

The Case for a European Heart Health Initiative

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The Case for a European Heart Health Initiative Executive Summary

In spite of a widespread belief that cardiovascular diseases (CVD) have been conquered, CVD remains the number one cause of death in Europe, taking more lives than all other causes combined. Of the approximately 1.5 million who die each year from CVD, 15% die before reaching the age of 65. For every person who dies each year of CVD, many more are suffering, either under medical care or living at reduced capacity.

The inordinate cost of CVD in human and economic terms will increase as the European population ages. When the Central and Eastern European countries join the European Union, the veritable epidemic of CVD underway in those countries will multiply the burden for the EU.

The European Heart Health Initiative aims at preventing cardiovascular disease (CVD) by addressing known risk factors in the European population. Much of CVD and the suffering it causes can be prevented by implementing life style changes such as adopting a diet rich in fruit and vegetables, with unsaturated fats replacing saturated fats; controlling obesity; following a regular programme of exercise; managing stress; controlling cholesterol levels and hypertension; and avoiding smoking. The European Heart Health Initiative is intended to publicise the changes necessary for CVD prevention and to persuade and help people to make these changes.

Cardiologists and public health experts recommend that the European Union undertake a European Heart Health Initiative aimed at promoting a healthy lifestyle and preventing CVD.

The key elements of the European Heart Health Initiative include:

- education & training in CVD prevention;
- effective interventions to persuade people to convert to a healthier lifestyle;
- policy which would actively favour increased health;
- research in health promotion and behavioural changes; and
- monitoring of risk factors and of health.

In each of these areas an exchange of current information and successful projects in various countries will be effected through improved networks of concerned organisations at the regional, national and international levels. The exchange of information between people in different disciplines concerned with CVD, including physicians, experts in health promotion and education specialists, will also be enhanced.

Three phases are envisaged for the European Heart Health Initiative. The first phase, to commence now, would create and strengthen alliances between organisations involved in CVD prevention in order to facilitate the exchange of information and to identify and prioritise needs. The second phase would be a series of events commencing with Valentine's Day, 14 February 2000, designed to focus the attention

of the public on heart health and the steps required to achieve it. The third phase would consist of continuing actions to address the needs identified in the first phase; the exact nature of the actions would be determined by the organisations and individuals who are brought together during the first phase.

A healthier Europe is the ultimate aim of the European Heart Health Initiative.

The Case for a European Heart Health Initiative

Introduction

Coronary heart disease and stroke kill more than 1.5 million people in the European Union each year. About 15% of these deaths occur before the age of 65, and about half of them before the age of 75. Cardiovascular disease (CVD) is the number one cause of death in Europe by far, taking more lives than all other causes combined. Even among younger people (34-65) it is the second most common cause of death. Each year the European Union loses on average 1,500 potential years of productive lives for every 100,000 people.

Europe can significantly reduce premature death and disability due to CVD. A great deal of information on how to prevent CVD is available, and actions in some countries have effectively proven that prevention of CVD is possible and feasible. What is needed is an initiative at European level to work toward heart health.

Reducing the incidence of CVD will lead to major human and economic gains. In fact CVD is clearly the area where the greatest health benefits can be achieved during the next decades in the European Union (EU). Europe can advance toward the ideal of citizens who are healthy throughout their productive years, who do not lose work time due to illness, and who do not create a burden on the health-care system. People will not only live longer, their quality of life will improve. The lifestyle changes involved in preventing CVD also make people healthier in general, more energetic and productive, and less apt to develop other serious diseases like cancer. It has been shown that successful CVD prevention also benefits the health of the elderly, increasing their functional capacity and thus reducing costs.

The total costs of CVD have not been calculated. It is clear, however, that CVD constitutes a very significant economic burden. Deaths leave families unsupported, while CVD survivors must undergo expensive treatment and rehabilitation, and often remain partially or completely disabled. It is estimated that the morbidity rate for CVD is twice the death rate. If vigorous measures to prevent CVD are not taken, the burden on the health-care system in Western Europe will continue to increase as the population ages.

Continuing high unemployment creates an additional challenge, since low income is associated with increased risk of CVD. The veritable epidemic of heart disease which is developing in the Central and East European countries will pose a serious problem for the EU as these countries are integrated into the Union.

Expensive clinical treatment is a very limited means of controlling the CVD epidemic in the population. Instead preventive efforts are needed.

Now is clearly the time to act.

Background

Article 129 of the Maastricht Treaty gives the EU a clear mandate for action in public health. Preventing cardiovascular diseases has been established as one goal of public health action. The Council Resolution of 2 June 1994 on cardiovascular diseases (94/C 165/02) invites the Commission 'to examine, in the overall context of Community action in the field of public health, incentive measures for the prevention of cardio-vascular diseases...'

One idea for implementing the resolution which has been discussed is to focus public attention on CVD through a specific event. In a meeting convened 26-27 March 1996 under the auspices of DGV/F/3 the idea of a Heart Week was discussed by a number of concerned experts from all the Member States. The group supported the concept of a heart week as a feasible way to increase awareness of CVD, but only if conducted as a part of a more extensive project. Planning of the week was to be continued by a smaller group of invited experts in cardiology and public health.

This paper is the result of the meeting of that expert group, held in Brussels on 8-9 January 1997. The group expanded the proposal for a heart week to the three-phase initiative described in this paper. The initiative covers both the specific focusing event and the more extensive initiative preferred, or even deemed necessary, by experts in the field.

Reasons for Action Now

Heart disease experts strongly support the Commission's position that ultimately public health actions should concentrate on positive messages about healthy living rather than on specific diseases. However, psychologically people seem to mobilise better around an 'enemy' like CVD. Actions for CVD will have spill-over benefits for other programmes, and for general health in Europe, since CVD risk factors are also risk factors for other diseases, especially cancer, respiratory illnesses, diabetes, osteoarthritis and osteoporosis. On the other hand, some factors like cholesterol and hypertension are powerful risk factors specifically for CVD. For these reasons a separate initiative for CVD is advisable. Heart health is crucially important in itself, and can also form a rallying point for broad public health action.

Incidence of CVD

One major barrier to action on CVD is a widespread perception that CVD has been conquered. Because great strides have been made in reducing death from heart disease in several Member States, it is easy to underestimate the extent and severity of CVD. Unfortunately, although progress has been made, CVD remains a serious health threat. In some Member States it is on the rise. It remains widespread and expensive, in terms of lives lost and of resources that must be devoted to survivors. As the population of Europe ages, the expense is bound to increase immensely.

Another barrier to action is the misconception that CVD is simply a phenomenon of normal ageing. Although the chances of an individual suffering or dying from CVD

increase with age, CVD is a specific and serious disease that can be prevented. With preventive actions older people can live longer and be far healthier.

By the year 2020 there will be 23 million more people over 65 in the EU, an increase of 45% over today. The total population is expected to remain stable, therefore the proportion of older people will increase. A healthy older population is an essential goal.

Moreover, CVD is not a disease restricted to the elderly, but is particularly a killer of men between 35 and 64; in 1991 alone, approximately 129,300 men in that age group in the twelve Member States of the EC died of heart disease or stroke, far more than from any other cause save cancer.¹ Although incidence of CVD among women CVD is much lower than for men, 47,500 women in the 35-64 age group died of CVD in 1991; it is on the rise among women in some countries.

Factors Increasing Risks

A great many premature deaths from CVD could be prevented. Gains in combating the disease have varied in the Member States, with higher rates of success in some regions than in others. However, although much CVD is preventable, recent statistics show an increase in the incidence of CVD in some countries, as for example in Greece. As mentioned above, CVD is also a major health problem in the countries of Eastern Europe, with the numbers of CVD sufferers multiplying.

Trends for the future are disquieting. There are indications that European children are not developing the eating patterns, smoke-free lifestyle and the habits of physical activity that will reduce their risks for CVD (and other diseases) in the future. Evidence shows that children are not as active or as physically fit as they should be, or as children of earlier generations were. Of particular concern is the fact that in some countries increasing numbers of teenagers are taking up smoking, and beginning younger.

Lower-income populations are at higher risk for developing CVD. As long as the number of unemployed in the EU remains high, high morbidity and mortality from CVD can be expected in these disadvantaged groups unless effective preventive action is taken.

Costs

The precise extent of the economic burden of CVD cannot be measured, but partial figures can indicate its gravity. Direct costs due to coronary heart disease (CHD) were estimated at 7.4 billion French francs in 1986 alone, with an additional 23 billion FF of indirect costs related to work incapacity and premature death. In the United Kingdom, 918 million UK£ were expended on CHD treatment in 1991. Finland estimates that total costs of CVD in 1992 were 14 billion Finnish marks.

¹ Deaths from cancer in the 35-64 age group were 150,200 men, 100,100 women. Statistics are taken from COM(95) 357 final- Report from the Commission on the State of Health in the European Community.

Beyond the death toll from CVD is the high rate of disability. Overall statistics are not available, but national statistics demonstrate that the number of sufferers is substantial. A survey of sickness and invalidity benefits received through social security in the UK revealed CHD as the leading cause of absence from work. In The Netherlands, 10% of those of working age who depend upon the Dutch disability system suffer from CVD. Figures for 1988 in Belgium indicate that 18% of all invalidity was related to CVD. Figures for Finland indicate that the costs of lost productivity and disability were 1542 million ECUs in 1992 alone.

The Challenge of Intervention Actions

Although treatment for CVD is increasingly successful, prevention of the disease should be the priority.

The difficulties people face in making the lifestyle changes necessary for heart health can and should be confronted with creative and aggressive public health education programmes. Education is only the necessary first step. Habits of eating particularly are rooted in family values and local traditions. Persuading people to change the habits of a lifetime, and then supporting their efforts to change, is the real challenge that we must take up. Intervention actions must be supplemented by policy changes that will make healthy easy to achieve.

Reasons for Confronting CVD at European Level

Actions carried out at European level have a degree of authority which exceeds that of the national level. People tend to pay attention to actions which have the backing of the whole European community.

Although individual action programmes in various countries have made progress in reducing the risks of CVD, exchange of experiences and more communication of their positive results across national borders is needed. Effective campaigns could be replicated in other regions or countries, thus increasing the number of people reached by the campaigns and reducing the resources expended in needless duplication of effort in developing and evaluating strategies for reducing CVD.

Because lifestyle is partly a matter of fashion, lifestyle changes cross borders rapidly. This can be an advantage when a positive change is needed. If smoking becomes unpopular among teenagers in one country, for example, their healthy habits may spread to the next country. Food choices are increasingly influenced by international cuisines; the same factors that currently favour the spread of fast food chains should be harnessed for fresh fruits and vegetables.

For some lifestyle changes it is necessary to counteract pressures from industries, such as the tobacco industry. For other industries there is an opportunity to work together to promote healthy products. Since the industries are international, action must be at an international level as well.

Certain kinds of projects can only be done on a European level. One example is comparative studies of risk factors in different populations, which could increase

knowledge of the factors that lead to heart disease and strokes. Comparing different ethnic groups to determine the relative importance of risk factors might be fruitful, but may not be politically feasible within one Member State, or may be difficult to carry out because of the limited number of members of the ethnic group in any one Member State, but such studies could be carried out on the whole European population through support at European level.

The high unemployment currently besetting the European economies, and acting as an additional risk factor for CVD, can best be confronted on European level as the national economies become ever more interdependent.

The European Heart Health Initiative

The expert panel proposes a three-phase European Heart Health Initiative. The first phase would develop alliances between concerned organisations and analyse needs for CVD preventive action. One or several large-scale events to draw public attention to CVD would constitute the second phase. In the third phase the needs identified in the first phase would be addressed with appropriate actions between and within Member States in the longer term.

First Phase

National heart organisations in the Member States have already begun to develop alliances through initiatives such as the European Heart Network. The first phase would concentrate on creating and expanding such networks at national level as well as across national borders and across disciplines. Ties should also be developed between heart associations and other organisations devoted to combating disease, for example with national health education centres, public health institutes and with cancer and diabetes associations. As communications between existing organisations are further improved, the successful programmes they have undertaken will be identified, and information about them will be disseminated throughout the relevant organisations in the Member States. Sharing information will lead to a wider knowledge of the possible actions that can be taken in CVD prevention.

The networks and alliances formed should draw on the expertise of specialists in different disciplines, including especially health-care providers concerned with CVD, both cardiologists and general practitioners, and public health experts concerned with health promotion, policy making and implementation.

As the specific needs and the possibilities for action are studied, gaps will be recognised and measures developed to close them. Increased understanding of the possibilities for public health campaigns will result, regardless of the further outcome of the initiative.

In this phase ties will also be developed with entities that would have an interest in sponsoring heart health events or campaigns. Among these entities are the medical devices industry, the pharmaceutical industry, the food industry, companies in the sports and recreation field, agricultural concerns, and others to be determined. As

health is more and more valued, health will increase sales arguments for industry, and new business possibilities will emerge.

Second Phase

The first, investigation phase would culminate in several events designed to focus public attention on heart health, the second phase of the initiative. It is envisaged that 14 February 2000 will mark the first of these events. The first Valentine's Day of the new millennium presents rich possibilities for creative campaigns that should not be missed. Valentine's Day is associated with the heart in many countries; this connection can be exploited where it is already strong, and developed where it is not yet a part of public consciousness.

The launching event of phase two should be directed at both experts and the general public. A high-profile conference of public health and medical personnel will share research and programme information, while an extensive multi-media event will be designed to attract the attention of the general public. Messages to be conveyed will emphasise the positive: heart health is a goal that can be achieved through pleasurable changes in lifestyle.

The events of the second phase are expected to include regional and national actions in addition to all-Europe events. Where a 'heart week' already exists, the activities planned should be either in addition to or in co-operation with the established actions, never in competition with them.

A number of activities can be envisaged for the Heart Health events. Competitions for the best national or regional action in each of several varieties of intervention, such as the best non-smoking campaign, or the best action to encourage higher consumption of fruits and vegetables, would both provide a further incentive to the regional and national programmes, and help to publicise effective intervention measures. School education programmes in nutrition, physical activity or healthy living could be featured. National recreation programs could be highlighted to encourage similar actions in other regions or nations.

The Valentine's Day events could be augmented by several further days spread throughout the year. Each day could be devoted to a particular heart health theme. Several possible themes have been suggested. The planners for phase two would need to decide on the strategy to follow for maximum effectiveness, whether to concentrate everything at one time or space things out over several weeks or months.

Third Phase

The third phase of the initiative should address the major issues in the heart health field which are identified during phase one. The alliances of national and regional organisations that are further developed during phase one should identify priorities for actions and target groups, and plan concerted action in the areas deemed to be most important or most likely to benefit from a pan-European approach. The European Union must play an active and supportive role in the European Heart Health Initiative, which includes committing appropriate funding.

Professional leadership and management should be developed for the appropriate, effective management of the concerted European Heart Health Initiative. People from several disciplines should be involved in the alliances that are fostered. Sharing of information across the disciplines will contribute different points of view and increase the knowledge base of the people involved in combating CVD. Cardiologists are trained in treating CVD once it is detected, but may lack knowledge of how to prevent its occurrence. General practitioners are key in the identification of risk factors and in advising their patients on the steps to be taken to lower their personal risk. Public health experts could benefit from increased knowledge about treatment of CVD; detecting and responding to a heart attack in process saves lives. Psychologists and advertising and marketing experts can help tailor convincing messages to target groups of the population.

Key Elements of the European Heart Health Initiative

The European Heart Health Initiative will address five areas:

- education & training
- effective interventions
- policy
- research
- monitoring

In each of these areas action on a pan-European basis will bring added value.

- **Education & Training**

Education and training programmes are directed at health-care and education professionals, at the general public, and at children. These target populations must be addressed in different ways and with different messages.

For health-care professionals, an increased emphasis on the prevention of CVD rather than just its treatment is desirable. Cardiologists and doctors in general have great authority and potential for advising their patients to take preventive action. Some medical schools have introduced short courses; these should be co-ordinated and expanded. All medical schools should be made aware of the need for training in CVD prevention, and courses should be established everywhere that physicians are trained. By sharing information, the medical schools can establish effective courses with no waste of time or financial resources.

General practitioners are crucial both in treating and in preventing CVD. On-going and additional training is desirable in assessing the risks for individual patients. Family doctors must understand how to present health-promoting information to their patients in a positive, persuasive way.

Cardiologists and other hospital specialists see patients with symptomatic coronary heart disease or other major atherosclerotic disease as well as high risk individuals referred from general practice. Training and risk factor management, secondary prevention and rehabilitation do not form a part of many specialist training programmes in cardiology. Such training needs to be encouraged at European level.

Training appropriate medical and public health personnel in intervention is an on-going goal. As part of the European Heart Health Initiative, training for the actions which are planned will be necessary to effectively implement the ideas developed.

Children must be informed about healthy lifestyle choices, including the nature and the importance of good eating habits, and the advisability of regular daily physical activity. Young people need to be helped to form the habits of healthy nutrition and physical exercise that will lower their long-term risk factors for CVD and other serious diseases. A range of programmes promoting a healthy lifestyle in schools already exists, but improved co-ordination and communication across national boundaries would increase their effectiveness.

The European Network of Health Promoting Schools Network (ENHPSN), a project supported by the European Commission, The Council of Europe, and the Regional Office for Europe of WHO, comprises an important step in health promotion for children. Co-ordination of the ENHPSN with the European Heart Health Initiative is necessary.

School meals and children's diet constitute an important issue in many countries. One example of a special project for schools is provided by the National Heart Forum of the UK. This alliance of thirty-five organisations has developed activities which help

children become informed food consumers, able to choose their food wisely, but also to understand food labelling and the techniques used in advertising food.²

The expert panel endorses investigation of the possibilities of including public health and especially heart health promotion in the mission of the PHARE and TACIS programmes.

- **Effective Interventions**

Intervention actions include efforts to convert people to a healthier lifestyle. There are effective CVD prevention programmes in place already. A transfer of knowledge and experience within Europe will lead to the expansion and extension of these programmes.

Intervention programmes would be aimed at promoting lifestyle changes in people to help them remain healthy, but should include CVD patients as well. For those who have already developed CVD, there is a wealth of scientific evidence that lifestyle intervention, together with medical treatment, can reduce further morbidity, and extend the life of the patient. The application of this knowledge in many parts of Europe is inadequate; co-operation between professional societies such as the European Society of Cardiology, European Atherosclerosis Society and the European Society of Hypertension could result in more effective preventive care of patients with CVD, leading to improved life expectancy and quality of life.

Some actions can be most effective if carried out simultaneously in several regions or countries. One example is the International Quit & Win action, which took place in twenty-five countries. Most of the countries involved found that the international dimension of the action enhanced its effectiveness.

Intervention actions would gain credibility from being accomplished at European level, for several reasons. Lifestyle changes, like fashions, pass quickly from one country to another. The industries are international, therefore emphasising health arguments in business and trade must be international as well. Some things are currently done better in one area than in another; sharing information from successful intervention programmes should enable their replication in other regions or countries.

Ties with organisations concerned with other diseases will lead to fruitful co-operation, but specific actions on CVD are necessary as well. To prevent CVD, most major changes are the same as for cancer prevention: quit smoking, lose weight, follow a diet high in vegetables and fruits and low in fats, increase physical activity and manage stress effectively. However, cancer experts emphasise the reduction of fat in general, while for CVD it is particularly important to stress the quality of fats in the diet. Cholesterol and hypertension are factors only for CVD. As research on CVD on women and particularly on the effectiveness of hormone-replacement therapy becomes available, it may be included in the list of recommendations as well.

Regular screening programmes for high blood pressure and cholesterol levels form a part of many community health programmes. Screening, accompanied by appropriate

² Reported in the *National Heart Forum Annual report 1995/96*.

counselling, plays an important role in preventing CVD, and should be encouraged throughout the EU.

Co-operative actions conducted jointly by organisations campaigning for various diseases can lead to public awareness gains. It is generally recognised among the general public that smoking is an important risk factor for cancer, for example, but less well-known that smokers are more likely to suffer from CVD than from cancer. Anti-smoking campaigns should mention smoking as a risk factor in heart disease and not just in cancer. If the aim is to convince smokers to become non-smokers, the knowledge that the risk to their health does not stop with cancer should be a more effective incentive to action.

Examples of co-operation among various organisations are provided by Swedish experience. One combined action of the Swedish Heart Lung Foundation and the cancer people targeted midwives to encourage the pregnant women in their care to give up smoking, and in a second phase, to create smoke-free homes for their babies ('Smoke-free Pregnancy' and 'Smoke-free Parents'). In another case the Heart Lung Foundation co-operated with the Diabetes Association in a joint programme to teach and promote light cooking; they are marketing a popular cookbook, 'A Million Light Menus'.

• Policy

The goal of the European Heart Health Initiative in the policy sphere would be to help ensure that EU and Member States' policies contribute to, or at least do not run counter to, CVD prevention. Among the areas that the experts feel are in need of additional attention are food labelling and claims and food choices, agricultural policy, tobacco policy, support for recreational facilities, and promotion of physical activity in schools and communities.

The policies in the Member States should be compared in light of these concerns. Research should be initiated to monitor the results of policies aimed at reducing CVD risk factors. Best practice should be shared across Europe.

The experts agreed that long-term reform of the Common Agricultural Policy (CAP) to bring it into line with health considerations should be a priority. Recommendations of heart health experts touch on areas such as availability and promotion of healthy food, including fresh fruits and vegetables, olive oil and other vegetable oils produced in the EU, and re-thinking the priorities when allocating tobacco subsidies.

Finally, but not least in importance, the socio-economic inequalities that lead to increase risk of CVD and early death for the poor should be confronted. Unemployment is a matter for great concern.

• Research

Biomedical research has been responsible for many gains against CVD. Although the existing programme on biomedical research (BIOMED II) includes research on CVD and public health research, there is a need not only for more medical research, but also

for further research into addressing the behavioural components that will reduce its incidence.

There is a degree of consensus in the medical community as to the risk factors for CVD. Many people have altered their lifestyles in order to reduce the risks of disease, but more should be known about how others can be convinced and helped. How can people be influenced to eat more fresh fruit and vegetables, and to reduce saturated fat in their diet, instead obtaining unsaturated fat from vegetables and fish? How can they be persuaded to be more active physically? How can smokers be convinced to quit, and once convinced how can they be helped to do so? How can young people be induced not to begin smoking? Which target groups should messages be addressed to for maximum effectiveness? These questions require both additional action and an exchange of experience about successful projects.

The expert panel suggests that CVD research should be extended to involve the Eastern European countries, where morbidity and mortality from CVD are massively on the rise. With these countries preparing to enter the EU, the European Heart Health Initiative will have to address their needs as well. More must be known about the factors which are currently dramatically lowering life expectancy in these regions, mainly through an increase in CVD and other related conditions, and action must be taken to reverse the current trend. Behavioural and public health experts will require more information about how attitudes in the Central and Eastern European countries resemble or differ from those in the West so that messages can be adapted to the needs of those populations.

It is known that lower socio-economic groups are more at risk for CVD. Part of the difference can be accounted for by differences in factors such as smoking, nutrition and levels of physical activity, but not all. Poverty itself seems to be a risk factor in CVD. More research should be done on how to reduce risks, and on how to encourage and enable healthy habits in the poorer part of the European population.

Research on the incidence of CVD and the risk factors in the population would also be vastly enriched by more pan-European co-operation. An extensive German study on CVD prevention which began in 1984 has yielded a valuable body of statistics on cholesterol levels, smoking behaviour, body-mass index, and blood pressure in a large sample of Germans; starting in 1991 the sample includes men and women from the former German Democratic Republic, so comparisons between the two regions will be possible.³ The on-going results of this study should be available to practitioners in other countries, and perhaps be replicated in other countries.

Competition between various research bodies for scarce resources should be replaced by co-operation. Co-ordination between units in the European countries involved in research on CVD and on the promotion of heart health could lead to a more efficient use of resources by reducing duplication of effort. Such co-operation should include all concerned bodies. For example, the agricultural and food industry could be involved for its input and for allocation of research funds.

³ A preliminary report on this study appears in the German government's annual statistical report *Daten des Gesundheitswesens*, Ausgabe 1995, Band 51, Schriftenreihe des Bundesministeriums für Gesundheit, pp. 80-93.

- **Monitoring**

The health monitoring programme currently in the conciliation phase⁴ exemplifies the kind of European level initiative which will promote health in the EU, and as such is applauded by the CVD expert panel. However, since this is a general programme with a limited budget, it remains a priority to include monitoring in the European Heart Health Initiative. Monitoring should include the major CVD risk indicators.

The monitoring of morbidity and mortality from CVD is not carried out consistently from one Member State to another. When consistent monitoring is established the resulting comparable statistics will aid researchers in CVD. The International Classification of Diseases (ICD) Codes of the World Health Organization (WHO) are used in all Member States, but they are implemented and interpreted differently. In particular attention should be paid to instances where CVD is only one factor causing death, and possible cases where CVD is assumed as the cause of death, without corroborating evidence.

Morbidity statistics are currently hard to come by, although available numbers suggest that morbidity is approximately twice the death rate. The Eurodata Conference organised by the European Heart Network in 1994⁵ made several recommendations for improving comparability of statistics. The conference report suggests factors which lead to a lack of accuracy in data, such as hospitals not correlating multiple discharges from hospital for individual patients, or not applying standard criteria for diagnosis of CVD. Among other recommendations, the report calls for an investigation of the current situation in each Member State with regard to 'the quality, accuracy and availability of CVD morbidity data', and suggests that standards be developed for diagnosing and tracking CVD to determine the numbers involved more precisely.

Monitoring for risk factors is an essential and powerful tool in heart health promotion. Accurate, standardised statistics on risk factors would enable more accurate predictions of the future burden of CVD on health-care systems. They would also supply information about populations to be targeted in interventions, and be of great importance in assessing and monitoring changes in the risk factors and behaviours that are targeted. The experts at the Eurodata conference recommended monitoring certain core risk factors such as cholesterol levels, blood pressure, body mass index, and lifestyle factors including smoking, diet, alcohol consumption and physical activity levels; these factors should be measured in a consistent way through national random samples, with cross-sectional surveys repeated at appropriate intervals.

Conclusion

The European Heart Health Initiative aims at approaching the problem of CVD from a positive standpoint. CVD is the number one cause of death in Europe. Much of the

⁴ Proposal for a Programme of Community Action on Health Monitoring.

⁵ Measuring the burden of Cardiovascular Disease in Europe: Steps towards establishing comparable data. Report of the European Heart Network's Eurodata Conference: A Meeting of European Experts on the Collection of Statistics on Cardiovascular Mortality, Morbidity and Risk Factors, May 6-8, 1994, Bilthoven, The Netherlands.

early death, disability and suffering that results from CVD can be prevented. The steps necessary to prevent CVD would also lower risks for other serious diseases, and would improve health and quality of life among the population.

The initiative envisioned includes a phase of alliance forming and fostering to bring together the organisations currently engaged in heart health promotion, to compare experiences, plan concerted actions and fund on-going campaigns. A major multi-media event for the year 2000, taking advantage of the first Valentine's Day (14 February) of the new millennium, is intended to focus public attention on heart health. An extensive third phase would further education & training, effective interventions, policy, research, and monitoring in CVD, with the overall aim of promoting health and supporting the prevention of CVD.

Dramatic reductions in the incidence of cardiovascular disease in Europe can be achieved. Confronting CVD with a European-level initiative for heart health will result in reduced direct and indirect costs, but more importantly in a healthier European population.

A healthier Europe is the ultimate aim of the proposed European Heart Health Initiative.