PUBLIC HEALTH POLICY AND PRACTICE

Substantial potential for reductions in coronary heart disease mortality in the UK through changes in risk factor levels

J A Critchley, S Capewell

Study objective: The UK government called for a 40% reduction in cardiovascular disease mortality in those aged under 75 by 2010. This paper examines the potential for cardiovascular risk factor changes to reduce coronary heart disease deaths in Scotland, and then extrapolates the findings to the UK population.

Design: Secondary analysis of published data using a previously validated mortality model. The model combines uptake and effectiveness of treatments with risk factor trends by sex and age group. It was used to estimate the expected reductions in coronary heart disease mortality: (a) if recent risk factor trends simply continued; (b) if additional risk factor reductions were achieved in line with Scandinavia and the United States. An “analysis of extremes” sensitivity analysis was then carried out.

Setting: Scotland and UK.

Participants: Projected Scottish population aged 45+ in 2010 (2.4 million) and UK population of 26.8 million.

Main results: Continuation of current trends would result in 2169 fewer coronary deaths in 2010 (minimum estimate 1191 from sensitivity analyses to maximum 3870). About 4749 fewer deaths (minimum 3085, maximum 7155) could be achieved by: (a) a reduction in smoking prevalence from 30% to 18% (about 1668 fewer deaths); (b) a mean population cholesterol reduction from 6.2 to 5.2 mmol/l (about 2167 fewer deaths); (c) a 3.7 mm Hg fall in diastolic blood pressure (about 914 fewer deaths). Extrapolation from the Scottish population to the UK suggests 24 000 fewer deaths in 2010 if current trends continue, or 53 000 fewer deaths with the additional reductions.

Conclusions: With additional interventions it would be possible to almost halve current UK coronary heart disease mortality. Even without gains from medical treatments, the UK government target of 28 000 fewer deaths in 2010 does not seem challenging.
assumed larger but feasible risk factor reductions. These results are then applied to the UK population to estimate the potential mortality reductions achievable.

**METHODS**

The model uses regression coefficients estimated from large cohort studies and MONICA analyses to describe the relationship between population changes in specific cardiovascular risk factors, and population mortality rates from coronary heart disease. For each major risk factor, the subsequent reduction in deaths is estimated as the product of the specific regression coefficient, the relative risk factor reduction, and the number of coronary heart disease deaths observed at the beginning of the time period of interest. The coefficients were decreased for older age groups to reflect the epidemiological evidence suggesting that relative risk attenuates with age (appendices 1 and 2, see journal web site).

**Extension of the model to 2010**

The refined model was extended from 1975 through 1994 to the year 2010, using deaths and population size by sex and age group for Scotland annually from 1986 to 1998, and projected population estimates to 2010. The “baseline” deaths expected in 2010 were calculated by applying the age specific death rates in 1994 to the 2010 projected population. Projected death rates from coronary heart disease in 2010 were then estimated by extrapolating current trends to the year 2010 using five year rolling averages.

(1) **Current trends in risk factors between 1994 and 2010**

We firstly assumed that the average annual trends in total cholesterol and blood pressure observed in the Glasgow MONICA population between 1986 and 1995, continued until 2010 and extrapolated to the wider Scottish population. Trends in smoking prevalence were estimated using Scottish data from the General Household Survey. Only limited information was available for those aged over 65; where necessary it was assumed that risk factor reductions were only necessary it was assumed that risk factor reductions were only 50% of those seen in younger age groups.

(2) **Additional reductions in risk factors between 1994 and 2010**

The calculations were then repeated assuming greater risk factor reductions. Realistic and feasible risk reductions were chosen, based on data from comparable populations.

(a) **Smoking**

The UK target to reduce smoking prevalence to 24% among adults by 2010 does not seem challenging, and may be achieved simply on the basis of current trends. In contrast, the US Healthy People 2010 smoking prevalence target of 12% by 2010 is therefore chosen. Smoking prevalences are already lower than 18% among people aged over 65 in the UK.

(b) **Cholesterol**

Reductions in population mean cholesterol levels have been modest in Scotland; less than 5% in men and women aged 45–64 between 1985–94. The annual relative falls of 1% in men and 1.4% in women observed in Gothenberg, Sweden were therefore applied to the Scottish population (target levels for 2010 would then resemble those observed in the 1990s in populations such as Gothenberg, Stanford, USA and Perth, Australia).

(c) **Blood pressure**

Finally, an additional 3.7 mm Hg decrease in population mean diastolic blood pressure between 1994 and 2010 was tested. Such falls have been observed in several countries within the MONICA study.

**Sensitivity analysis**

Because of the uncertainties surrounding some values, an analysis of extremes sensitivity analysis was performed. Estimated mortality reductions were generated using minimum and maximum plausible values for the main parameters (appendix 2).

**RESULTS**

**Trends observed in Scotland, 1986–1998**

Overall annual declines in coronary heart disease mortality rates were 2.6% in men, and 2.2% in women, ranging from 5% in the younger age groups to 1% in women aged over 85.

**Estimated changes in coronary heart disease mortality in Scotland between 1994 and 2010**

Assuming that current trends in age specific death rates continued to 2010, 11 287 deaths would be expected in 2010 (6048 among men, 5239 in women, overall reductions of 39% and 32% respectively from 1994). The estimated age specific percentage declines between 1998 (the most recent year for which data were available) and 2010 in those aged 45–54, 55–64 and 65–74 would be 46%, 42%, and 36% in men and 45%, 40%, and 32% in women respectively.
Cardiovascular risk factor changes

(a) Based on current trends only
Projections of current risk factor trends suggest that 2169 deaths would be prevented or postponed in 2010 as a result of the reductions since 1994 (minimum estimate from sensitivity analyses 1191, maximum 3870, table 1). These 2169 fewer deaths would result from 937 attributable to falling trends in smoking (from a population prevalence of 30% to 21%), 774 attributable to a reduction in cholesterol (from 6.3 mmol/l to 5.8 mmol/l among under 65s), and 459 attributable to falls in population diastolic blood pressure (from 76 mm Hg to 73 mm Hg among under 65s, tables 1 and 2).

(b) Additional reductions in major risk factors (tables 1 and 2)
A total of about 4749 deaths (minimum 3085, maximum 7155) could be prevented or postponed by additional but feasible reductions in the major cardiovascular risk factors.

(i) 1668 fewer deaths assuming that smoking prevalence fell to 18%;
(ii) 2167 fewer deaths assuming that population mean cholesterol levels declined as in Gothenburg, Sweden (by 2010 reaching 5.2 mmol/l among men, and 5.1 mmol/l among women under 65);
(iii) 914 fewer deaths assuming an average further decrease in mean diastolic blood pressure of 3.7 mm Hg across all age and sex groups (from 76 mm Hg to 69 mm Hg among those aged under 65).

The number of deaths prevented or postponed in 2010 due to these additional risk factor changes could thus be increased more than twofold from 2169 if current trends continue, to 4749 (table 1). The absolute risk factor levels that would be achieved in 2010 are detailed in table 2.

In women, much of the benefit would occur among older age groups, whereas in men benefits would be more evenly distributed (table 3).

Comparison with UK targets and extrapolation to the UK population
The UK target calls for a 40% reduction in coronary mortality, with 28 000 lives to be saved in 2010. Simple extrapolation from the Scottish model estimates (4749 lives saved with additional risk factor interventions in a population of 2.4 million) to the UK population of 26.8 million suggests that 53 000 lives could be saved in the year 2010. Conservatively assuming that 60% of these (32 000) are in the target age groups (<75), it seems that the 28 000 target could be met entirely through risk factor changes. Furthermore, substantial improvements in treatment efficacy and uptake are also expected.

DISCUSSION
Over 50 000 coronary deaths could be prevented or postponed in 2010 in the UK with the additional risk factor reductions. This would represent almost half the 110 000 current annual cardiac deaths in the UK. Over 60% of the reduction would occur in the premature deaths aged under 75 specified in government targets. Most of the reduction would be seen among men, because of the lower mortality rates among younger women. Simple extrapolation of current mortality trends suggests that the UK target is not testing.

To date, the biggest mortality benefits have come from reductions in smoking, as elsewhere in Europe, the US, and New Zealand. However, reductions in cholesterol seem to have even greater potential to further reduce coronary heart disease mortality rates in the UK and elsewhere. Past falls

<table>
<thead>
<tr>
<th>Year</th>
<th>Smoking (prevalence)</th>
<th>Cholesterol (mmol/l)</th>
<th>Diastolic blood pressure (mm Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>1994 (baseline)</td>
<td>34</td>
<td>34</td>
<td>6.2</td>
</tr>
<tr>
<td>2010 (current trends)</td>
<td>23</td>
<td>24</td>
<td>6.0</td>
</tr>
<tr>
<td>2010 (additional reductions)</td>
<td>18</td>
<td>18</td>
<td>5.2</td>
</tr>
</tbody>
</table>

| Table 2 Risk factor levels at 1994 baseline and projections to 2010, for men and women aged 45–65 years |

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Number of deaths prevented or postponed</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>45–54</td>
<td>(1) current trend</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>328</td>
</tr>
<tr>
<td>55–64</td>
<td>(1) current trend</td>
<td>359</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>944</td>
</tr>
<tr>
<td>65–74</td>
<td>(1) current trend</td>
<td>528</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>745</td>
</tr>
<tr>
<td>75+</td>
<td>(1) current trend</td>
<td>379</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>604</td>
</tr>
<tr>
<td>Totals (all ages)</td>
<td>(1) current trend</td>
<td>1413</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>2620</td>
</tr>
</tbody>
</table>

*Proportion of all deaths prevented or postponed in 2010 by risk factor reductions. Percentages and number of deaths may not sum to totals due to rounding.

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Number of deaths prevented or postponed</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>45–54</td>
<td>(1) current trend</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>98</td>
</tr>
<tr>
<td>55–64</td>
<td>(1) current trend</td>
<td>234</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>429</td>
</tr>
<tr>
<td>65–74</td>
<td>(1) current trend</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>532</td>
</tr>
<tr>
<td>75+</td>
<td>(1) current trend</td>
<td>295</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>1070</td>
</tr>
<tr>
<td>Totals (all ages)</td>
<td>(1) current trend</td>
<td>756</td>
</tr>
<tr>
<td></td>
<td>(2) additional reduction</td>
<td>2129</td>
</tr>
</tbody>
</table>
have been modest, and cholesterol levels in Britain remain higher than most other Western countries. Importantly, population coronary heart disease mortality is reduced more by a 1% relative reduction in cholesterol than by a 1% relative reduction in population mean blood pressure or smoking prevalence.\(^{12-26}\) (appendix 2). The need for more effective dietary interventions is clear.

As with all models, this analysis contains a number of limitations (see appendices 1 and 2). Firstly, it considers only mortality, and not years of life lost or morbidity. Our estimates of deaths prevented or postponed would translate into substantial numbers of life years gained.\(^6\) Secondly, the model is cell based and comparatively simple.\(^4\) The results should be replicated in a more complex simulation model, to explicitly consider lag times and interactions between various interventions.\(^7\) \(^8\) \(^9\) \(^10\) We considered only deaths from coronary heart disease, and it is possible that some increase in death rates from other “competing causes”\(^11\) may be observed. However, reductions in risk factors such as smoking would decrease deaths from other causes such as lung cancer.\(^12\)

A number of further assumptions have been made. For example, whether mortality and risk factors will continue to decline at the same rate until 2010. It has also been assumed that the estimates obtained from Scotland can be extrapolated to the entire UK. Although socioeconomic factors may differ, this assumption seems justifiable as population distributions, life expectancy, and CHD risk factors are reasonably similar. Extensive sensitivity analyses were performed to consider higher or lower values for each regression coefficient.\(^12\) \(^13\) \(^14\) \(^15\) These influenced the number of deaths postponed or prevented, but did not change the relative contribution of each risk factor. International comparisons also suggest that much lower coronary death rates might well be achievable. Overall, the observed reduction between 1994 and 1998 has been slightly higher than expected from extrapolation. Our estimated reductions in 2010 may prove to be conservative. Furthermore, the recent National Service Framework for coronary heart disease treatment targets will probably also achieve substantial reductions.\(^16\) \(^17\)

Existing UK government Saving Lives targets’ therefore seem achievable. However, continuation of the current trends cannot be assumed, given the “levelling off” in coronary heart disease mortality recently seen in the UK.\(^18\) Britain lags behind many other countries and coronary heart disease will remain the biggest cause of death for the foreseeable future. Fresh initiatives to reduce major cardiovascular risk factors could produce further substantial reductions in mortality.\(^19\)

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Coronary heart disease mortality


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