

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

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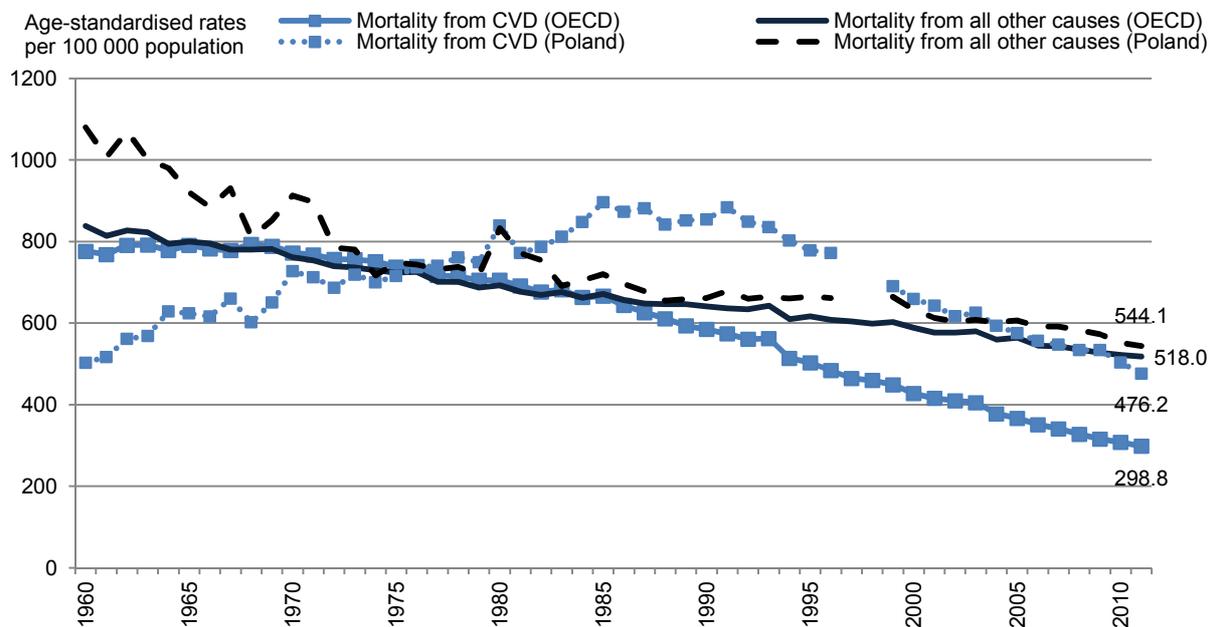


## Country Note – Poland

**In Poland, the mortality due to cardiovascular diseases (CVD) is still high and the burden of CVD and diabetes is also high**

The mortality from CVD has decreased in recent decades after its peak in mid-1980s at a slightly faster pace than many other OECD countries but it is still higher than the OECD average, at 476 per 100 000 population in 2011, 59% higher than the OECD average of 299 (Figure 1). Potential years of life lost, a commonly used measure of premature mortality, at 1 079 per 100 000 population for diseases of the circulatory system in 2011, is 83% 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 prevalence of diabetes is 9.2%, higher than the OECD average of 6.9%, and early onset of diabetes is more prevalent than elsewhere (12.2% for people aged 40-59 and 3.7% for people aged 20-39, compared to an OECD average of 8.9% and 1.7%, respectively). Early onset has important implications for a patient’s health status and also for their social and economic status as 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 higher risk of suffering complications.

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

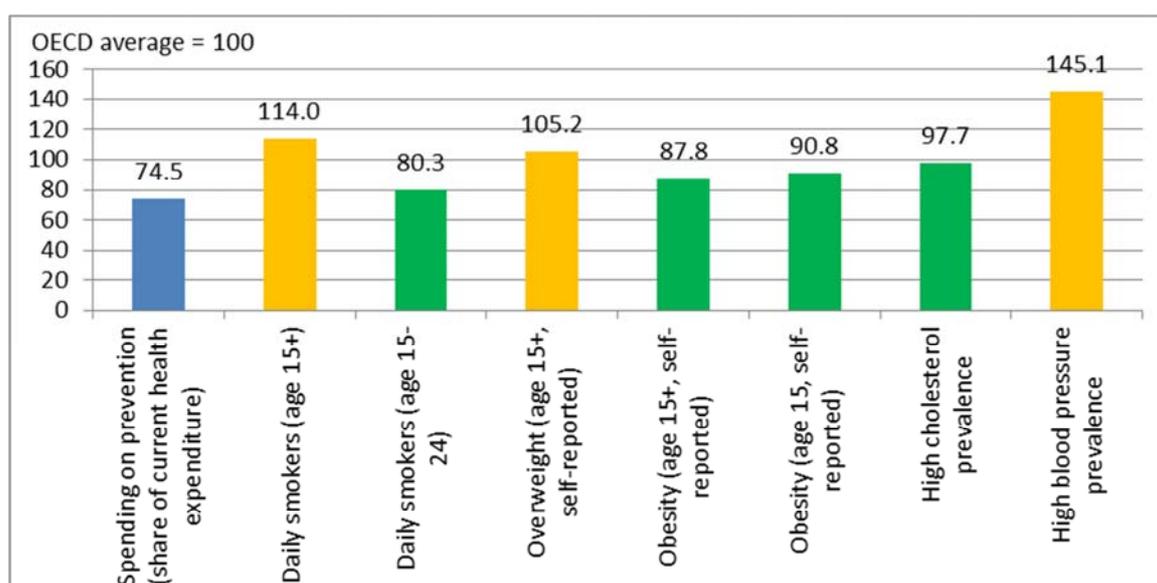


Source: OECD Health Statistics.

## The prevalence of some risky behaviours is high and increasing

Figure 2 shows that for some indicators of prevention and lifestyle, Poland does not perform as well as other OECD countries. Adult smoking rate is 23.8%, compared to an OECD average of 20.9% and it is particularly high for men (30.9% vs the OECD average of 26.0%). The prevalence of overweight, at 36.4%, is higher than the OECD average of 34.6% while the prevalence of obesity among adults and children are lower than the OECD average (15.8% vs 18.0% and 13.5% vs 14.9%, respectively). But both overweight and obesity prevalence are increasing rapidly while some OECD countries have managed to contain the increase in recent years. The reported prevalence of high blood pressure is at 37.2%, much higher than the OECD average of 25.6%. The spending on prevention, at 2.1% of the current health expenditure, is lower than the OECD average of 2.9% and more could be done to promote healthy lifestyles.

**Figure 2. Prevention and healthy lifestyle related to CVD and diabetes in Poland, 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.

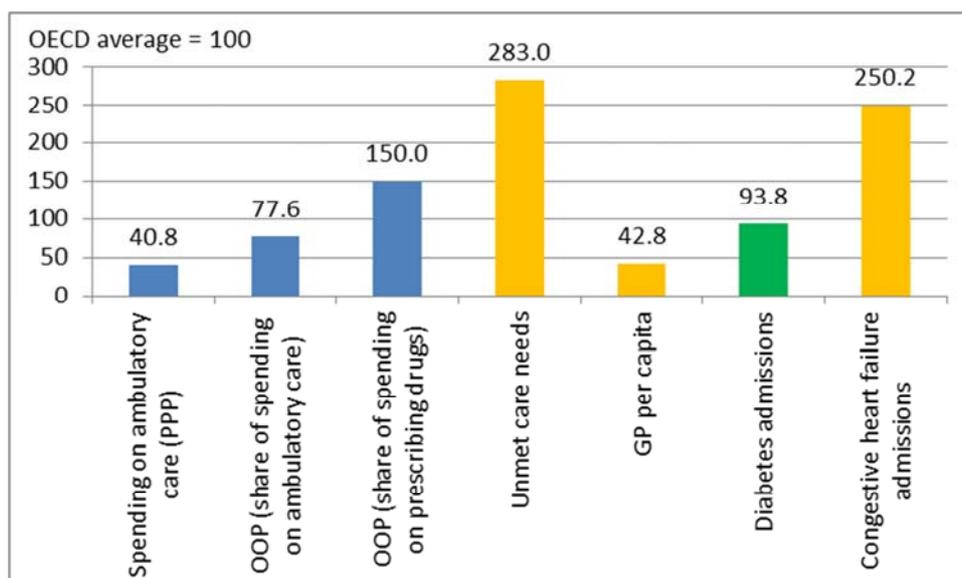
Source: OECD Health Statistics.

## Access to primary care may not be as good and quality can be improved

Resources in and access to primary care may not be optimal in Poland (Figure 3). Spending on ambulatory care in 2011, at 282 USD PPP on a per capita basis, was the lowest in the OECD after Estonia and Hungary. The out-of-pocket payment (OOP) is also much lower than the OECD average, but the share of the population with unmet care needs, at 9.0%, is the highest in the OECD average after Turkey. Based on a study using fasting blood glucose tests, the prevalence of undiagnosed diabetes is almost 30%, higher than few other OECD countries which have such data, and the number of GPs per capita is 0.4 per 100 000 population, less than half the OECD average of 1.0.

As to the quality of primary care for CVD and diabetes, there is also scope for improvement. Hospital admissions for chronic conditions such as diabetes and congestive heart failure can be avoided if high-quality primary care is provided. Although the hospital admission rate in 2011 was 22.3 per 1 000 diabetics slightly lower than the OECD average of 23.8, the rate for congestive heart failure was 6.0 per 1 000 population, two-and-a-half times the OECD average of 2.4.

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



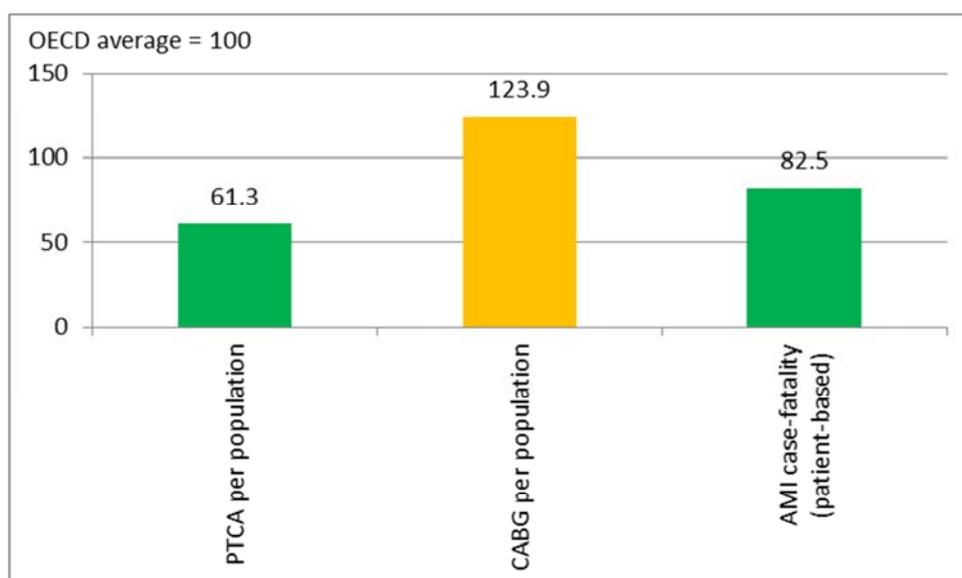
Note: a bar in blue refers to an indicator in which an evaluation needs to be done together with other indicators, a bar in green refers to the value better than the OECD average, and a bar in orange refers to the value worse than the OECD average.

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

#### Access to acute CVD care has been improving but quality is not well known

Poland has increased resources to assure access to acute CVD care in recent years. Although they are still below the OECD average, there are reported to be 111 percutaneous transluminal coronary angioplasty (PTCA) procedures per 100 000 population (Figure 4), 3.6 percutaneous coronary intervention (PCI) centres per million population and 60 cardiologists per million population. Almost all ambulances now carry defibrillators and 70% of stroke patients are treated in specialised stroke units. However, to complete the assessment on access, some data such as hospital spending on CVD and diabetes and the number of coronary artery bypass graft operations (CABG) procedures are not available for international comparisons.

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



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

Source: OECD Health Statistics.

The quality of acute care for CVD is not well known yet in Poland. Based on the patient-based data which allow monitoring patients in and out of hospitals, the 30 day case-fatality rate for patients with AMI has improved in recent years and reached 8.9% in 2011, lower than the OECD average of 10.8%. Recent policy focus may have contributed to the improvement. Poland has started to use the timeliness of intervention as an important process indicator of hospital performance, and emergency room arrival to initiation of angioplasty has reportedly reduced to 30 minutes. The quality of acute care outcomes for stroke patients, however, is not known, although emergency room arrival to initiation of thrombolysis has reportedly been reduced substantially.

### **Poland has developed acute CVD care and more needs to be done to promote healthy lifestyles and strengthen primary care**

Poland has strengthened its hospital sector in recent years supporting it with better information and monitoring systems. In 2004 and 2005, it implemented a number of cardiovascular registries including the National Registry of acute coronary syndromes and the National Registry of cardiac surgical procedures. Acute care targets are set and hospital performance is monitored at a regional level. Further efforts can be made to promote evidence-based medicine by monitoring adherence to clinical guidelines and evaluating quality of acute care particularly for stroke.

Poland needs to turn its attention to strengthen primary care. For example, Denmark has made better use of electronic patient records and shown notable improvements in primary care quality. The system includes data on diagnoses, procedures, prescribed drugs and laboratory results and automatically derives information that can be used to benchmark GP practice against other practices and to improve patient care as it enables the identification of patients treated sub-optimally.

In order to reduce the increasing burden of CVD and diabetes, Poland could also 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 relation to high blood pressure, which is linked with increased level of salt intake, many countries have used a variety of policy instruments to reduce salt intake such as public information, food labelling, taxation, regulation and marketing controls and food reformulation. They have also successfully worked with food industries to set new salt targets for reformulating existing processed food.

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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](http://www.oecd.org/health)