

## Cardiovascular Health of the Brazilian Male - the View of the Brazilian Society of Cardiology

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The comprehension of the mechanisms of disease has led Medicine to intensely develop new therapeutic strategies in the last decades, strategies based mainly on intervention. However, these indisputable achievements in mortality and quality of life have not promoted the cure or complete remission of the disease symptoms and have been accompanied by a significant increase in healthcare costs that affect even the wealthier countries. These questions are setting the Medicine of the XXI century in motion toward the search for a new strategy to face Man's sickness and again have as the main focus the prevention of diseases, instead of waiting for the diseases to appear and treat them after they have set in. This path is becoming irreversible, as demonstrated by a lecture given by Professor Eugene Braunwald, at the last European Congress of Cardiology in the city of Barcelona, Spain. Dr. Braunwald participated in the symposium "Future of Cardiology as a Medical Specialty" and presented the lecture "Cardiology as a Profession in 2020 and beyond" and focused his presentation on the aspects of prevention as the best way to approach cardiovascular disease and the cardiologists' high priority in the next century.

The concept of prevention is not new and it is currently being used in our country. The Ministry and State Secretaries of Health have already developed several programs of health promotion that currently reach children and adolescents, women and the elderly. However, some questions have arisen: for which diseases should prevention be prioritized and which population should be the focus?

Brazil is rapidly going through a demographic transition, in which the mean age of the population is older. In 2000, approximately 15% of the population (27 million people) was 50 years or older. This percentage should increase to 42% (96 million people) in 2050. The mean age of the Brazilian individual, which in 2000 was 26 years, will be 44

years in 2050. As the population ages, the non-transmissible diseases will result in a burden to the Public Health System, considering that the cost of these diseases already represents half the costs of all hospital admissions in Brazil. These diseases are already responsible for a large and increasing part of the disease burden in Brazil, reaching a percentage of 66%, compared to 24% of transmissible diseases and 10% of wounds. The change in this profile, with a higher burden of non-transmissible diseases is due to the urbanization, improvement in healthcare quality, changes in life style, specific policies and globalization itself, expanding and disseminating technical-scientific knowledge. This burden of non-transmissible diseases is not necessarily an inevitable result of a modern society, but of a harm that can be prevented. For most of these diseases (coronary diseases, strokes, diabetes and several types of cancer), the main cause is not found in genetics, but in modifiable environmental and behavioral risk factors.

Among the non-transmissible diseases, the main focus is on the cardiovascular diseases, due to their current morbimortality rate as well as the somber perspectives for the following years.

The World Health Organization, in a study that projects a worldwide increase in the morbimortality of cardiovascular diseases, having as basis for this analysis the year 2040, elevates us to the tragic condition of world champions, by estimating that Brazil will reach an incremental rate of 250% when compared to China (200%) and India (180%)<sup>1</sup>. About this aspect, Lotufo's observation deserves attention, that an epidemics of cardiovascular disease (CVD) is about to be installed in our country, mainly due to the higher incidence of diabetes and obesity<sup>2</sup>.

The experience of the United States of America (USA) can be used as a starting point for the necessary changes in the public health system of our country. The USA presented a 51% decrease in the incidence of CVD among women and a 49% decrease among men, between the years of 1980 and 2000. And the fight against smoking and sedentary life style alone resulted in a 12% and 5% decrease in CVD rates, respectively<sup>3</sup>.

Another relevant aspect is the existence of health characteristics that are different between the sexes, according to data indicative of population health. In Brazil, in the year 2001, the women presented an 8-fold higher life expectancy when compared to men (73 x 65 years, respectively) and in the southeast region, this difference was of 12 years<sup>4,5</sup>. In Brazil, male mortality is practically higher at all age ranges, although the incidence of health complaints and the

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presence in outpatient clinics is predominantly female<sup>6</sup>. This information, instead of demonstrating a higher morbidity among women, may be due to a higher concern of the female sex with healthcare attention and might be the result of specific policies directly exclusively at the woman's health. Another interesting information concerns the age, considering that the latter is directly related to cardiovascular morbimortality. In Brazil, however, it is estimated that 40% of all deaths by CVD are situated in the age range < 65 years and also that the disease is affecting younger individuals, with 26.8% of cardiovascular deaths occurring in individuals aged 25 to 59 years.

### National Policy of Primary Attention to Men's Health

All these data on CVD, demonstrating that it affects more men than women, the current prevalence and increase estimates in a near future, including the epidemics aspects, together with the disabling characteristics at a productive age, in addition to the fact that men do not prioritize their own health care, justified the creation of a Health Program specific for the male sex, similar to the healthcare programs directed at children, adolescents, women and the elderly. For that purpose, the Brazilian Society of Cardiology (SBC) had already developed, among its activities, programs of continuing

education in preventive, therapeutic and rehabilitation measures that can be shared and multiplied at national level together with other medical specialties, seeking an impact on the variables that affect the men's health.

Invited by the Ministry of Health, the SBC participated in meetings on the implementation of a health policy directed at men's health, proposing a concrete and objective basis for the implementation of this policy regarding its cardiovascular aspect, recommending as the focus of the action four chapters of cardiovascular etiopathogeny that must be approached as a first strategy: risk factors; coronariopathies; arterial hypertension; rheumatic fever and myocardiopathies.

As the result of this effort, the Ministry of Health, through the Secretary of Healthcare Attention and Department of Strategic Programmatic Actions, with the support of several medical societies, including the Brazilian Society of Cardiology, implemented in August of 2008 the National Policy of Primary Attention to Men's Health. This policy has the objective of promoting the health and decreasing the premature death of male individuals due to cardiovascular, urologic, oncologic and psychiatric diseases<sup>7</sup>.

The Brazilian Society of Cardiology is confident that the development of this program, through the joint efforts of different medical societies, the Government and society, will result in a higher social insertion in healthcare, positively influencing the quality of life of the Brazilian men.

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### The SBC Document for the National Men's Health Program

As this is a low-cost strategy, as well as extremely practical, the Brazilian Society of Cardiology (SBC) considers as priorities the following propositions:

- Inclusion criteria for patients treated by the Men's Health Program

- a) Male sex
- b) Age between 25 – 59 years ( \* )
- c) Presence of family risk factors ( < 30 years )
- d) Presence of any detected risk factors ( # )
- e) Patients undergoing cardiovascular treatment

f) Patients referred by the primary care network  
(\* ) Age range understood as the target for the men's health policy: 37414900 individuals

(#) Use the following criteria as risk factors: Framingham; InterHeart

- SBC propositions for the development of The Men's Health Policy

a) We see as priority the establishment of a specific policy directed at Men's Health.

b) We see as fundamental, the training of technical teams specifically directed at this area (general practitioners, healthcare agents, nurses and psychologists).

- c) Permanent participation of specialty societies (SBC; SBH; SBHCI; SBCCV) in specific policies.
- d) Definition, in actuarial terms, of the resources supplied by the Brazilian Public Health System (SUS) for diagnosis and therapeutics.
- e) Inclusion of objectives and indices to be established at short, mid and long-term, based on evidence by acknowledged health organizations.
- f) To understand the role of the man (as yet) as the provider in the family financial structure and program in this item, functional, corporative and assistential strategies (time schedules, availabilities, incentive and transportation) that can minimize this item in the primary and/or secondary prevention.
- g) To promote educational campaigns at the level of primary prevention, at schools, clubs and organizations (civil, military and religious ones), with the purpose of stimulating the adoption of a healthy life style that can inhibit the perpetuation of the so-called risk factors. To stimulate the initiatives directed at a healthy diet and strategically disseminate these concepts in society.
- h) To promote, together with the Ministry of Health and the Ministry of Education, the creation of an interministerial committee that can develop the curricular bases of a didactic subject: Education in Health, which will promote the fundamentals and basis for a healthy quality of life at the Elementary School level.
- i) Provide a better basic healthcare to the Brazilian population in all regions of the country. We understand that the difficulty to have access to primary assistance remains a limiting factor preventing the excellence in cardiovascular treatment.
- j) The presence of trained health agents and general practitioners would result in a 40% decrease in the incidence of CVD. To promote the program of hypertension detection and control at the primary attention. To stimulate these agents to observe and analyze the acknowledged risk factors.
- k) Disseminate a prevention policy among companies. To clearly show, through the presentation of concrete data, the profitability of investing in prevention. And, in this specific aspect, the SBC puts all of its technical potential, as a determinant of the objectives of this strategy.
- l) The creation of multidisciplinary centers directed at the men's healthcare (and in this item, we understand as fundamental, the participation of academic entities as collectors, evaluators and determinants of the acquired statistics).
- m) The participation of the media as a dissemination and critic agent of the determinants of this process.
- n) The use of prognostic cardiovascular risk scores based on the SBC guidelines, with sporadic assessment by the SBC.
- o) The incentive to the healthcare teams (state and municipal) that reach their previously established goals.
- Incentives (fiscal or functional) to the companies (public and private) that reach such goals.
- p) The compulsoriness of performing sporadic examinations (ANNUAL ONES) in all workers, by companies.
- q) The creation of a database that will annually analyze the participation of society in this specific health area.
- r) The creation of a cardiovascular rehabilitation program that will allow the reintegration of patients, with sequelae due to CVD, to society.
- s) The training of the Medical Emergency Service (SAMU) staff to treat cases of Acute Coronary Syndrome (ACS). In this aspect, we highlight the need for the assessment of the use of standardized thrombolytic agents by SUS, during the ACS treatment strategy.
- t) Qualification of cardiovascular drugs, under the supervision of the specialty societies, which can improve the cardiovascular health of the Brazilian male.
- u) The availability of a telemedicine network that can promote the access of any part of the country to technical resources provided by SUS.
- v) The creation of a permanent technical team that will assess based on the evidence, the most adequate treatment under an epidemiological point of view, at the primary and/or secondary prevention level (for instance, ASA in hypertensive patients with risk factors).
- w) Increase taxes on tobacco products, alcohol, trans-fats and salt. To evaluate the economical impact: tax collection/healthcare costs.
- x) Promote and develop physical activity programs in the companies (5% decrease in the incidence of CVD) and in the community, as a whole.
- y) To intensify the Smoking Control Program. To create specific teams that can assess the tax collection/healthcare costs ratio in this area.
- z) To evaluate the "polypill" strategy in the primary and secondary prevention of DCV.
- aa) To implement a Brazilian Society of Cardiology "seal" in all state initiative regarding the cardiovascular health of the Brazilian population.
- ab) To investigate, together with the teams specialized in consumers, the causes of lack of adherence by the target population to the medications supplied by the public health system.
- ac) To promote, together with the Ministry of Health, a policy for the effective remuneration of health agents, compatible with the severity of the problem in our country.
- ad) To develop, together with ANVISA and SBC, a program of "pharmacovigilance" regarding cardiovascular drugs throughout the country.
- ae) To stimulate the creation of specialized men's health centers in all Brazilian cities and towns.
- af) To disseminate, together with the media, campaigns to raise the population awareness, under the guidance of SBC, on healthy food and life styles. These campaigns will be part

of a permanent health policy and not only directed at “Theme Days”.

### - Indicators of Cardiovascular Disease

These indicators shall be complemented, followed and updated by the Database Service of the Ministry of Health (DATASUS) and SBC:

- 1) Mortality of Cardiovascular Disease
- 2) Morbidity of Cardiovascular Disease
- 3) Epidemiological data due to Chagas Disease
- 4) Epidemiological data due to Rheumatic Fever
- 5) Epidemiological data on Smoking
- 6) Rate of Hospitalizations due to Cardiovascular Disease
- 7) Rate of Procedures due to Cardiovascular Disease
- 8) Statistics on risk factors (variable or not)
- 9) Emergency treatments due to CVD
- 10) Healthcare costs with CVD
- 11) Level of absenteeism due to CVD
- 12) Retirement costs due to cardiovascular “disability”
- 13) Costs of the functional rehabilitation policy
- 14) Effect of loss of function due to CVD on the GNP
- 15) Social security benefits generated by disability caused by CVD