “Heart Plan for Europe” as a major project – it had started under the Spanish Presidency and the required tools and objectives had been taken forward under Luxembourg’s lead.

Dr. Wijns added that there was a gap between education and awareness. There was a problem in the process, as it should be part of the core curriculum. In addition, there should be much more focus on gender-related issues. He listed the planned actions and Dr. Wijns added that there might be a need to enlist the help of non-medical professionals.

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#### **Mr. Brian Crowley, MEP, European Parliament (UEN, IE)**

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With CVD being the biggest killer in Europe (with more than 1 million women dying every year from CVD), Mr. Brian Crowley highlighted the massive economic resources that were being wasted. One problem was national parochialism that led to a lack of continuity in the EU’s plans and actions. Ireland had been one of the first countries to put CVDs on the agenda but progress had come to a halt after the Luxembourg Presidency.

Mr. Crowley wanted real action and he wanted an informed debate. Despite health services improving (both in terms of funding received and technology employed), the EU’s citizens were presenting new problems for the medical profession. He argued that “real medical problems” had to be dealt with rather than an increased focus on avian flu.



> SESSION 3: EU PUBLIC POLICY ON CVD: EUROPEAN INSTITUTIONS AND STAKEHOLDERS

Mr. Crowley acknowledged the wide divergences between East and West, between North and South, and wanted these to be examined and discussed (and actions taken). He also wanted members of the nursing and caring professions to be included in the debate. Face-to-face contact with people on the ground was important.

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## KEY QUESTION: THIRD SESSION

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### *Disease specific approach*

Mr. Ian Graham had noticed a certain reticence on the panel to follow a disease-specific approach, did they have any comments?

Mr. Hübel commented that many bodies were good at addressing issues such as cancer, but were less successful at adopting a more holistic approach. So it was better to look at health determinants (that approach had support from the European Parliament and the Council) as that gave participants a better chance to look at causes of diseases.

Mr. Hübel added that both approaches (disease-specific and health determinants) were needed, as they were not contradictory.



Dr. Ines Stamm speaking with conference participant

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## SESSION 4:

# EU PUBLIC POLICY ON CVD: MEMBER STATES' PERSPECTIVES

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Opening statement by Prof. Zilvinas Padaiga, Minister of Health, Lithuania

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*Mr. Chairman, Ladies and Gentlemen, Dear Colleagues,*

*I am delighted to be here in Brussels today to take part in this high-level conference devoted to promoting women cardiovascular health and preventing cardiovascular disease. Cardiovascular disease (CVD) is the number one killer in Europe, accounting for 1.9 million deaths in the EU each year. The economic cost of CVD in the EU amounts to 69 billion euros a year in healthcare costs and lost working days, making it the most costly disease in Europe. As for a Minister of Health, the social and economic aspect of CVD finds an immediate resonance and calls for urgent appropriate actions for prevention and early treatment.*

*Mr. Chairman, dear colleagues, the presence of modernized infrastructures for both CVD prevention and disease treatment in Lithuania allowed for decisive actions, which has been credited from the substantial increase in stroke incidence (2.2% per year) as well as in attack rate of stroke (3.0% per year) for the middle-aged women in recent years. The only question one could give is why these rates are increasing? Is this the "harm" brought by social transition and global changes or may there be a lack of personal care for health? Today we see that both questions are substantial – prevalence of daily smoking among women is increasing from 4.1 % to almost 12 % in recent years. The same tendencies are with alcohol consumption - 68.3% of females are using either strong or weak alcoholic beverages. As you see these numbers are daunting and probably all of us here would agree that costs associated with CVD infarctions - not to speak of the associated costs of long-term care - can be reduced to the benefit of the healthcare budgets, if we invest in appropriate action for prevention and early treatment.*

### **MOVING TO CONCRETE ACTIONS**

*Lithuania has a general policy to promote women's cardiovascular health and prevent cardiovascular disease. Comprehensive prevention programs for cardiovascular diseases are funded from government allocations which give a strong impetus for developing the*



## &gt; SESSION 4: EU PUBLIC POLICY ON CVD: MEMBER STATES' PERSPECTIVE

infrastructure, medical facilities and advanced telecommunication and information infrastructures in hospitals. Another progress achieved is the continuous education of medical personnel and population and this policy is included into national health strategies. Taking this opportunity, I would also like to highlight Lithuania's impact on the identification of high-risk cardiovascular patients and the implementation of methods of prevention, which mainly focuses on reducing morbidity caused by acute cardiovascular syndromes, and identifying diabetes mellitus and latent conditions of arteriosclerosis. Women are essential targets of this programme including in particular age, gender-specific risk factors and many others.

Nevertheless we are striving to fight against this harm by using allocations from EU Structural Funds also. At the moment we have two projects (development of infrastructure and training of medical professionals) running with the main goals to improving prevention, diagnostics and treatment of cardiovascular diseases. We know the current trends but I believe that our harmonized action plans in this field will change the direction of increasing morbidity and mortality rates from this disease.

Mr. Chairman, dear colleagues, we need to act - and especially from an Eastern European perspective, it is urgent. We need to exchange the best practices and information to ensure better health for European citizens.



Minister Zilvinas Padaiga

If the EU can enable the exchange of best practices, we can learn from each other's mistakes - and successes. This is the global unique threat and the entire Europe must join together in the alliance to protect our population.

In conclusion, Mr. Chairman, let me express my strong belief that only ongoing efforts of our countries would fully set forth our mutual intention to collaborate to strengthen our response to the CVD "epidemic".

Thank you all for your attention, but more specifically, for your invitation to be with you here today.

I wish you all a successful, profitable and sustainable future endeavours.

Thank you Mr. Chairman.

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Mr. Vasja Klavora, Member of the Slovenian Parliament

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Mr. Vasja Klavora explained that CVD was the leading cause of death in Slovenia, even though the percentage of those dying had dropped from 48% (of all deaths) to 38%. He added that the figures were improving due to:



Mr. Vasja Klavora

- improvements in medical care and new medicines, and
- better and healthier lifestyles

One reason for the decreasing rates of CVD was the successful implementation strategy that included dissemination of the necessary information by professional organisations.

A problem identified by Mr. Klavora was the increasing rates of smoking by young women. This led Mr. Klavora to call for a total ban on smoking. Additionally, he backed the promotion of healthy lifestyles (more exercise in order to reduce cholesterol and blood pressure).

Addressing these issues, Mr. Klavora called for more EU focus on smoking cessation, and dissemination of information on CVD prevention best practices.



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**Dr. hab. Danuta Czarnecka, Adjunct Professor, Cardiac Clinic,  
Krakow University Hospital**

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Dr. hab. Danuta Czarnecka opened her remarks by stating that although CVD was the main cause of death in Poland in 2003 (47% of deaths), the situation was now improving and could be equal to the average EU rate by 2018 if current rates of progress were maintained.

- Arterial hypertension was not treated in 35% of women and 53% of men
- A high percentage of patients (13% women, 27% men) did not take drugs prescribed for arterial hypertension
- Smoking rates were highest in the 31-44 year-old age group
- 16.5% of men and 5.5% of women had insufficient good cholesterol
- Metabolic syndrome was present in 22% of women and 18% of men
- The risk of myocardial infarction (MI) was increasing with age

Based on these figures, it was decided to introduce a campaign (of information, education and intervention) in order to reduce the number of MIs. This was based around four programmes targeting 400 cities and villages to detect hypertension, diabetes and metabolic syndrome: to reduce the rates of smoking; aiming to change children's lifestyles and eating patterns; using educational commercials on television; and disseminating key patient data to over 1,500 general practitioners.

In conclusion, Dr. hab. Czarnecka called for comparable data across the EU, more research and an integrated approach to the problems of CVDs and CHDs.

## KEY QUESTIONS: SESSION FOUR

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### *The new Member States*

Mr. Clive Needle addressed the socio-economic conditions in the new Member States and asked what the EU could do to rectify the situation.

Minister Padaiga said he appreciated the EU recommendations and the exchange of ideas (at the conference) and felt that the issue should be placed firmly on the agenda. He said he was pushing through a ban on smoking, and that he wanted to build on the experience from other EU Member States. Overall he favoured progress by consensus.

Mr. Klavora wanted the EU to offer advice but he also wanted Slovenian experts to have their say.

### *Continuity of EU policy*

Mr. Needle asked Dr. Stamm if the Austrian Presidency would be offering continuity of action in the fight against heart-related problems.

Dr. Stamm certainly wanted to have common recommendations and she wanted to ensure that the EU's programmes would lead to views being changed (as to how women were treated). The key event for Dr. Stamm would be the informal meeting of Health Ministers.

### *Next steps from the Commission*

Turning to the Commission, Mr. Needle asked Mr. Hübel what was next on the Commission's agenda.

Mr. Hübel replied that progress around the objectives of the Charter could act as a building block for the next steps as it would bring together all the players. It could both clarify the process and help in the creation of a much-needed legal framework. However, funding was important and that was the next (and formidable) hurdle to be addressed.



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**Finnish Presidency plans to take forward EU action on CVD: Mr. Tapani Melkas, Director, Ministry of Social Welfare and Health, Finland**

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Continuity was the byword of Mr. Tapani Melkas' remarks. He explained that women's health had improved significantly (decreased mortality due to CHD) in Finland in the last 50 years, due to a raft of factors. These included the introduction of new drugs, tobacco legislation and educational programmes. Mr. Melkas said that the successful reductions had been achieved by a mixture of better treatment (25%) and prevention programmes (75%). As the treatment had been more expensive to implement than the prevention programmes, he argued that it was possible to achieve successful results cheaply.

Highlighting two priorities in the health programme sector of the Finnish Presidency – postponing the retirement age of workers and injecting the “health element” into all policies – Mr. Melkas explained why the latter objective was so important.

**The determinants of major diseases were much the same**

- Determinants could be influenced by many factors and not just by those covered by the health sector
- The benefits of multi-sectoral policies had been demonstrated in Finland
- The EU had been mandated to include an element of health protection in all of its policies

**FUTURE PLANS**

An important step for Mr. Melkas was the Health in all Policies (HIAP) conference, planned for September 2006. In particular the conference would examine:

- Health inequalities as a multisectoral challenge (high priority)
- Nutrition, physical activity and major diseases (high priority)
- Health-targeted alcohol policy
- Transport policy and health
- Promotion of children's health (multi-sectoral)
- Health impact assessment

The expected outcome would be proposals for Commission policies and information on Member States' activities for submission to the Council.

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# PRESENTATION OF CONFERENCE CONCLUSIONS AND CALL FOR ACTION

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**Prof. John Martin, Chair, Committee for EU Relations, European Society of Cardiology**

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Prof. John Martin called for concrete EU action and for greater mobilisation of the professional bodies in Europe.



Prof. John Martin

Prof. Martin noted that Spain had made a declaration of intent and that Ireland had performed an in-depth analysis of the problems related to CVD and CHD. Now it was time for a top-level agreement from the Council, one that would provide enough authority for the Commission to take significant actions.

## **The importance of the Heart Health Charter**

In order to develop continuity, Prof. Martin called for the Heart Health Charter to be driven forward through as many EU Presidencies as possible.

Recommending the use of the Charter, Prof. Martin called for it to be followed by all Member States as it was built on science and experience. He also called for action from the medical profession and heart foundations.

Prof. Martin also called for unity of message and recognised the need to be sensitive to political issues. While thanking the Commission for its contribution and its constant and intelligent guidance, Prof. Martin argued that it could do more to help if it showed more confidence and more active leadership.

The Commission should continue to support activities on cardiovascular health promotion, such as collecting relevant information, establishing expert networks, drafting guidelines on prevention and screening through the existing and future EU public health action programmes.



In order to ensure the best cardiovascular health for all Europeans, gender-specific aspects must be taken into account in every EU strategy for future research and action.

**The EHN and the ESC call upon the Council of Ministers to adopt an EU Recommendation on a tangible EU-wide cardiovascular strategy on the basis of a Commission proposal encompassing:**

- Cardiovascular health promotion
- Mechanisms in support of the Member States' strategies and activities
- Guidelines on risk assessment, optimal preventive methods, treatment, rehabilitation and screening
- Education of doctors by doctors (ESC)

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# PROGRAMME

- 8:30 – 9:00 Registration and Coffee
- 9:00 – 9:10 **Welcome remarks and introduction by Dr. William Wijns**, Vice-President, European Society of Cardiology (ESC), and **Ms. Susanne Volqvartz**, President, European Heart Network (EHN)
- 9:10 – 9:30 **Opening address by Ms. Maria Rauch-Kallat**, Federal Minister for Health and Women, Austria
- 9:30 – 9:50 **Keynote address by Mr. Markos Kyprianou**, European Commissioner for Health & Consumer Protection, replaced by Mr. Philippe Brunet, Deputy Chef de Cabinet

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## CARDIOVASCULAR DISEASE TODAY - HOW ARE WOMEN DIFFERENT?

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- 9:50 – 10:50 Chair: Mr. Peter Hollins, Director-General, British Heart Foundation
- **Burden of CVD:**  
Prof. Guy de Backer, Chair, Joint European Societies Cardiovascular Prevention Committee; Co-chair of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR) of the ESC
  - **European Parliament Activities on EU Health and CVD:**  
Dr. Georgs Andrejevs, MEP, European Parliament (ALDE, LV); Professor in Anaesthesiology
  - **Women are not just men in disguise:**  
Dr. Marco Stramba-Badiale, Chair of the Policy Conference on Women of the European Society of Cardiology, Istituto Auxologico Italiano, Milan

- 10:50 – 11:20 Coffee Break

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## ADDRESSING CARDIOVASCULAR HEALTH GAPS IN EUROPE: SHARING GOOD PRACTICES

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- 11:20 – 12:45 Chair: Dr. Susana Sans, Chronic Diseases Epidemiology Program, Institute of Health and Studies, Barcelona; Chair, Steering Committee Heart Plan for Europe
- **Looking at Risk Factors: How modification affects CVD Risk**  
Dr. Julia Critchley, Lecturer in epidemiology and research synthesis International Health Research Group, Liverpool School of Tropical Medicine





■ **Addressing Tobacco: the Canadian experience**

Ms. Elinor Wilson, Chief Executive Officer,  
Canadian Public Health Association

■ **Reducing Blood Cholesterol – Reducing CVD**

Prof. David Wood, Professor of Cardiovascular Medicine, National Heart and Lung Institute, Imperial College, London, Charing Cross Hospital

■ **What Women Need**

Ms. Peggy Maguire, Director General, European Institute of Women's Health

12:45 – 14:00 **Buffet Lunch**

**EUROPEAN VISION AND EU ACTIONS**

- 14:00 – 15:00 Chair: Mr. Clive Needle, Director, EuroHealthNet  
**EU Public Policy on CVD: European Institutions and Stakeholders**  
 Panellists:
- Mr. Michael Hübel, Head of Unit, European Commission, DG SANCO, Health Determinants
  - Dr. Ines Stamm, Expert on Women's Health Affairs, Austrian Ministry for Health and Women, Austrian Presidency of the European Union
  - Mr. Brian Crowley, MEP, European Parliament (UEN, IE)
  - Ms. Linda McAvan, MEP, European Parliament (PES, UK)
  - Ms. Susanne Løgstrup, Director, European Heart Network
  - Dr. William Wijns, Vice-President, European Society of Cardiology
- 15:00 – 16:00 **EU public policy on CVD: Member States' Perspectives**  
**Opening statement by Prof. Zilvinas Padaiga**, Minister of Health, Lithuania  
 In addition to the above panellists:
- Mr. Vasja Klavora, Member of the Slovenian Parliament
  - Dr. hab. Danuta Czarnecka, Adjunct Professor, Cardiac Clinic, Krakow University Hospital
- 16:00 – 16:20 **Finnish Presidency plans to take forward EU action on CVD**  
 Mr. Tapani Melkas, Director, Ministry of Social Welfare and Health, Finland
- 16:20 – 16:30 **Presentation of Conference Conclusions and Call for Action**  
 Prof. John Martin, Chair, Committee for EU Relations, European Society of Cardiology

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For further information: please contact [info@cvhconference.org](mailto:info@cvhconference.org)

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