INSTITUT CHOISEUL

AT THE HEART OF HEALTHY AGEING

Raising awareness, detecting, and prioritising in the face of cardiovascular emergencies

EXCUTIVE SUMMARY

Abstract

A draft version of this Note was presented at the Convention on Health Analysis and Management - CHAM 2022 during a round table discussion on the cardiovascular prevention strategy, its implementation and financing, with the following speakers: Dr François Sarkozy, President of the FSNB Health & Care; Dr Philippe Besset, Pharmacist and President of the FSPF; Pr Ariel Cohen, Cardiologist and former President of the SFC; Ms Valérie Devillechabrolle, Director of Social Protection at Klesia; Dr Corinne Duguay-Assouline, Director of Edwards France; Paul Gadel, Director of Operations and of Studies at the Institut Choiseul; Dr Jean-Yves Grall, Director General of ARS AuRA; Lionel Pfann, Secretary General of 'Alliance pour le Cœur'; Andrea Rappagliosi, Senior VP, Public Affairs of Edwards EMEACLA; Stéphane Roze, Health Economist, President of Vyoo; Mr Jean-François Thébaut, President of Xperis and Vice-President of the French Federation of Diabetics.

This Note has benefited from the institutional support of Edwards Lifesciences within the framework of the *Choiseul Club Santé*, a programme of the Institut Choiseul dedicated to health policy and key players.

This Note is a collective effort; special thanks to Clément Girardot for his contribution.

Executive Summary

The structural ageing of the population is one of this century's major challenges for the European Union and for France. By 2050, 30% of the European population, 150 million people, will be over 65. According to the National Institute of Statistics and Economic Studies' (INSEE) projections, the over-65s could represent 23.4% of the French population by 2030, compared with 20.5% today. In 2060, 23.6 million people could be aged 60 or over, an increase of around 80% in 53 years.

France could reach 76.4 million inhabitants in 2070 and "*almost all of the population increase by 2070 would concern people aged 65 or over, with a particularly strong increase for people aged 75 or over.*"

France ranks first among European countries in terms of life expectancy: in 2021, French women aged 65 have 23.7 years left to live while French men aged 65 have 19.6 years. On average, the French live longer than most Europeans, but are in poorer health than most of them.

An ageing population will result in more people living longer. An increasing amount of French people will live longer, but without the guarantee of healthy and independent ageing, as this demographic dynamic is expected to be accompanied by an increase in the prevalence of age-related chronic diseases, such as neurodegenerative or certain heart diseases.

In this perspective, the question of "ageing well" is a crucial issue for our society. An important part of "living together" will thus reside in "ageing well together". Anticipation and adaptation are key: delaying the slide towards a loss of autonomy and dependence (INSEE predicts that 4 million senior individuals will lose their autonomy by 2050); containing the increase in "dependence ratios",i.e. the ratio between the over-65s and people of working age, even though the retirement age is likely to soon be increased. The main lever for action is to prevent the onset and aggravation of certain age-related diseases.

A major effort has already "*been made to prevent*" neurodegenerative diseases and cancer. These diseases are relatively well known to medical and institutional professionals and well known to the public, thanks to awareness campaigns, as well as the visible and often devastating impact on patients and their families. Cardiovascular diseases, on the other hand, remain more discreet and much less well known to the French; they have never risen to the rank of "diseases of the century".

Yet cardiovascular diseases are the leading cause of death globally, the second leading cause of death in France and the leading cause of death among French women. These diseases refer to a multitude of pathologies affecting the heart (heart muscle, valves, pericardium, etc.) and/or the blood vessels supplying the heart, the brain or the network of blood vessels (arteries) throughout the body. Whilst it is possible to live with cardiovascular disease, it severely impairs quality of life, accelerating the onset of loss of independence, thus resulting in increased dependency on caregivers.

These diseases result from two main types of risk factors. The so-called "avoidable factors" are diet, alcohol, smoking and lack of physical activity: these call for a change in lifestyle, which has become the basis of prevention policies. The unavoidable risk factors relate to the intrinsic characteristics of individuals: gender, family history and, generally old age. Ageing is indeed an important but often unrecognised factor in the development of heart diseases. This is particularly the case for so-called "structural heart diseases", caused by abnormalities in the heart's structure, such as the valvular heart disease. There is a strong correlation between increased mortality rates due to structural heart disease and age, which some point to as the next 'heart epidemic' to come.

Cardiovascular diseases reveal inequalities between the French. Imposing a "double sentence", they affect the most disadvantaged more, who also have harder and delayed access to screening and care. Cardiovascular diseases are a major factor in social inequality, with a 7-year gap in life expectancy between socio-professional categories.

Age can be a major factor in discrimination, from the poor recognition of symptoms that are sometimes inadequately identified and wrongly considered as "natural" consequences of age, to a lower quality and level of therapeutic care. Isolation at home further increases the loss of screening opportunities for the elderly population, while the ratio of nurses and carers per inhabitant is constantly decreasing in France. Women suffer from the persistent prejudice that cardiovascular diseases are "masculine" ones, although they are the leading cause of death for women in France, claiming nearly 200 victims every day. In addition to these age and gender related inequalities, there are social and territorial inequalities for many French people; exposure to cardiovascular risks can increase according to social determinants and geographical locations.

Furthermore, the specialised health care system appears to be insufficiently equipped and adapted to the expected wave. Again, inequalities are becoming territorial in terms of access to cardiological care. Private cardiologists are unevenly distributed across the country, the density per inhabitant remains low (from about 1 to 13 per 100,000 inhabitants) and waiting times for patients are on average 50 days and increasing.

In France, cardiovascular diseases are treated by access to healthcare and only insufficiently by prevention. We need to make the "prevention turn" and significantly increase the impact of prevention policies to make them the basis for healthy ageing in France.

The curative approach, which focuses heavily on human, technical and financial resources, can be perceived as a failure of prevention when it has not been sufficiently deployed. However, the health system still favours a curative approach to care. Health expenditure on prevention in France totalled to only 2.4% in 2012 and 1.9% in 2021.

However, by focusing on avoidable risk factors, most of the prevention actions implemented cannot address the entire spectrum of cardiovascular diseases. In the context of a structurally ageing population, there remains an urgent need to complement the prevailing prevention schemes, first and foremost through early detection and treatment of age-related cardiovascular diseases. Without it, France risks a silent epidemic caused by an ageing population.

In this regard, structural heart diseases are the most difficult cardiac pathologies to prevent:

- No awareness campaign has yet been deployed and few measures exist in France concerning these little-known diseases;
- Structural heart diseases are gradual and initially "subtle". Evolving symptoms may be perceived as a natural part of ageing, with sufferers adapting to the symptoms rather than seeking help;
- There is insufficient data on the actual occurrence of structural heart disease, and this lack of information undermines any effort to raise awareness;
- Simple screening for structural heart disease exists, via stethoscope auscultation by a general practitioner. Such screening is still inadequately practised, and if so only on an opportunistic basis.

In 2022, prevention appears to be on the French domestic agenda, as illustrated by the French government's announcement of prevention appointments at key stages of life, and its intention to make the health system and policies "*take the turn towards prevention*". To bring about a paradigm shift in the fight against cardiovascular disease, an ambitious strategy for the prevention of these diseases can be rolled out as part of an overall prevention strategy. Structured around clear and transparent objectives, considering the interplay of the various chronic pathological conditions (cardiovascular, cancer, addictions, etc.) and the disparity of the affected populations, this long-term strategy would take the form of a prevention continuum and would rely on the "stereophonic" involvement of the entire ecosystem, merging collective and individual approaches adapted to every profile.

Axis 1

A "multi-vector" approach to cardiovascular preventive health care, using the entire ecosystem, to provide support for every French person over the course of their life:

› Achieve a continuum of prevention in the life of every French person, by mobilising the entire ecosystem, from early childhood to later life:
  » Education from childhood and awareness of the issues and good practices throughout initial training, followed by support throughout the rest of life by all healthcare workers (including pharmacists), which could entail the creation of an industry and new professions trained to "reach out" to communities and to handle the variety of profiles by operating in different settings (schools, institutions);

› Calibrate incentives for all stakeholders, including targeted groups:
  » a range of messages, between general public information campaigns and personal private communication carried out by health professionals adapted to profiles of at-risk subjects;
  » a new educational approach based on the 'proximity' of risk and cardiovascular diseases (simple scores, tools for visualising changes over time, testimonies, etc.);
  » a change of tone and culture for preventive messages, between individual responsibility and involvement and an incentivising discourse on prevention, clarifying the individual and intergenerational benefits;
  » and finally, consistency between economic incentives and prevention incentives for all actors;

› Basing the strategy on a series of simple and readable health indicators, to measure progress over time and stimulate the motivation of the various institutional and professional players.

Axis 2

An adapted approach combining universal prevention and differentiation according to population and risk:

› Mixing universality of prevention and subsidiarity/equity according to populations and at-risk profiles: segmenting into target populations corresponding to the risk of developing cardiovascular diseases according to different dimensions (medical, psycho-behavioural, territorial and socio-economic); guaranteeing equity of access to prevention; leveraging the resources available within territories and in particular professionals closest to each population concerned; optimising the allocation of means according to the expected return on investment (expenditure avoided, impact on individual quality of life and collective productivity, etc.).

› Pay particular attention to cardiovascular diseases linked to non-preventable risk factors, in particular age:

» Break the inertia as a result of lack of information and awareness by collecting data and establishing a state of play and a prospective analysis on all cardiovascular diseases;

» Carry out an ambitious study on the epidemiology of structural heart disease in France to fully understand the subject in a holistic manner, evaluate the real prevalence of the disease, the groups affected, its burden on the health care and insurance system. It should include a forecasting component to show the estimated evolution of the disease, as well as practices and needs in terms of screening and treatment.

» Possibly deploy a major national awareness campaign, which could complement the current national National Health Insurance (CNAM) campaign for heart failure, to educate the French about the realities of structural heart disease and increase recourse to primary care in the event of symptoms, coupled with private communication by general practitioners.

Axis 3

Systematic and early detection to improve everyone's chances in the face of "silent" cardiovascular diseases:

Adopt a strategy of systematic detection of structural cardiovascular diseases at a key age in life, to improve the level and impact of screening, reduce inequalities in access (in terms of age, gender, socio-economic and territorial profiles) and delay the development of chronic cardiac pathologies. This screening could be deployed through preventive medical appointments announced by the government, such as the current plan to introduce one at the age of 65.

› Inform and train all health professionals and encourage them to detect and/or screen for structural heart disease.

Axis 4

Prioritising cardiovascular diseases in health strategies in France and Europe:

› Develop a long-term strategy that considers the timeframe of prevention, its objectives, and its results, which is often long. Political and budgetary commitments of at least five years are necessary, so that they can not be jeopardised by political changes in government, as is the case with certain energy and sustainable development roadmaps.

› Secure a dedicated and robust budget, which should not be carried by the Ministry of Health alone.

» The push for global prevention suggests that funding should no longer be viewed as a cost (for care, for treatment) but as an opportunity to build for the future; a "national priority" for increased future productivity, equity between generations and territories, and greater resilience of the economic and social fabric.

» Different avenues of funding could be mobilised, reflecting a national, longterm commitment, such as those of the National Education system (educating children about health, risks, basic gestures and behaviours), the health system (for populations at significant cardiovascular risk), pension funds or supplementary health funds (for the elderly), solidarity, territories and communities (differentiated, territorial and psychosocial approach for the most disadvantaged territories and populations).

› Include a specific strategy for cardiovascular diseases in the main public health guidelines, which could take the form of a "Heart Plan" that would include prevention and systematic screening. Such a global plan for cardiovascular diseases is necessary today, as is a possible Heart Institute responsible for coordinating national efforts. Prevention for all and systematic screening must be one of the major axes of this "Heart Plan" and become a national priority in the face of an ageing population, as has been done for cancer and neurodegenerative diseases.

› Support collaboration and partnerships at a European level. Initiatives in Europe pave the way for coordinated and ambitious cardiovascular strategies (Spain, Scotland), as does the June 2022 Healthier Together EU Non-Communicable Diseases plan. A joint European action on heart disease would allow for pooling of resources of the different Member States and the Commission for a greater resonance throughout society.

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