

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

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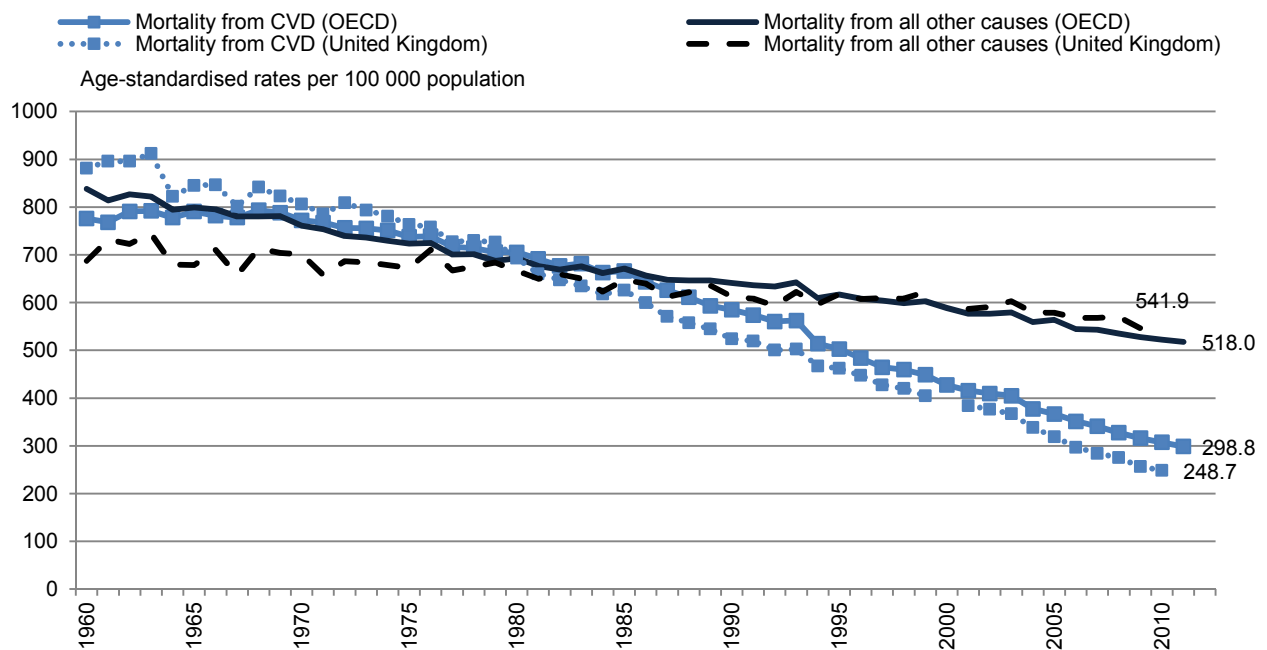


Country Note – United Kingdom

The United Kingdom has been successful at reducing the mortality due to cardiovascular diseases (CVD)

The mortality from CVD has decreased over the past 50 years at a slightly faster pace than the OECD average, reaching 249 per 100 000 population, 17% lower than the OECD average of 299 in 2011 (Figure 1). Likewise, potential years of life lost, a commonly used measure of premature mortality, at 543 per 100 000 population for the diseases of circulatory system in 2011, is 7% lower than the OECD average of 581 (by using the age limit of 70). The prevalence of diabetes is also low at 5.4%, compared with the OECD average of 6.9%. The number of patients with end-stage kidney failure (ESKF), often caused by diabetes and hypertension, is 87 per 100 000 population, lower the OECD average of 101.

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



Source: OECD Health Statistics.

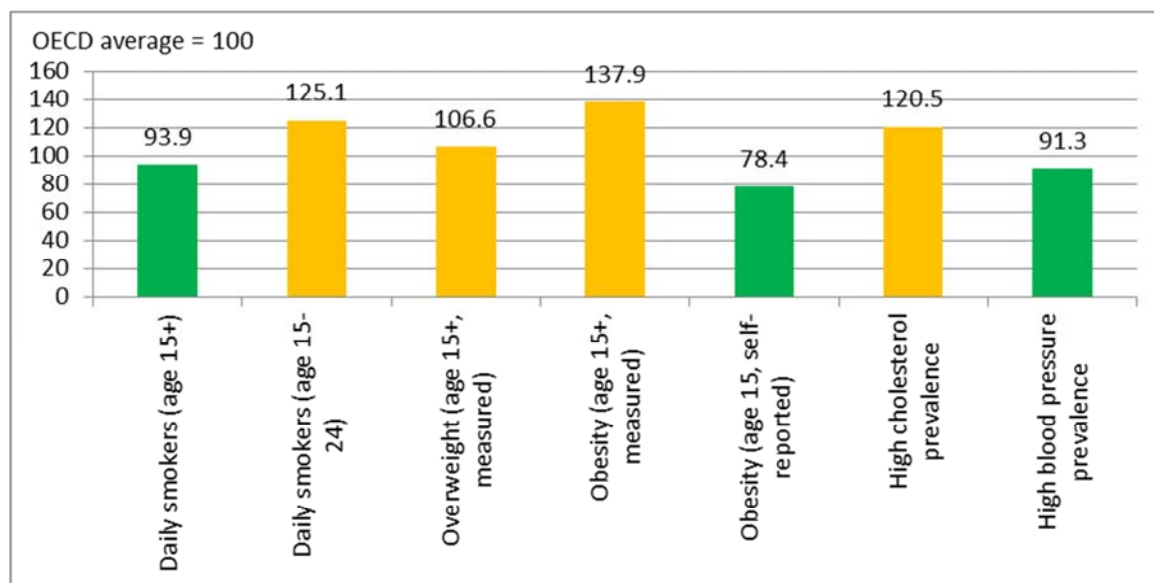
Kidney transplant is an effective treatment and a viable alternative to dialysis for many ESKF patients, and 49% of ESKF patients received a kidney transplant in 2011 while in countries such as Iceland and the Netherlands, the rate was over 60%.

Obesity among adults and smoking among youth are high

Figure 2 shows that for some indicators of prevention and lifestyle, the United Kingdom performs worse than the OECD average. The rate of overweight and obesity, risk factors for CVD, is 36.9% and 24.8% based on

measured data, higher than the OECD average of 34.6% and 18.0% respectively¹, although the growth is becoming stagnant in recent years. The smoking rate for youth, at 24.3%, is also much higher than the OECD average of 19.5% and also higher than the adult smoking rate of 19.6%, although the United Kingdom has a relatively stringent and comprehensive set of anti-tobacco policies in place. The reported prevalence of high cholesterol level, at 21.7%, is also higher than the OECD average of 18.0%. Spending on prevention is not available for international comparison.

Figure 2. Prevention and healthy lifestyle related to CVD and diabetes in the United Kingdom, 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.

On the other hand, the United Kingdom successfully reduced salt intake among their citizens through public information, food reformulation, and food labelling. The average salt intake has decreased by 15%, from 9.5g in 2000/01 to 8.1g in 2011. The reported prevalence of high blood pressure is lower than the OECD average (23.4% vs 25.6%).

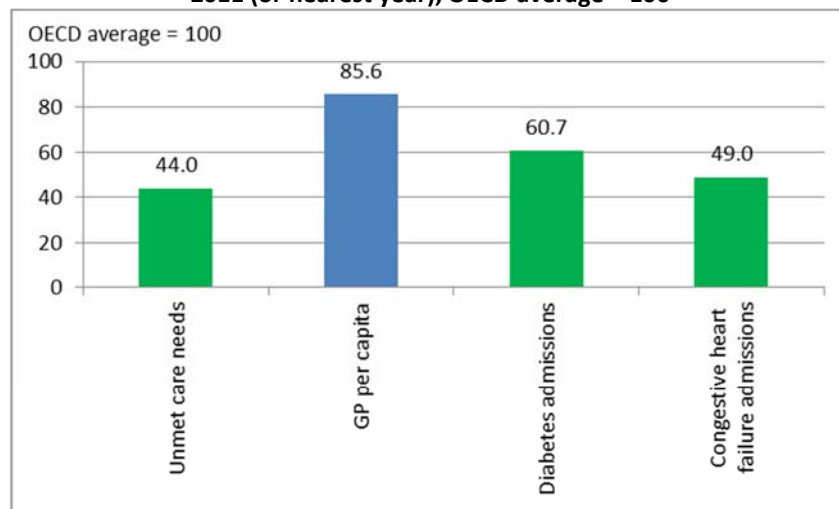
Primary and community care is generally good

Access to primary care seems good in the United Kingdom (Figure 3). The number of Generalist Medical Practitioners is 0.8 per 1 000 population, lower than the OECD average of 1.0, but the share of population with unmet care needs is 1.4%, much lower than the OECD average of 3.2%. The number of defined daily doses (DDD) of drugs such as antihypertensive and cholesterol lowering medications used for CVD risk factors are higher than the OECD average, suggesting that these drugs are accessible. However, spending on ambulatory care and the share of out-of-pocket payment are not available for international comparisons, hence not allowing a fuller assessment on access to primary care.

As to the quality of primary care for CVD and diabetes, this appears to be good. Hospital admissions for chronic conditions such as diabetes and congestive heart failure could be avoided if high-quality primary care is provided. The rate of hospital admissions was 14.5 per 1 000 diabetics, much lower than the OECD average of 23.8. However, based on a study using fasting blood glucose tests, about 20% of diabetic patients are reportedly undiagnosed, although the share is one of the lowest among the few OECD countries which have such data. For congestive heart failure, there are 1.2 hospital admissions per 1 000 population in 2011, half of the OECD average of 2.4.

¹ The OECD average of overweight and obesity includes data based on self-reporting which are typically lower than the measured figures, from over a half of its countries.

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



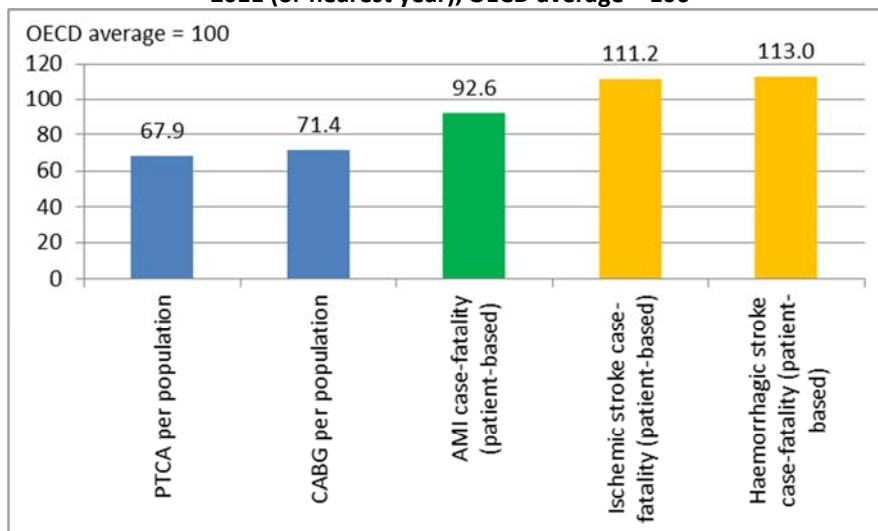
Note: a bar in blue refers to an indicator in which an evaluation needs to be done together with other indicators, and a bar in green refers to the value better than the OECD average.

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 improving

The quality of acute care for CVD is good in the United Kingdom. Based on the patient-based data which allow monitoring patients in and out of hospitals, the 30-day case-fatality rates for patients with Acute Myocardial Infarction (AMI) is 10.0%, lower than the OED average of 10.8%. However, the numbers of cardiologists, and percutaneous transluminal coronary angioplasty (PTCA) and coronary artery bypass graft (CABG) procedures are lower than the OECD averages (Figure 4). In addition, despite a substantial increase in recent years, the number of percutaneous coronary intervention (PCI) centres is still lower than many other OECD countries at 1.9 per million population.

Figure 4. Acute care related to CVD and diabetes in the United Kingdom, 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.

30-day case fatality rates for Ischemic and Haemorrhagic stroke has been improving, reaching 12.4% and 33.7%, close to the OECD average of 11.1% and 29.8%, respectively.

30-day case fatality rates for Ischemic and Haemorrhagic stroke has been improving, reaching 12.4% and 33.7%, close to the OECD average of 11.1% and 29.8%, respectively. The reduction of the case-fatality rate over time for Ischemic stroke is much faster than in many other OECD countries in recent years. The progress may be also related to the increase in access to specialised stroke care; as part of a concerted effort under the National Stroke Strategy, the share of stroke patients treated in dedicated facilities has increased nearly four-fold since the early 2000s, reaching 93%.

The United Kingdom has intensified its efforts to improve quality of care, but more can be done to reduce some risk factors of CVD and diabetes

The United Kingdom has increased its focus to promoting quality improvement in recent years. In primary care, the Quality and Outcomes Framework (QOF), established in 2004, rewards GPs for the proper management of some of the most common chronic diseases including diabetes, how well the practice is organised and how patients view their experience at the surgery, leading to some quality improvement. However, given the cost of QOF, there has been debate about the scheme's cost-effectiveness. The United Kingdom also introduced health checks for people aged 40-74 to systematically address the top seven causes of preventable mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Recognising the importance of empowering patients to take effective control of their chronic diseases, the United Kingdom has been promoting self-management through different measures. The contracts for GPs encourage them to promote self-management among patients. Furthermore, the Skills for Health Organisation was established to help create a skilled and flexible health care workforce by developing national workforce competency frameworks to improve the scope and capacity of health professionals to support the chronic disease agenda, including better self-care.

The United Kingdom has successfully reduced some risk factors such as smoking and salt intake in recent years by implementing multifaceted and comprehensive strategies, but more needs to be done to promote healthy lifestyles. Australia, for example, has introduced a number of innovative anti-tobacco programmes and regulations, including its plain-packaging laws which ban branding and logos on all tobacco product packaging, and tobacco products must be sold in drab dark brown packaging and labelled with updated and expanded health warnings. Similarly, in the United Kingdom, standardised tobacco packaging legislation will come into force in 2016. To fight against obesity, the United Kingdom has introduced nationwide health promotion programmes and has engaged in voluntary partnership work with the food industry to drive reformulation of products and provide healthier choices to consumers. Denmark, Finland, France, Hungary, and Mexico have also introduced taxes on unhealthy food and/or sugar-sweetened non-alcoholic beverages in recent years. The UK government is consulting on sugar reduction policies, and it should be noted that combining these single interventions in comprehensive strategies results in a more effective and efficient approach because it increases the coverage of groups at risks and exploits potential synergies across the different interventions.

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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

OECD Reviews of Health Care Quality: United Kingdom – Raising Standards (forthcoming)

<http://www.oecd.org/els/health-systems/health-care-quality-reviews.htm>