January 2022

British Heart Foundation briefing

Westminster Hall debate: Office for Health Improvement and Disparities and health inequalities

Key points

- The British Heart Foundation (BHF) welcomes the opportunity for refocus and innovation brought about by the establishment of the Office or Health Improvement and Disparities (OHID) at this critical time for public health, and we have been supporting Professor Sir Chris Whitty and his team in identifying key priorities as they seek to set the new Office's direction.
- Cardiovascular disease (CVD) is strongly associated with health inequalities, with 4 in 5 cases being attributable to modifiable risk factors like diet and smoking status, and medically manageable risk factors like high blood pressure. CVD must therefore be a key focus for OHID.
- The pandemic has exacerbated inequalities in CVD, and IPPR found that 470,000 fewer new prescriptions of preventative cardiovascular drugs were issued between March and October 2020 compared to the previous year. They forecast that this could lead to an additional 12,000 heart attacks and strokes in England in the next five years.
- OHID is well positioned to play a crucial role in confronting inequalities and levelling up across the country. For OHID to fulfil its potential, clarity is first needed on how it will operate in practice, and how it will interact with the Levelling Up White Paper.

The BHF and health inequalities

Cardiovascular diseases cause a quarter of all deaths in the UK and are the largest cause of premature mortality in deprived areas. There are 7.6 million people living with heart and circulatory diseases in the UK today. Many millions more have risk factors for these conditions such as high blood pressure, raised cholesterol, obesity, and type 2 diabetes.

CVD is strongly associated with health inequalities, and cardiovascular health is deeply connected to wider determinants of health, including factors such as income, housing, education, and the environment. In the UK, 4 in 5 cases of heart and circulatory disease can be attributed to modifiable risk factors, such as diet and smoking status, and medically manageable risk factors like high blood pressure.

These factors are often influenced by access to health and care services and the social, physical, and economic environments in which people live that impact on our choices, behaviours, and exposure to risk. For example, food advertising and promotion has been shown to influence children's food preferences, as well as how much they eat, which has a bearing on their dietary health; while more ambient air pollution is typically found in more socioeconomically disadvantaged areas.

Many heart and circulatory diseases can be therefore prevented through systemic action that addresses inequities in the wider determinants of health, including:

- Population level health measures, such as initiatives designed to address smoking, obesity, diet, and air pollution.
- Social, environmental, and economic changes that support equity, for example in relation to education, employment, and housing.

Over the past twenty years, mortality rates attributable to CVD have declined significantly. However, these declines have not been realised equitably across all population groups, and CVD remains a leading cause of mortality and morbidity in the UK. Inequalities in CVD manifest in many ways:

- People living in England's most deprived areas are more than three times more likely to die prematurely of CVD than those in the least deprived area. Between 2016-18 the average

premature (under 75 years) death rate for Blackpool (124.6 per 100,000) was more than three times higher than that for Hart, Hampshire (39.1 per 100,000). In the same period, the average life expectancy in Blackpool was 77, while it was 84 in Hart.

- Research has shown that people with South Asian ethnic background may be more likely to develop coronary heart disease than White Europeans, and some risk factors for coronary heart disease are also more prevalent in younger South Asians. People with Black African or African Caribbean ethnic backgrounds may be at higher risk of developing high blood pressure (hypertension) and having a stroke.

- Coronary heart disease kills twice as many women as breast cancer in the UK, but there is a widespread misconception that it is a man's disease. Research suggests that women are 50% more likely than men to receive the wrong initial diagnosis for a heart attack. Women may also be less likely to recognise they are having a heart attack, leading them to delay seeking help.

- The prevalence of heart failure, stroke, and mini stroke in adults with learning disabilities in England is higher than the general population, and circulatory diseases are one of the main causes of death in people with learning disabilities. For the most part, this can be attributed to differences in the social determinants of health.

Covid-19 and CVD

The coronavirus pandemic has amplified pre-existing inequalities in heart and circulatory diseases, particularly in relation to socioeconomic deprivation and ethnicity. Many existing health conditions, including risk factors for heart and circulatory diseases such as high blood pressure, obesity and type 2 diabetes, predispose people to experience severe complications from Covid-19.

The early detection and management of cardiovascular risk factors is vital for preventing the onset of disease and can help people live longer, healthier lives. But the pandemic has significantly impacted the delivery of heart services, including "routine" health checks, which continues to drive the health gap.

Analysis by IPPR found that 470,000 fewer new prescriptions of preventative cardiovascular drugs (including anti-hypertensives and statins) were issued between March and October 2020 compared to the previous year. This means that thousands of people could be living with undiagnosed hypertension, or other CVD risk factors. If these 'missing' patients are not found, diagnosed, and commenced on treatment, the IPPR forecast that an additional 12,000 heart attacks and strokes will occur in England in the next five years.

The role for Office for Health Improvement and Disparities

OHID will be key to the Government's levelling up agenda and to addressing inequalities in the prevalence of heart and circulatory diseases and their risk factors, including obesity, tobacco and high blood pressure. We welcomed the establishment of OHID, at a critical time for the prevention of CVD and have been supporting Professor Sir Chris Whitty and his team in identifying key priorities as they seek to set their direction. However, there is still a lack of clarity on how OHID will bring together policy teams in the department and the technical expertise and advice from PHE.

It is also promising that the cross-government committee on prevention and health improvement that aims to track the wider determinants of health and reduce disparities is being chaired by the Health Secretary. While this clearly indicates that health is being prioritised across Government, there has been little information shared by the Department on how organisations like the BHF can feed into and engage with this committee. There has also been little confirmation on how this will interact with, or is different to, the Levelling Up White Paper, expected in February. Clarity and transparency on these points is critical if OHID is to truly tackle the root causes of health inequalities.

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