

Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care

June 2015

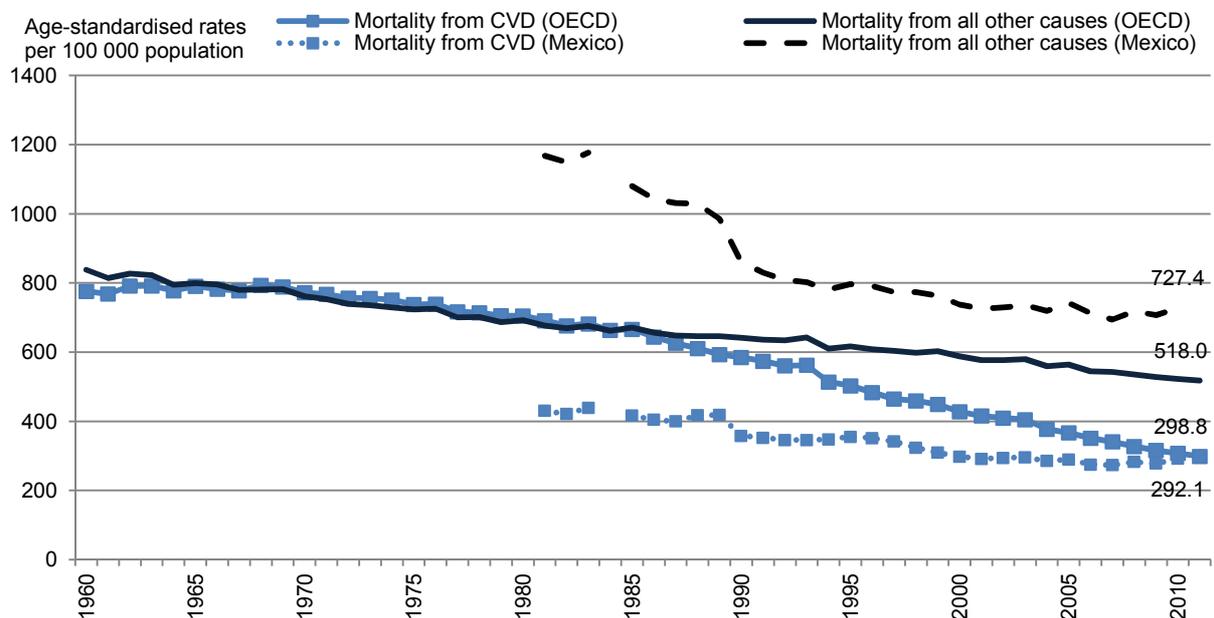


Country Note – Mexico

In Mexico, the mortality from cardiovascular diseases (CVD) has decreased slower than in many OECD countries and the burden of CVD and diabetes is increasing rapidly

Although CVD mortality is 292 per 100 000 population, still lower than the OECD average of 299 (Figure 1), potential years of life lost, a commonly used measure of premature mortality, at 728 per 100 000 population for diseases of the circulatory system in 2011, is 25% higher than the OECD average of 581 (by using the age limit of 70), suggesting that CVD-related deaths occur earlier in life than in many other OECD countries. The reported diabetes prevalence is 15.9%, by far the highest in the OECD. Early onset of diabetes is more prevalent than elsewhere (23.8% for people aged 40-59 and 5.9% for people aged 20-39, both the highest in the OECD where the averages are 8.9% and 1.7%, respectively). The early onset has important implications for a patient’s health status and also for their social and economic status. Young survivors of CVD events such as Acute Myocardial Infarction (AMI) and stroke may face serious deterioration in their quality of life, leading to greater social and health care needs over longer periods of time and a reduced ability to work. People living with diabetes for longer periods of time also have a higher risk of suffering complications.

Figure 1. Mortality rates for cardiovascular diseases and all other causes of death in Mexico and OECD countries



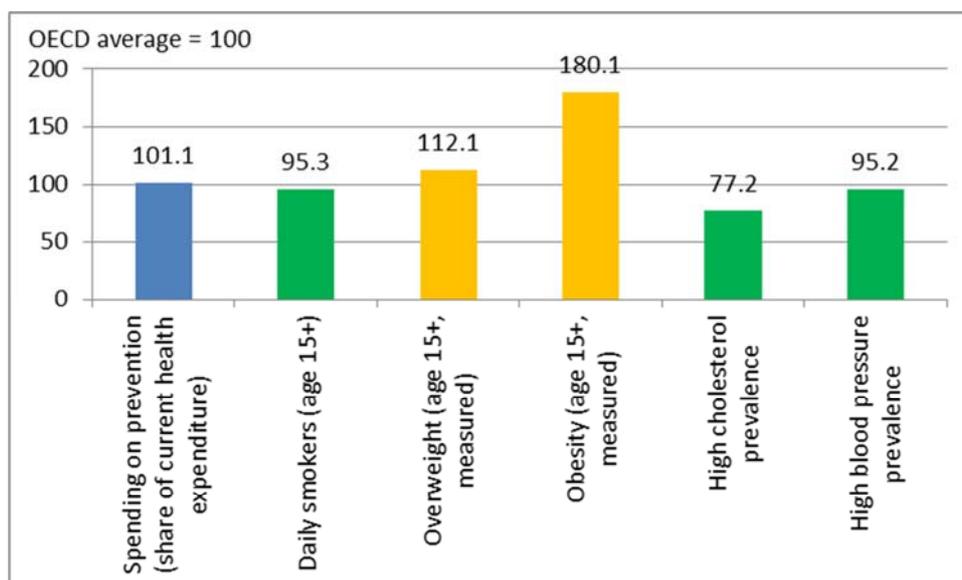
Source: OECD Health Statistics.

The prevalence of overweight and obesity, risk factors for CVD and diabetes, is one of the highest in the OECD

The prevalence of overweight is 38.8%, the second highest after Chile in the OECD, and the prevalence of obesity is 32.4%, the second highest after the United States; both rates are much higher the OECD averages of 34.6% and 18.0% respectively (Figure 2). However, reported prevalence of high cholesterol and high blood

pressure is lower than the OECD average (13.9% and 24.4% vs 18.0% and 25.6%, respectively). Spending on prevention is at the same level as the OECD average at 2.9% of the current health expenditure.

Figure 2. Prevention and healthy lifestyle related to CVD and diabetes in Mexico, 2011 (or nearest year), OECD average = 100



Note: a bar in blue refers to an indicator in which an evaluation needs to be done together with other indicators, a bar in green refers to the value better than the OECD average, and a bar in orange refers to the value worse than the OECD average.

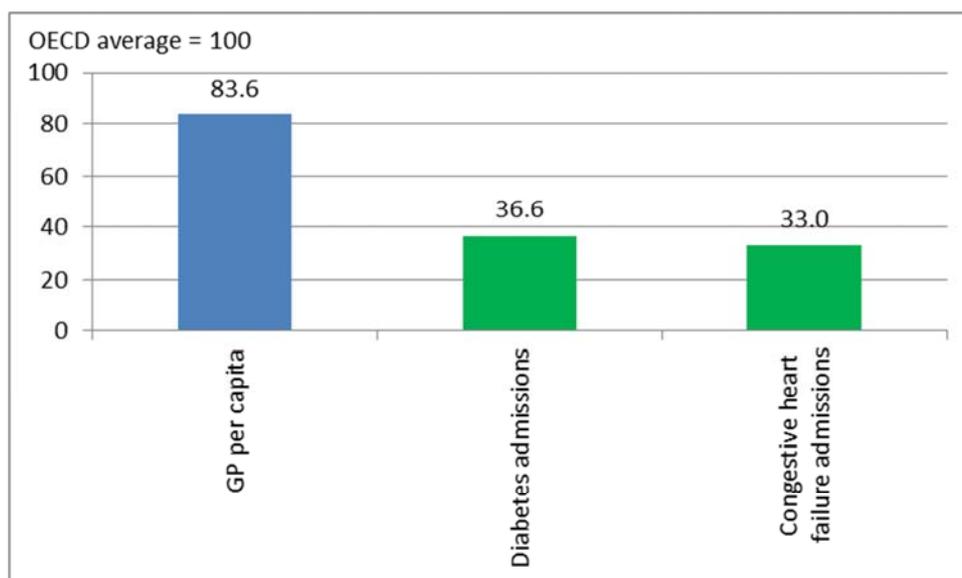
Source: OECD Health Statistics.

The smoking rate among male adults is also high. Although adult smoking is 19.9%, below the OECD average of 20.9%, male smoking, at 31.0%, is higher than the OECD average of 26.0%. In Mexico, together with other countries such as Finland, Estonia and Italy, tobacco prices has increased by less than 1.5% between 2008 and 2010 while in countries such as Spain, Turkey, the United States and Australia, prices increase was larger at more than 20% during the same period.

Access to primary and acute care seem low

Although comparable data on health spending in ambulatory care are not available for Mexico, a study finds that patients pay more than 50% of the total health care costs for their diabetes-related treatment despite the fact that additional coverage is available for specific treatments for diabetes and CVD. Hospital admissions for chronic conditions such as diabetes and congestive heart failure can be avoided if high-quality primary care is provided. Admission rates are 8.7 per 1 000 diabetic patients, the lowest in the OECD, and 0.8 per 1 000 population for congestive heart failure, the second lowest after Slovenia (Figure 3). But these low rates of avoidable hospital admissions do not seem to relate to good quality of primary care but rather to low access to primary and hospital care. The number of GPs per population in 2011, at 0.8 per 1 000 population, was lower than the OECD average of 1.0, and the number of hospital beds was 1.6 per 1 000 population, the lowest in the OECD where the average is 4.9. Although the number of coronary artery bypass graft (CABG) surgeries and percutaneous transluminal coronary angioplasties (PTCA) increased considerably in recent years, they are still the lowest in the OECD at 3.7 and 2.5 per 100 000 population (Figure 4).

Figure 3. Primary care related to CVD and diabetes in Mexico, 2011 (or nearest year), OECD average = 100



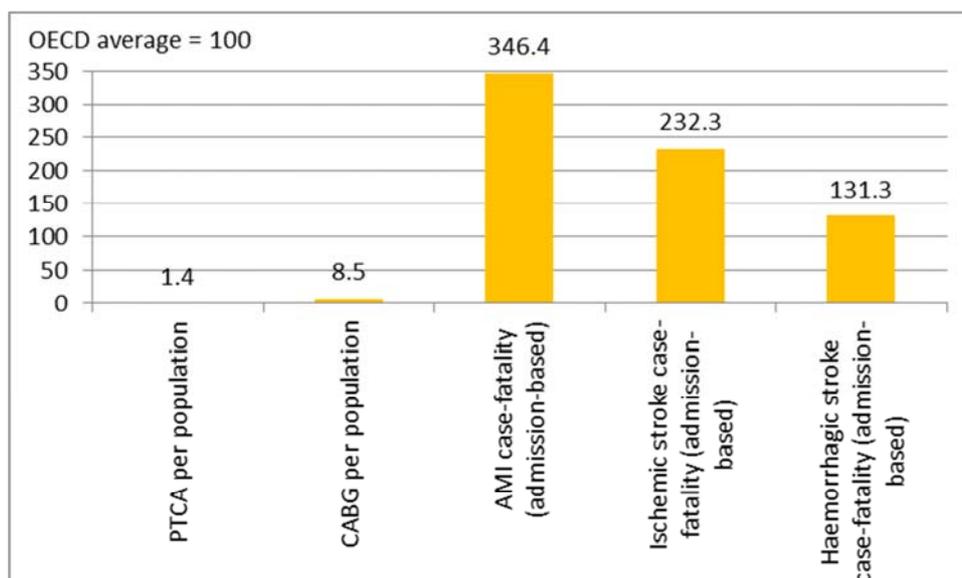
Note: a bar in blue refers to an indicator in which an evaluation needs to be done together with other indicators, and a bar in green refers to the value better than the OECD average.

Source: OECD Health Statistics; Diabetes prevalence: IDF (2013), IDF Diabetes Atlas, 6th Edition, International Diabetes Federation, Brussels, www.idf.org/diabetesatlas/previouseditions.

Quality of acute CVD care is the lowest in the OECD

The 30 day case-fatality rate for AMI is the highest at 27.2%, more than three times as high as the OECD average (7.9%). The rate is also high for Ischemic and Haemorrhagic stroke at 19.6% and 29.7%, compared with the OECD average of 8.4% and 22.6%. The reported case-fatality rates for Ischemic stroke have been deteriorating over recent years, and although some progress has been made for Haemorrhagic and AMI, the improvement is slower than in many OECD countries.

Figure 4. Acute care related to CVD and diabetes in Mexico, 2011 (or nearest year), OECD average = 100



Note: a bar in orange refers to the value worse than the OECD average.

Source: OECD Health Statistics.

Mexico needs to focus on reducing obesity and strengthening primary and acute care

In order to reduce risk factors of CVD and diabetes, particularly obesity, Mexico could introduce multifaceted and comprehensive strategies that include both population-wide measures and measures for high-risk individuals by using all available tools such as regulations, education, incentives, as well as health care programmes and services to work in unison and strengthen their effectiveness. Strong advocacy and stakeholder engagement is also needed to develop support for making healthy lifestyle choices easier and less costly. In 2014, Mexico implemented new tax policies on sugar-sweetened beverages and processed food that contains more than 275 calories per 100 g and the tax revenue is earmarked for health programmes. The introduction of these fiscal measures is a good start to combat obesity and combining these interventions in comprehensive strategies would result in a more effective and efficient approach because it increases the coverage of groups at risks and exploits potential synergies across the different interventions

Mexico also needs to strengthen primary and acute care to deliver prevention, early diagnosis, treatment and management of CVD and diabetes more effectively across providers. OECD countries try to overcome barriers to the implementation of CVD and diabetes guidelines in primary care including a shortage of physician time, prescribing costs and a lack of dedicated health care resources for preventive medicine as they may lead to suboptimal quality of care, poor compliance with recommended guidelines, adverse health outcomes and higher resource use as patients suffer more complications. OECD countries have also managed to decrease case-fatality rates by assuring better access to high-quality acute care for patients through timely transportation of patients, evidence-based medical interventions and care at high-quality specialised health facilities such as stroke units. In Europe, the “Stent 4 Life” initiative, launched in 2008, has improved the delivery of care and patient’s access to primary percutaneous coronary interventions, based on a partnership between professional associations, government representatives, industry partners and patient groups.

Mexico can further strengthen governance over the full pathway of CVD and diabetes care. OECD countries are using a variety of policy instrument to improve the quality of services along the entire pathway such as through the introduction of integrated care models, financial incentives for improved quality and performance, benchmarking, target setting and training. For example, France developed a monitoring framework for AMI to promote effective operation and interaction of many parts of the health system and delivery of better care over the full pathway.

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Useful links

Read the report online, access the press release, country notes, and data at:

<http://www.oecd.org/health/cardiovascular-disease-and-diabetes-policies-for-better-health-and-quality-of-care-9789264233010-en.htm>

OECD Health: www.oecd.org/health

Obesity and the Economics of Prevention: Fit not Fat: <http://www.oecd.org/health/obesity-and-the-economics-of-prevention-9789264084865-en.htm>

OECD Reviews of Health Systems: Mexico 2015 (forthcoming)
<http://www.oecd.org/health/health-care-quality-reviews.htm>