

**Gender Impact Assessment  
No. 6**



**Women's Health  
Victoria**

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**Women and Cardiovascular Disease**

December 2008

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ISSN: 1837-4425

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**Women and Cardiovascular Disease**  
(Gender Impact Assessment No. 6)

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Published December 2008

ISSN: 1837-4425

This paper is also available at:  
<http://www.whv.org.au/publications-resources/gender-impact-assessments>

## Table of Contents

<b>1 Introduction .....</b>	<b>2</b>
<b>2 The issue.....</b>	<b>3</b>
2.1 Sex and gender differences.....	3
2.2 Women from areas of socioeconomic disadvantage .....	4
2.3 Aboriginal and Torres Strait Islander women.....	5
<b>3 Policy context and challenges .....</b>	<b>5</b>
<b>4 Recommendations .....</b>	<b>7</b>
<b>5 References .....</b>	<b>8</b>

## 1 Introduction

Cardiovascular health relates to the health of the heart and blood vessels. Cardiovascular Disease (CVD) covers a number of conditions including coronary heart disease, heart failure and stroke, some of which are described briefly below.

Coronary Heart Disease (CHD) is a chronic condition where blood vessels are clogged and narrowed<sup>1</sup>. CHD can lead to a heart attack where there is a sudden complete blockage of an artery that supplies blood to an area of the heart<sup>1</sup>. Heart failure is where the heart muscle becomes too weak to effectively pump blood through the body. This can be caused by a previous heart attack. A stroke occurs when an artery supplying blood to a part of the brain becomes blocked or bursts, depriving the brain of oxygen<sup>1</sup>. There are several different types of strokes.

CVD is Australia's leading cause of death accounting for 76,928 registered deaths in 2006<sup>2</sup>. As a result CVD contributes to 34% of all deaths in Australia<sup>2</sup>. Increased recognition that CVD is a serious health issue for women is required since women make up 24,205 (53%) of these deaths<sup>2</sup>. Many of these deaths are both premature and preventable<sup>3</sup>. The perception that CVD is more common in men impacts the outcomes for women who develop CVD. Women tend to delay seeking treatment for their cardiac related events<sup>4</sup> possibly leading to worse outcomes.

CHD death rates in Australia have dramatically reduced since their peak in the 1970s<sup>5</sup>. This has been attributed to both a reduction in heart attacks and better survival following a heart attack<sup>5</sup>. These advances may be difficult to maintain with increased rates of overweight and obesity across the Australian population.

While CVD is the cause for many deaths in Australia, it is also one of leading causes of disability. In 2004-05, 18% of Australians (approximately 3.5 million people) reported having a long-term cardiovascular condition including hypertension<sup>6</sup> while 1.4 million Australians have a disability associated with cardiovascular conditions<sup>5</sup>. Disabilities and core activity restrictions can be long-term consequences of cardiovascular conditions, particularly stroke, and can have a severe impact on the quality of life of the sufferer<sup>7</sup>. The 2003 Survey of Disability, Ageing and Carers estimated that of all those Australians who had a disability, 69,800 or 1.8 % were caused mainly by stroke<sup>8</sup>.

CVD is the most expensive group of diseases in Australia<sup>9</sup>. Substantially more is spent on direct health care expenses for males (\$321 per person) than on females (\$261)<sup>9</sup>. While this discrepancy in funding may reflect differences in diagnosis, treatment and course of the disease, further research is required to explain this discrepancy when the prevalence of CVD is significantly higher among females (55%) than in males (45%)<sup>5</sup>. A range of cardiovascular diseases are more prevalent in women, including stroke. For every 64 male deaths due to stroke there are 100 female deaths<sup>6</sup>. Additionally, more females than males have had a stroke while men tend to have the stroke at a younger age<sup>5</sup>.

## 2 The issue

### 2.1 Sex and gender differences

Women tend to develop CVD approximately 10 years later than men<sup>10</sup>. This is attributed to the protective properties of oestrogen which is reduced once women reach menopause<sup>11</sup>. Menopause compounds other traditional risk factors for developing CVD though changes in body fat distribution and increased blood pressure<sup>12</sup>. This later presentation of CVD in women contributes to more women having co-morbidities (A pre-existing condition which may affect the care or treatment for the current condition) influencing their treatment and outcomes<sup>13</sup>.

To date, a significant amount of research on CVD has not included women. This has resulted in treatments being offered to women based on the results of men in research. Even in 2008 atorvastatin, marketed as Lipitor, a drug used to prevent heart attacks is marketed to men and women without disclosing the absence of benefits for women<sup>14</sup>. This drug is currently the world's top selling drug with more than US \$12bn in annual sales and neither the label nor other product information disclose that the key clinical trial of atorvastatin actually found its use led to a moderately raised risk of heart problems in women<sup>14</sup>. Atorvastatin is currently available in Australia on the Pharmaceutical Benefits Scheme for use in patients that meet the criteria set out in the general statement for lipid lowering drugs<sup>15</sup>.

Sex differences exist in the symptoms women and men experience during a heart attack. Women are more likely to have less recognised symptoms of CHD<sup>4</sup>. These include fatigue, isolated shortness of breath, nausea and vomiting, numbness of the arm and jaw pain. To better understand these differences and their implications for treating women with CVD, women need to be better represented in cardiovascular trials<sup>10,16</sup>.

Women and men respond differently to treatment of CVD. Secondary prevention involves treating people who have already received a diagnosis of CVD to reduce their risk of having a heart attack. Low dose aspirin is one treatment commonly used in secondary prevention. The benefits of low dose aspirin in prevention for those with no symptoms are less clear. Aspirin therapy has been shown to significantly reduce the risk of heart attack in men with no reduction in the risk of stroke<sup>10</sup>. Results were very different for women with aspirin therapy significantly reducing the risk of stroke<sup>4</sup> with no reduction in risk of heart attack or cardiovascular death<sup>10</sup>. Consistent benefits of aspirin were only shown in women over the age of 65<sup>10</sup>. These differences need to be acknowledged and understood to provide the best care for women at risk of CVD. Recognising CVD in women is not the only barrier to optimal care. Even when women have established CVD, they continue to receive less aggressive care than men<sup>18</sup>.

The Framingham Risk Score is a commonly used tool to measure a person's 10 year risk of developing CHD. This tool commonly underscores women<sup>17</sup> and young people, particularly those aged between 20 and 50 years of age<sup>19</sup>. Substituting the Framingham Risk Score for a tool that measures lifetime risk will more accurately identify women at risk of developing CHD allowing them to take measures to reduce their risk.

A significant amount of CVD is preventable. Risk factors associated with CVD include being overweight or obese, smoking, poor nutrition, physical inactivity, high blood pressure, high cholesterol, diabetes and kidney failure. Of women who have been diagnosed with heart disease, 66% are overweight or obese<sup>21</sup>. With 45% of Australian women overweight or obese this is key risk factor for CVD that should be addressed to prevent more women developing CVD<sup>21</sup>. Excess body weight is also associated with other risk factors for developing CVD such as high cholesterol and high blood pressure.

Diabetes is another key risk factor for developing CVD. The risk of having a heart attack is the same in people with type 2 diabetes who do not have CVD as those who have already had a heart attack<sup>20</sup>. As diabetes is such a strong risk factor it should be a priority that women with diabetes or who have had gestational diabetes are identified as high risk for developing CVD. Diabetes prevalence in Australian has more than doubled over the last two decades, increasing the number of women and men who have risk factors for CVD<sup>5</sup>. As women tend to develop CVD at a slightly older age than men they also are more likely to have co-morbidities such as diabetes. The increased complexity in treating people for CVD with co-morbidities leads to less than favorable outcomes.

Smokers are also at increased risk of developing CVD. Women smoking just one to four cigarettes a day are at double the risk of developing CHD as those who have never smoked<sup>4</sup>. Young women in Australia are taken up smoking at higher rates than men<sup>22</sup> and the potential impact on women developing CVD is of great concern.

One acknowledgement of the differences in outcomes for women who develop CVD has been gender based guidelines for preventing CVD recommended in the United States in 2007<sup>23</sup>. These guidelines recommend daily aspirin for women aged 65 and over for the primary prevention of heart attack and stroke. Similar guidelines have not been developed in Australia.

## **2.2 Women from areas of socioeconomic disadvantage**

Women from the most disadvantaged areas of Australia have CVD death rates 29% higher than those women from the least disadvantaged areas<sup>24</sup>. This is most obvious when death rates from stroke are considered as women in the most disadvantaged areas experience mortality due to stroke 84% higher than those from the least disadvantaged areas<sup>24</sup>. If all women in Australia experienced the same death rates as those in the least disadvantaged areas, 31% of CVD death in women would have been avoided<sup>24</sup>. The health inequality between the most and least disadvantaged Australians has increased from 1992 to 2002<sup>24</sup>.

Equalities also exist in hospitalisation rates and CVD risk factors. Women from the most disadvantaged groups are hospitalised for CVD 1.4 times the rate for the least disadvantaged<sup>24</sup>. Risk factors such as smoking and inadequate physical inactivity are more common in disadvantaged groups<sup>25</sup> and this may relate to less opportunity to adapt their risk behaviours. Obesity is more common among the most disadvantaged groups; with the rate for the most disadvantaged women being nearly double that of the least disadvantaged women<sup>26</sup>. To ensure that these inequalities do not continue to increase, prevention initiatives need to focus of this group of women.

### 2.3 Aboriginal and Torres Strait Islander women

CVD risk varies between diverse groups of women and Aboriginal and Torres Strait Islander (ATSI) women are one population group that have particularly high rates of CVD. ATSI women commonly have more risk factors for CVD than non-ATSI women including higher rates of smoking, diabetes and obesity<sup>27</sup>. A clear example of this is the 47% of all ATSI women were daily smokers<sup>28</sup> compared to 15% of non-ATSI women who smoke daily<sup>22</sup>. These risk factors are compounded by environmental and socioeconomic factors. After adjusting for age, ATSI women are 5.4 times more likely to have five or more risk factors than non-ATSI Australians<sup>27</sup>.

Diabetes is both a chronic disease and also a risk factor for CVD. As half of all ATSI peoples who have diabetes also have CVD, many ATSI women are in a high risk category for developing CVD<sup>27</sup>. ATSI peoples have diabetes at 4 times the rate of non-ATSI Australians. After adjusting for age, the prevalence among ATSI women is 1.2 times as high as for men<sup>25</sup>.

The inequitable health disparities are most evident among ATSI women who are more likely to develop CVD than ATSI men<sup>29</sup>. The situation is particularly shocking for ATSI women in the 35–44 year age group who are 21.3 times more likely to die from CHD than non-ATSI Australians<sup>27</sup>.

Rheumatic fever and chronic rheumatic heart disease are a significant problem among ATSI peoples<sup>5</sup> and again are more common in ATSI women than ATSI men<sup>27</sup>. Rheumatic heart disease is caused by the long-term damage done to the heart muscle or heart valves by acute rheumatic fever. These are both preventable and very rare in non-ATSI Australians.

## 3 Policy context and challenges

National Health Priority Areas were established in a joint effort by the commonwealth and state governments in 1996. National Health Priority Areas are diseases and conditions chosen for focused attention at a national level because of their significant contribution to the burden of illness and injury in the Australian community. CVD has been identified as one of seven National Health Priority Areas. Deaths associated with the seven National Health Priority Areas accounted for 77.4% of all deaths across Australia in 2006<sup>30</sup>.

The *National Chronic Disease Strategy* has been developed to provide national policy directions to improve chronic disease prevention and care in Australia<sup>31</sup>. This strategy is supported by five disease specific *National Service Improvement Frameworks* that include heart, stroke and vascular disease; cancer, diabetes, osteoarthritis, rheumatoid arthritis and osteoporosis.

The *National Service Improvement Framework for Heart, Stroke and Vascular Disease* was released in 2006<sup>32</sup>. This framework outlines opportunities for improving prevention and care without prescribing detail on individual services. One of the aims of the framework is to reduce variations in care across people residing in different regions and those from disadvantaged groups. The document lists special population groups including ATSI peoples; people in regional, rural and remote communities; people with mental health disorders; the frail elderly and people with disabilities.

With overweight and obesity strong predictors of CVD, the *Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults* are clearly important<sup>33</sup>. These guidelines released by the National Health and Medical Research Council in 2003 are a clear example of using a gender lens. These evidence based guidelines are important in identifying strategies that work best for women and men to reduce their weight. The implementation of these guidelines is a positive example for other publications to follow.

The National Heart Foundation's strategic plan for 2008-2012 *Championing hearts* covers six priority areas, one of which is to inform and educate women about their risk of CVD and how to reduce their risk of developing it<sup>34</sup>. This significant inclusion is progress in reducing the number of Australians that see CVD as a men's illness. The National Heart Foundation of Australia website contains information for the general population as well as health professionals. The information available on this website however, is gender blind.

The National Heart Foundation of Australia has a *Go Red for Women* campaign. Information on this campaign is available separately to their main site at <http://www.goredforwomen.com.au>. The *Go Red for Women* campaign aims to raise money for research and education into women's heart disease. This is an important step to increase public and professional awareness of CVD as a disease experienced by a great number of Australian women with greater variation in female presentations. The website also profiles 5 women in their forties who have had a heart attack to encourage people to examine their personal risk factors.

The Victorian Government have been building on their *Go For Your Life* Strategic Plan since it was launched in 2006<sup>35</sup>. This four year plan aims to increase levels of physical activity and healthy eating by Victorians in an effort to combat increasing levels of chronic disease. The *Go For Your Life* plan acknowledge the poorer health outcomes that people from socioeconomic disadvantaged backgrounds experience. This strategic plan also acknowledges that health is experienced differently by different groups of people, however the key population group focus does not include women. Many groups are identified for specific population group activities including children, adolescents, men, culturally and linguistically diverse communities and seniors. The absence of women as a population group within this strategic plan is a serious omission that can contribute to the misperception that chronic disease has a greater impact on men.

## 4 Recommendations

1. CVD is the major cause of death and a significant cause of disability for Australian women. To ensure a high quality of care both the general population and health professionals need to be aware of the difference between women and men's experience of CVD.
2. Implementing the *National Service Improvement Framework for Heart, Stroke and Vascular Disease* would improve both prevention initiatives and care of those who have already developed CVD.
3. Finally, as with many chronic diseases, CVD is disproportionately experienced by those women from disadvantaged areas and ATSI women so a prevention effort should begin with these groups of women.

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