Medical Xpress

Your pay, postcode and parents affect your heart disease risk

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Credit: AI-generated image (disclaimer)

Most of us know our risk of heart disease increases as we age, and it's more common in men. But are you aware the risk of heart disease, and of death from heart disease, is greater if you're Indigenous or of low socioeconomic status? And do you know it's also a leading cause of illness and death among women?

Most people are not aware your risk of heart disease is greatly affected by who you are. But this does not have to be the case. And there are things we can do about it.

First, what do we mean by 'heart disease?'

Heart and vascular disease encompasses a range of conditions that can cause angina (chest pain), heart attack and stroke (bleeding or blockages in the brain).

Commonly, this group of conditions is referred to under the broader term of "heart disease." It's frequently used interchangeably with the term "cardiovascular disease."

Cardiovascular disease remains the leading cause of death worldwide.

How many people does it affect?

The Australian Bureau of Statistics estimates 1.2 million Australians aged 18 and over (6.2% of the adult population) had one or more conditions related to heart, stroke or vascular disease in 2017–18.

Heart disease was the main cause of more than half a million hospitalizations in 2019–20, or 5% of all hospitalizations.

And, in 2020, a fifth of all deaths in Australia were attributable to heart disease (33,052 deaths), of which 50% were due to ischemic heart disease, the most common type of heart disease in which major blood vessels of the heart are damaged.

Almost a quarter (24%) of deaths from heart disease were premature (the person died before they reached 75 years of age); for ischemic heart

disease the proportion was 27%.

Does it affect some more than others?

Heart disease impacts everyone differently and is related—among other characteristics—to our age, sex, socioeconomic status and Indigenous status.

The prevalence of heart disease increases rapidly with age, affecting 11.3% of adults aged 65 years and over, and is substantially higher, at 17.5%, in those aged 85 years and over. While more men than women have heart attacks, strokes and vascular disease, the risk in women is largely under-recognized.

Although the prevalence of heart, stroke and vascular disease between adults living in the most and least disadvantaged socioeconomic areas is not significantly different, the premature death rate from heart disease in the most disadvantaged areas is a statistically significant 2.4 times that in the least disadvantaged areas.

The rate of heart, stroke and vascular disease among Aboriginal adults is more than twice that of non-Indigenous adults.

Of greater concern is that the rate of premature death (in this case deaths before 65 years of age) from heart disease in the Indigenous population is four and a half times that in the non-Indigenous population.

And the premature death rate from heart disease in very remote areas is 2.4 times that of the major cities areas. For ischemic heart disease, the gap is wider, at 3.2 times.

While this is partly due to the fact these areas have a higher proportion of Aboriginal people—who are at higher risk—distance itself also adds

to the lack of access to timely and appropriate care.

What affects heart disease risk?

Aside from age and sex, there are many risk factors for heart disease, several of which are modifiable. These include tobacco smoking, insufficient physical activity, poor diet and nutrition, obesity and high blood pressure.

These risk factors are also more prevalent among more disadvantaged populations, for whom the data consistently show higher rates of hospitalization and death, including premature death, from heart disease.

Access, in particular related to distance from hospitals, adds another dimension to the outcome for those with heart disease, in particular for Aboriginal and Torres Strait Islander people living remotely.

What can we do about it?

Better and more focused primary health care is the way forward. But if the investment is only in emergency centers and GPs charging a fee for service, it will not make a difference to preventable illness and death—at least not for those with the poorest outcomes. Funding for community-controlled primary health care services and centers, with multidisciplinary staff including GPs, would be an immediate help. Such a big-picture idea should not be too great a challenge for a reinvigorated federal government.

Heart health education campaigns exist. However, it's usually those with access to health care, resources and time who change their behavior following such campaigns. Those who live "hand-to-mouth" are less able to worry about things not in their immediate present.

That's why addressing systemic and social determinants of health, with a considered primary health care approach, are of the utmost importance. Those with fewer resources need access to secure housing, transport, quality early learning and schooling, secure jobs and a welfare net above the poverty level.

Not only would these address their socioeconomic disadvantage, but also chronic stress, which is a major influence on heart health.

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