Cardiovascular disease causing increasing inequity between rich and poor

December 2 2008

A new paper released today by The George Institute for International Health is warning a cardiovascular disease based epidemic is gaining pace among many low- and middle-income countries (LMIC), exemplified at its worst in the world's largest populated countries – China and India. Preventive cardiovascular treatments that are widely available in high income countries are not yet widely accessed in LMIC, contributing to an escalating inequality in health status between rich and poor. Cardiovascular disease was the leading cause of death globally in 2005 with more than 80% of these deaths occurring in LMIC. In China, stroke, chronic obstructive airways diseases, cancer and heart disease are the four highest contributors to the country's total disease burden almost half of these are due to cardiovascular disease.

The paper reveals that cardiovascular disease risk factors such as obesity, high blood pressure, tobacco smoking and diabetes, are on the increase in LMIC. China's obesity rate, for example, has increased fourfold over the past two decades. In addition to the disease burden, there is a large economic burden from loss of family income and loss of long term productive working years because people of working age in LMIC are most disease-prone. India, as an example, has twice the mortality rate from cardiovascular-related deaths among people of working age between 39 and 59 years, compared to the USA.

Author of the report, published in the *Journal of the American College of Cardiology*, Dr Rohina Joshi at The George Institute, said, "Even with China's booming economy, the costs associated with the cardiovascular

disease burden are unsustainable. China's poor now has less access to healthcare due to higher costs and lower levels of both insurance cover and public funding. Most patients in low- and middle-income countries have a choice between foregoing expensive treatment and taking financial ruin. There is no health system in place to deliver the affordable drugs that can treat and prevent the disease burden for those in need."

Little change has occurred since the 1978 Alma-Ata declaration defining primary healthcare needs for LMIC and particularly deprived populations to ensure delivery of preventive interventions and early treatment of overt illnesses. Most LMIC have not invested in the declaration's recommended healthcare system and remains reliant on mostly hospital-based care and treatment. The primary healthcare facilities which were designed for infectious disease control and childbirth have not evolved with the changing pattern of disease burden in these countries and they do not have the facilities to prevent and manage non-communicable disease such as cardiovascular disease.

The healthcare workers are based in the hospitals where they both prescribe and dispense treatments -their main source of income. "Treatment choices become more about the price of the treatment and the amount of income to be paid to the health worker rather than the effectiveness of the treatment for the patient's illness. Over time, this has corroded people's confidence in the system. Although China's health reform is working on Urban Community Health Services and a new Rural Cooperative Medical System, an ideal system that delivers safe, effective and a low cost focus on prevention and treatments, in both urban and rural, remains far from being seen. There is so much to change before this can occur and there can be delivery of reliable, cost effective primary cardiovascular healthcare in China", said Prof Yangfeng Wu, Director of The George Institute, China and co-author of the paper.

Reductions in the world's cardiovascular disease burden and a more equitable health status between rich and poor will come only through the establishment of primary healthcare systems in LMIC that reliably deliver available, cost-effective therapy to those most in need. "China and many other LMIC require immediate national policy and institutional changes to have the long term care provided for the control of cardiovascular disease. Researchers at The George Institute for International Health are well aware of the enormous difficulty in tackling the issue because they felt their previous efforts to call for this change have not been heard by the key players who determine priorities for international health investment." said Dr Joshi.

Source: Research Australia