WHF/AHA/ACCF/EHN/ESC Presidential Advisory

Moving From Political Declaration to Action on Reducing the Global Burden of Cardiovascular Diseases

A Statement From the Global Cardiovascular Disease Taskforce

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September 18, 2013 marks two years since the monumental meeting of Heads of State at the United Nations in New York to take action against non-communicable diseases (NCDs), which include cancer, cardiovascular disease (CVD), diabetes mellitus, and chronic respiratory disease. Recognizing that the rising human and financial costs of NCDs required a profound shift in the way countries viewed development, United Nations member states gathered for the second time in history to address a health concern (the first being the United Nations General Assembly Special Session on HIV/AIDS in 2001).

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Supporting the United Nations Political Declaration on the Prevention and Control of NCDs, countries acknowledged NCDs as a development issue and made a commitment to address this global crisis by taking action on the major modifiable risk factors–including tobacco use, raised blood pressure, poor nutrition, physical inactivity—triggering the new pandemic of NCDs, as well as the social, economic, and political determinants that shape these lifestyle choices[1]. Although the declaration was a political commitment, it was an important first step, bringing together health and development leaders from across the globe to ensure that progress would be made to reduce the burden of NCDs. The past two years have witnessed concrete commitments, meaning that our work is only just beginning.

The World Heart Federation and its members spearheaded global advocacy, with other colleagues in the NCD community, calling on the World Health Organization and member states to commit to tangible and achievable goals[2]. In 2012, a global target was adopted to reduce premature NCD mortality 25% by 2025—"25by25".[3] Now in 2013, this target, as well as eight additional targets addressing modifiable risk factors and committing to the use of essential medicines, technologies, and drug therapies to prevent heart attacks and strokes, has been adopted as part of a global monitoring framework and included in the World Health Organization's Global Action Plan for the Prevention and Control of NCDs (see Appendix for a list of the globally agreed targets and indicators). [4,5]

Figure 1: Reducing cardiovascular disease through a World Heart Federation global target of 25% by 2025[6]. CVD indicates cardiovascular disease; NCDs, non-communicable diseases; and WHF, World Heart Federation

These collective decisions taken by governments and ministers of health have ensured that a global architecture is in place that requires governments to be accountable for the actions they take to address NCDs in their countries. This is an extraordinary time of opportunity for the CVD community. As we move from political aspiration to practical application, what role can the CVD community play in developing and implementing a coordinated international strategy of action to attain these fundamental goals for the health of nations?

At the global level, the adoption of this architecture—a global monitoring framework with nine ambitious targets and 25 indicators—means that governments, for the first time, are accountable for progress on NCDs. These commitments will be translated into action at the national level through strong and cost-effective national plans. Each of our professional organizations will advocate for

and offer solutions that can be implemented nationally to address these targets. Systems change is not limited to systems that address health. As the world develops a framework to eradicate poverty and to reassess the Millennium Development Goals, further progress will depend on recognizing that determinants outside health services affect the health of populations and patients. How people live, move, work, and eat is of paramount importance, and interventions to reduce exposure to modifiable risk factors, as well as to address the underlying social determinants, must be planned and implemented now to protect future generations.

The changes we are seeing in models of care in high-income countries toward controlling upstream determinants of NCDs must be expanded. Even the most advanced healthcare systems need to improve how they address primordial and primary prevention through change in population behavior across the life span. Acknowledging that health systems in low- and middle-income countries have been built around infectious disease, these systems must now transform to address CVD morbidity and mortality. Tackling the growing burden of NCDs requires not only a whole of government approach but also a whole of society approach involving non-governmental organizations, local communities, and industry, where appropriate. The CVD civil society community of heart and stroke foundations and societies across the globe must have a leading role in the implementation of national NCD plans and ensure a focus on CVD primordial, primary, and secondary prevention and rehabilitation. Sharing best practices, aligning measurements, fostering expertise, advancing implementation strategies and providing leadership are critical and feasible measures to ensure that we achieve the "25by25" target, not only for NCDs, but for CVD as well (Figure[6]).

The Global Cardiovascular Disease Taskforce—comprising the World Heart Federation, American Heart Association, American College of Cardiology Foundation, European Heart Network, and European Society of Cardiology, and expanded representation from Asia, Africa, and Latin America along with global CVD experts—is helping to sharpen our collective efforts to address CVDs. Working with the World Health Organization, we are assessing and defining those specific metrics for addressing CVD that will be key to achieving the global target of "25by25." These metrics will extend beyond health systems and will be essential to preventing premature mortality. As CVD organizations operating with and through the World Heart Federation, which itself represents >200 organizations across the globe, and as partners to the World Health Organization, we are committed to the following:

1. Developing and publishing metrics around the "25by25" target that are specific to CVD and tailored by geography by 2014.

2. Shaping and supporting inclusion of CVD language in national plans.

3. Co-ordinating and aligning efforts around implementation of the CVD-related targets under the "25by25" global target, with a particular focus on reducing tobacco use and hypertension and improving secondary prevention and rehabilitation of CVD.

As we move forward together as professional societies and heart foundations, let us be the global advocates, speaking with one voice, calling for CVD prevention, treatment, and care. We celebrate the Political Declaration of "25by25" and its aspiration to reduce the burden of NCDs, and we now face the challenges of ensuring its reality and ensuring that government plans turn to action to improve the health of all of our populations.

Writing Group Disclosures

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This table represents the relationships of writing group members that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit.

A relationship is considered to be "significant" if (a) the person receives $10 000 or more during any 12-month period, or 5% or more of the person's gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns $10 000 or more of the fair market value of the entity. A relationship is considered to be "modest" if it is less than "significant" under the preceding definition.

*Modest.
†Significant.

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