

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

June 2015

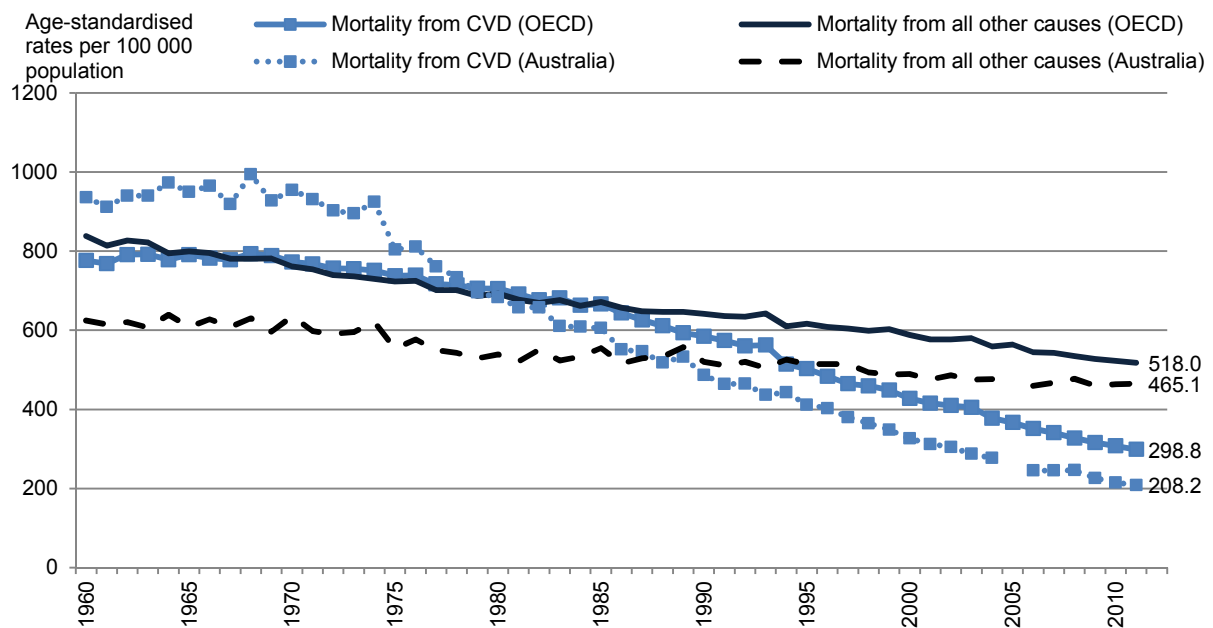


## Country Notes – Australia

**Australia has been successful at reducing the mortality due to cardiovascular diseases**

The mortality from cardiovascular diseases (CVD) has decreased over the past 50 years at a faster pace than the OECD average, reaching 208 per 100 000 population, 30% 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 372 per 100 000 population for diseases of the circulatory system in 2011, is 36% lower than the OECD average of 581 (by using the age limit of 70). The reported prevalence of diabetes is 6.8%<sup>1</sup>, slightly lower than the OECD average of 6.9%. Furthermore, the number of patients with end-stage kidney failure (ESKF), often caused by diabetes and hypertension, is 88 per 100 000 population, compared to an OECD average of 101.

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



Source: OECD Health Statistics.

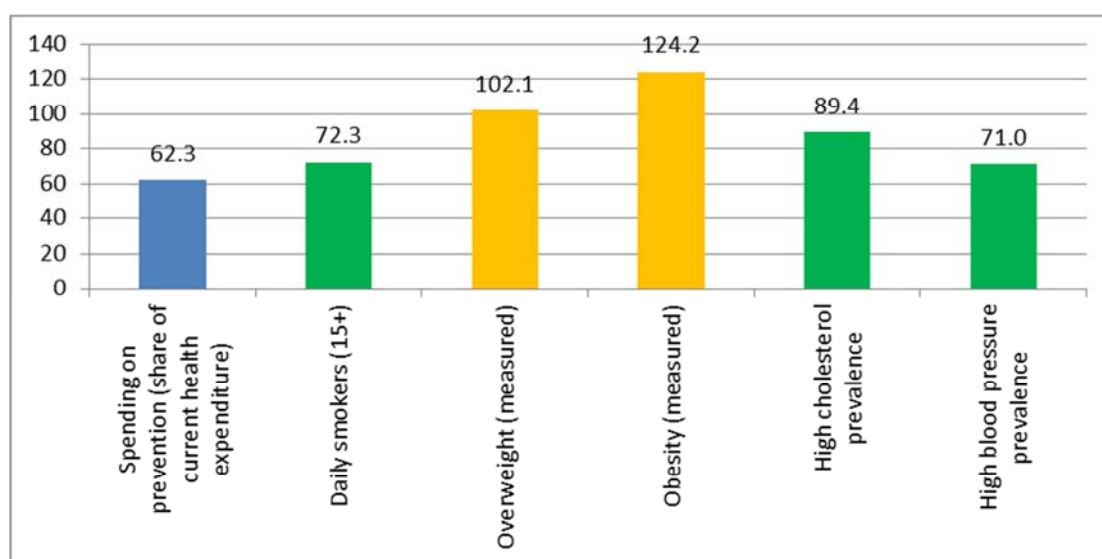
Kidney transplant is an effective treatment and a viable alternative to dialysis for many ESKF patients, but 44% of ESKF patients received a kidney transplant in 2011 while in countries such as Iceland and the Netherlands, the rate was over 60%. Australia has been making an effort to increase transplants by introducing paired kidney exchanges which allow the donation of a kidney from an incompatible donor/recipient pair to a compatible recipient and covering the cost of taking a leave from work for organ donation.

<sup>1</sup>Data source is International Diabetes Federation. Based on the Australian Bureau of Statistics 2011-12 Australian Health Survey, the diabetes prevalence is 5.2% in 2011-12 for the Australian population aged 18 years and over.

**The Australian population generally has a healthy lifestyle but obesity, one of the CVD and diabetes risk factors, is high and increasing**

Figure 2 shows that for some indicators of prevention and lifestyle, Australia performs better than the OECD average. The rate of smoking, one of the risk factors for CVD, has declined faster than in many OECD countries after the introduction of a comprehensive set of tobacco control measures which included a large excise increase on tobacco products, reaching one of the lowest in the OECD after Iceland, Sweden and the United States, at 15.1%<sup>2</sup> in 2010, compared to an OECD average of 20.9%. In 2012, Australia introduced plain packaging laws which ban branding and logos on all tobacco product packaging. Tobacco products must be sold in drab dark brown packaging and labelled with updated and expanded health warnings. The reported prevalence of high cholesterol level and blood pressure, at 16.1% and 18.2%, is also lower than the OECD average (18.0% and 25.6%, respectively).

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

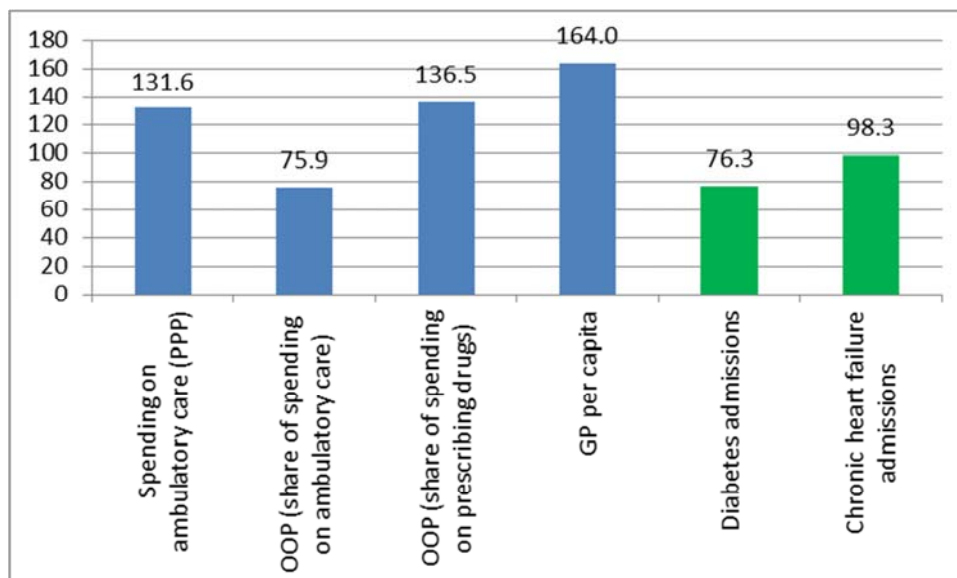
Despite this positive outlook, the rate of obesity continues to increase, reaching 28.3%, higher than the OECD average of 18.0%. Spending on prevention is 1.8% of the current health expenditure, lower than the OECD average of 2.9%, and more could be done to reduce obesity.

**Primary care is generally good**

Access to primary care is generally good in Australia (Figure 3). Spending on ambulatory care in 2011 was 910 USD PPP on a per capita basis, higher than the OECD average of 691, and out-of-pocket payment (OOP) is higher than the OECD average; 134 USD PPP on ambulatory care, compared to the OECD average of 100 USD PPP. But to protect people with chronic diseases and to assure access to care, additional coverage is available on the basis of income, age and health status. The number of defined daily doses (DDD) of antihypertensive medications is about the OECD average but that of cholesterol lowering medications, at 0.7, is the highest in the OECD, suggesting that the access to drugs for CVD risk factors is good and reliance is particularly great for cholesterol lowering drugs. Access to GPs is also relatively easy as there are 1.6 GPs per 1 000 population, higher than the OECD average of 1.0.

<sup>2</sup> The smoking rate has declined even more in recent years and it is 12.8% in 2014 (14 years and older) (Australian Institute of Health and Welfare 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. No. PHE 183. Canberra: AIHW)

**Figure 3. Primary care related to CVD and diabetes in Australia, 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.

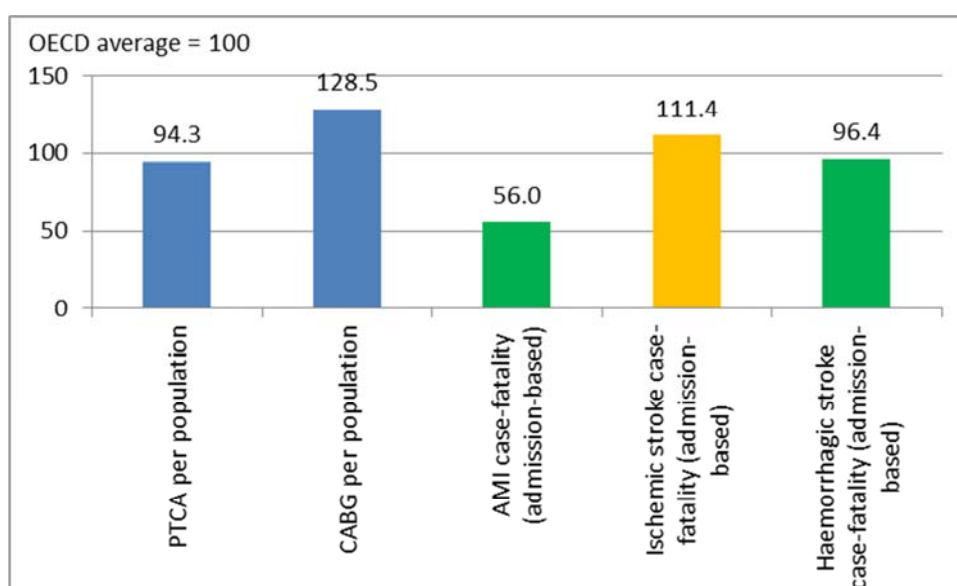
Source: OECD Health Statistics; Diabetes prevalence: IDF (2013), IDF Diabetes Atlas, 6th Edition, International Diabetes Federation, Brussels, [www.idf.org/diabetesatlas/previouseditions](http://www.idf.org/diabetesatlas/previouseditions).

The quality of primary care for CVD and diabetes in Australia is relatively good. Hospital admissions for chronic conditions such as diabetes and congestive heart failure can be avoided if high-quality primary care is provided. The rate of hospital admissions was 18.2 per 1 000 diabetics, and for congestive heart failure, 2.3 per 1 000 population in 2011, lower than the OECD average of 23.8 and 2.4 respectively.

#### Quality of acute CVD care is good but some aspects of access is not well known

The quality of acute care for CVD is good in Australia (Figure 4). The 30-day case-fatality rate for patients with Acute Myocardial Infarction (AMI) is 4.4%, one of the lowest in the OECD. The case-fatality for Ischemic and Haemorrhagic stroke are about the OECD average (9.4% and 21.8%, compared to the average of 8.4% and 22.6%) while the share of stroke patients treated in dedicated facilities, at 78%, is higher than in many other OECD countries.

**Figure 4. Acute care related to CVD and diabetes in Australia, 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.

Some data on resources in acute care in relation to CVD and diabetes are available. The number of percutaneous transluminal coronary angioplasty (PTCA) procedures is 170 per 100 000 population, lower than the OECD average of 181, but the number of coronary artery bypass graft (CABG) procedures is 56 per 100 000 population, compared to an OECD average of 43. The number of percutaneous coronary intervention (PCI) centres, at 4.3 per million population, is higher than many OECD countries. Data on the number of specialists such as cardiologists and neurologists and disease-specific spending are not available for international comparisons, although they are sometimes monitored within the country.

### **Australia can do more to reduce obesity and strengthen the health information system**

In order to reduce the burden of CVD and diabetes particularly obesity, Australia is currently developing a National Diabetes Strategy and National Strategic Framework for Chronic Conditions. OECD analyses show that effective prevention strategies are multifaceted and comprehensive, including 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. For example, recently, Denmark, Finland, France, Hungary and Mexico have taken further actions to fight against obesity through the introduction of taxes on unhealthy food and/or sugar-sweetened non-alcoholic beverages, and Switzerland, the United Kingdom and the United States also introduced nationally co-ordinated health promotion programmes to increase physical activities. 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.

Australia can further strengthen health information infrastructure to promote high-quality care for CVD and diabetes across providers. For example, Denmark has made better use of electronic patient records and has 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.

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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)

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 Care Quality: Australia – Raising Standards (forthcoming): <http://www.oecd.org/els/health-systems/health-care-quality-reviews.htm>