EDITORIAL

The Canadian Heart Health Strategy and Action Plan

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The Canadian Heart Health Strategy and Action Plan (CHHS-AP) was released to the public in late February 2009, with input from The Honourable Leona Aglukkaq, Minister of Health, and Dr David Butler-Jones, Canada's Chief Public Health Officer. This was the culmination of two-and-a-half years of work by a dedicated group with expertise in all aspects of cardiovascular (CV) health – from public policy needed to create healthy environments through prevention, acute and chronic care, to rehabilitation and end-of-life planning. The development of the Strategy included a consideration of the information needs, research requirements and particularly, the needs of our Aboriginal and Indigenous peoples. The comprehensive plan (the what) and the Action Plan (the how) can be accessed at <www.chhs-scsc.ca>. However, the work is not finished because funding for implementation has not yet been secured.

WHY A HEART HEALTH STRATEGY?

CV diseases are a major health burden for Canadians – almost one-third of Canadians die from heart attack and stroke, and approximately 16% of hospitalizations are due to CV diseases. This disease burden, in turn, results in a major economic burden, with more than $22 billion in direct and indirect costs attributed to CV diseases based on 2000 costing. Despite these statistics, there is reason for some optimism because there has been an impressive decrease in the mortality rate for both heart attack and stroke in recent decades and, recently, an actual decrease in the number of Canadians dying from CV diseases each year. Unfortunately, the future does not look so bright – the prevalence of some of the risk factors for CV diseases is increasing at an alarming rate. There is a marked increase in obesity, particularly among the young, and this can be anticipated to result in more diabetes, hypertension and lipid abnormalities – in turn, this will lead to more heart attacks and strokes. Therefore, although current data appear to be encouraging, the future looks much more bleak.

Canada is not alone in contemplating such a future. Indeed, the World Health Organization has called on all member states to develop national strategies to deal with the common chronic diseases, which currently account for 60% of mortality worldwide, a number that is expected to increase to 73% by 2020 (1,2). In 2005, Steven Fletcher, the Member of Parliament for Charleswood-St James-Assiniboia in Manitoba, introduced a private member's bill into the House of Commons that called on Canada to develop national strategies for three common chronic diseases – cancer, mental health and heart disease. The bill received all-party support. The Cancer Strategy had been in development for a number of years but, perhaps because of this emphasis, was funded in 2006 and is now being implemented. More recently, the Mental Health Commission was established and is working to develop a Strategy within the next five years. A Diabetes Strategy was developed in the late 1990's and has just been reviewed and funded for continued implementation. Recently, a Lung Framework was developed and the federal government has just provided some funding for it. Finally, the Heart and Stroke Foundation of Canada collaborated with the Canadian Stroke Network to develop and implement a Stroke Strategy. Although this strategy has received support from the provinces, it has not yet received federal support. Clearly, Canada now needs a Strategy to address the impending epidemic of CV diseases and the huge health and economic burdens associated with them.

THE PROCESS

The then-Minister of Health, The Honourable Tony Clement, announced funding for the development of the CHHS-AP in October 2006. A 29-member Steering Committee, comprised of a multidisciplinary group of Canadian and (one) American experts, oversaw the development of the plan. The Steering Committee developed six Theme Working Groups, each with approximately 12 members, to develop the expert content in the perceived major areas for focus. Through a series of retreats and conference calls, each Theme Working Group developed a comprehensive description of the current situation and made a series of recommendations to the Steering Committee as to what should occur to reduce the identified gaps. These Theme Working Group reports are rich with information and expert insights, and are available at <www.chhs-scsc.ca>. Overall, approximately 100 people were involved in the development of the Strategy. This included some members of the public as well as individuals working with provincial and territorial governments and agencies. Moreover, a much larger group of stakeholders (more than 1500) was consulted, which included representatives of industry (pharmaceutical, medical devices, food and financial), national organizations of health professionals (medical, pharmacy, nursing, physiotherapy, chiropractic, nutritionists, etc) and the public (seven focus groups were held in both French and English across Canada). Finally and very importantly, the national Aboriginal and Indigenous organizations were consulted early and were involved throughout the process.

THE STRATEGY AND ACTION PLAN

Although called the Heart Health Strategy, the approach taken was much more inclusive and involved all vascular disease – cerebrovascular, CV and peripheral – as well as other forms of heart disease such as congenital, cardiomyopathic diseases and arrhythmias. From the outset, it was recognized that perhaps the major potential for significant impact was through prevention across the continuum of the health system. This approach is particularly germane to atherosclerosis, which is the cause of approximately 70% to 80% of the burden of heart disease, a large portion of stroke and the majority of peripheral vascular disease. There is accumulating evidence (3) that much of the consequence of this disease can be prevented if addressed early (focus upstream) on a population basis as well as diligently throughout the care system. The Steering Committee members were also determined to make the recommendations practical, implementable and integrated, while respecting the Canada Health Act and jurisdictional responsibility. The Steering Committee also recognized that to effectively deal with the chronic disease burden, as exemplified by CV disease, would require an all-of-government and all-of-society approach. That is, this is not just an issue for the health care system.

The Strategy makes six major recommendations:

1. Create heart healthy environments. This stresses the importance of policy development to improve food quality (particularly reducing trans fats, salt and high fat content) and help Canadians deal with the emerging epidemic of overweight and obesity. This recommendation also addresses ways to improve opportunities to be more physically active and for fewer Canadians to smoke.

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2. Help Canadians lead healthier lives. This recommendation acknowledges that Canadians are capable of doing much more to improve personal health status but recognizes that citizens do not receive the support required – including access to reliable Canadian sources of information – to make this possible. The common chronic disease organizations need to work more collaboratively to develop common messages concerning risk factors and develop more convenient, community-based screening and education opportunities.
3. The third recommendation deals with the urgent crisis existing in our Aboriginal and Indigenous populations. These communities should have access to the same quality of health services as the rest of Canada – something that is far from the current reality. To achieve this, the Strategy recommends the development of a specific Action Plan involving all of the important stakeholders, as well as the creation of a national Aboriginal Centre(s) for chronic disease prevention and management to implement the plan.
4. Continue the reform of health services. The Strategy acknowledges that most CV care can and should be provided by primary care teams based in the community, using the Chronic Disease Prevention and Management Model popularized by Wagner et al (4). Specialized cardiac care (consultation, diagnostic testing and therapeutic interventions) should be organized as networks with effective triage systems and should use system navigators to help patients and their information move quickly and effectively among the various levels of care. The recommendation also addresses other inefficiencies in the current care delivery system and calls for regularly updated clinical practice guidelines and the development of a national set of quality indicators to be regularly monitored and reported to Canadians.
5. Build the knowledge infrastructure. Unlike cancer, CV disease lacks proper surveillance systems. This must be improved because it is clear that good information is needed to make good decisions. Faster implementation of both electronic health and medical records is also advocated. Finally, there are recommendations for more research in several important areas. This includes more support for genomic and proteomic research, and the establishment of a network of centres of excellence in vascular health.
6. Develop the right service providers. This recommendation calls for a comprehensive health human resource plan and the development of incentives to faculties of health sciences to provide more attention to health promotion and disease prevention in the curricula and to provide more emphasis on preparing graduates to work in interprofessional teams.

The Steering Committee identified a set of targets that they believe can be attained if the above recommendations are instituted. These include:

By 2020:

- Decrease annual deaths from heart attack and stroke by 25%;
- Bring CV disease burden among Aboriginal and Indigenous populations in line with other Canadians;
- Decrease high blood pressure by 32%;
- Decrease hospitalizations for stroke by 25%; and
- Decrease the smoking rate by 25%.

By 2015 (working with others):

- 20% more Canadians eating healthy diets;
- 20% more Canadians being active; and
- 20% fewer adults and children with obesity.

Based on experiences in other countries and jurisdictions, it is believed that, although aggressive, these targets are realistic. Moreover, there is increasing evidence that investing in prevention more broadly can provide impressive economic returns. The Conference Board of Canada will soon release their assessment of the effects of achieving only five of the CHHS-AP targets – reducing high blood pressure prevalence, reducing the smoking rate, and more Canadians eating healthier and being physically active, with reduced prevalence of obesity. This conservative analysis reveals that achieving these targets could reduce the number of Canadians with myocardial infarction or stroke by approximately 600,000 in 2020, with cumulative cost savings of more than $75 billion. These estimates for cost savings are in general agreement with those developed in other countries (5).

THE CHALLENGE

Timing is a critical factor in the success of any policy development. The Steering Committee planned for completion of the CHHS-AP in time for release in October 2008 and, therefore, an opportunity for consideration in the 2009 federal government budget. However, a federal election call in the autumn of 2008 resulted in a delay in its release and by then, the worldwide economic crisis had focused federal government spending on infrastructure projects, with commitment to at least several years of deficit spending. This is a much different situation from just one year ago. The reality is, therefore, that it will be challenging to secure the funding necessary to implement the Strategy. However, the fact remains that the CHHS-AP is the result of an enormous effort by individuals motivated to improve the health and well-being of Canadians. It has already received many accolades (both nationally and internationally) for the comprehensive approach taken. This is seen as a model for all chronic diseases, and some jurisdictions are already implementing certain proposals. Indeed, the CHHS-AP is really a roadmap to guide Canada to improved health; when implemented, Canada will not only be healthier, but also more productive and therefore, more competitive. The economic analysis performed by the Conference Board of Canada documents that the return on such an investment could be substantial.

The challenge now is to inform decision-makers of the enormous opportunity for Canada to provide international leadership in this important area while taking aim at improving the longer-term health of Canadians. This is important to all Canadians.

NOTE: Dr Smith served as Chair of the Steering Committee for CHHS-AP.

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