

3. MORTALITY FROM CARDIOVASCULAR DISEASES

Cardiovascular diseases (CVD) are the number one cause of death globally and were estimated to have caused 1.8 million annual deaths in the WHO Region of the Americas (PAHO, 2017[6]). CVD covers a range of diseases related to the circulatory system, including ischaemic heart disease (IHD) and cerebrovascular disease. Ischemic heart disease is caused by the accumulation of an atherosclerotic plaque in the inner wall of a coronary artery, restricting blood flow to the heart. Cerebrovascular diseases refer to a group of diseases that relate to problems with the blood vessels that supply the brain. Common types of cerebrovascular disease include ischemic stroke, which develops when the brain's blood supply is blocked or interrupted, and haemorrhagic stroke which occurs when blood leaks from blood vessels onto the subarachnoid space (subarachnoid haemorrhage) or within the brain (intracerebral haemorrhage).

The majority of CVD is caused by risk factors that can be controlled, treated or modified, such as high blood pressure, high blood glucose (see section “Blood glucose and high blood pressure” in Chapter 5), high blood cholesterol, obesity (see section “Overweight or obese adults” in Chapter 4), lack of physical activity (see section “Physical activity” in Chapter 4), tobacco use (see section “Tobacco” in Chapter 4) and excessive alcohol consumption (see section “Alcohol” in Chapter 4).

CVD is the leading cause of death in the LAC region (see section on “Mortality from all causes”). Average mortality from CVD decreased both in LAC and OECD between 2000 and 2017, although the reduction was considerably smaller in LAC (-18% versus -35%) (Figure 3.11). Countries like Peru, Belize and Colombia have experienced the largest decreases in CVD mortality rates of over -35% in the period, being the only LAC countries above the OECD average reduction. Notably, Dominican Republic is the only country that has increased CVD mortality from 211 to 267 deaths per 100 000 population in the period.

Mortality from CVD exceeded 300 deaths per 100 000 population among men in Suriname, Dominican Republic, Haiti and Guyana in 2017 (Figure 3.12). Peru, Nicaragua, Colombia, Panama, Chile and Ecuador were the countries below the OECD average of 162 male deaths per 100 000 population. For women, the highest rates were observed in Haiti and Guyana, with 473 and 340 deaths per 100 000 population, respectively. In contrast, Peru had the lowest figures for women in the region, with 78 deaths per 100 000 population being the only country below the OECD average of 103.

Together, IHD and stroke comprise 78% of all CVD deaths in all LAC countries combined, very similar to the 77% in OECD

countries, but hypertensive deaths in LAC are almost double than in the OECD (8% versus 5%) (Figure 3.13). IHD deaths represent over 60% of all CVD deaths in El Salvador, Honduras and Mexico, while less than 35% in Saint Lucia, Jamaica and Dominica. In Jamaica, stroke deaths take 45% of all CVD deaths while is less than 23% in El Salvador, Costa Rica, Mexico and Argentina.

Success of reducing the mortality rates from CVD in OECD countries owes to a decline in smoking rates, expanded health system's capacity to control high cholesterol and blood pressure, and greater access to effective care in the event of an acute episode such as a stroke or heart attack (see indicator “In-hospital mortality following acute myocardial infarction and stroke” in Chapter 7) (OECD, 2015[9]). As the proportion of older people increases in the LAC region (see section “Ageing” in Chapter 3), demand for health care will increase and the complexity and type of care that CVD patients require will change, for instance, due mounting multi-morbidity. Increases in total cholesterol and blood pressure, along with smoking, overweight/obesity and high blood glucose highlight the need for management of risk factors to prevent further development of CVD. In addition to efforts to improve lifestyles, primary care needs to be strengthened and quality of acute care also needs to improve through better emergency care and improved professional skills and training capacity (OECD, 2015[9]).

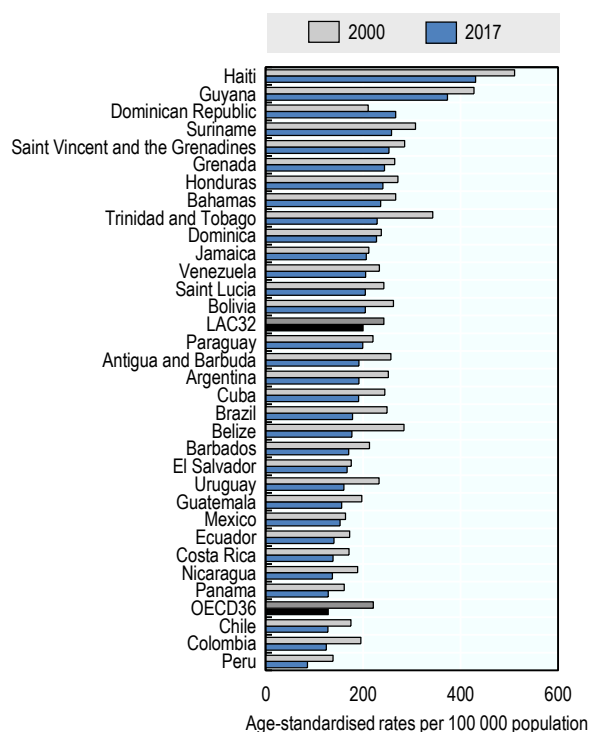
Definition and comparability

See indicator “Mortality from all causes” in Chapter 1 for definition, source and methodology underlying mortality rates.

References

- [9] OECD (2015), *Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care*, OECD Health Policy Studies, OECD Publishing, Paris, <https://dx.doi.org/10.1787/9789264233010-en>.
- [6] PAHO (2017), *Health in the Americas+, 2017 Edition. Summary: Regional Outlook and Country Profiles*, Pan American Health Organization, Washington, D.C., <https://www.paho.org/salud-en-las-americas-2017/wp-content/uploads/2017/09/Print-Version-English.pdf>.

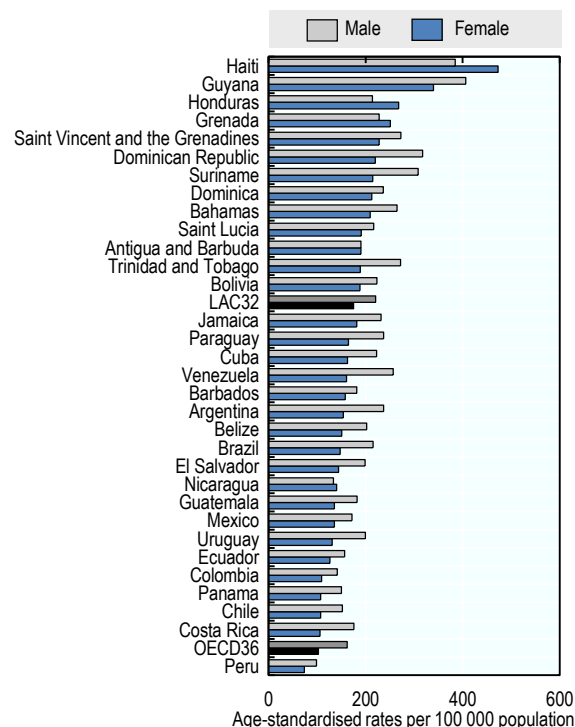
Figure 3.11. Cardiovascular disease, estimated mortality rates, 2000 and 2017 (or nearest year)



Source: Global Burden of Disease (2019), IHME.

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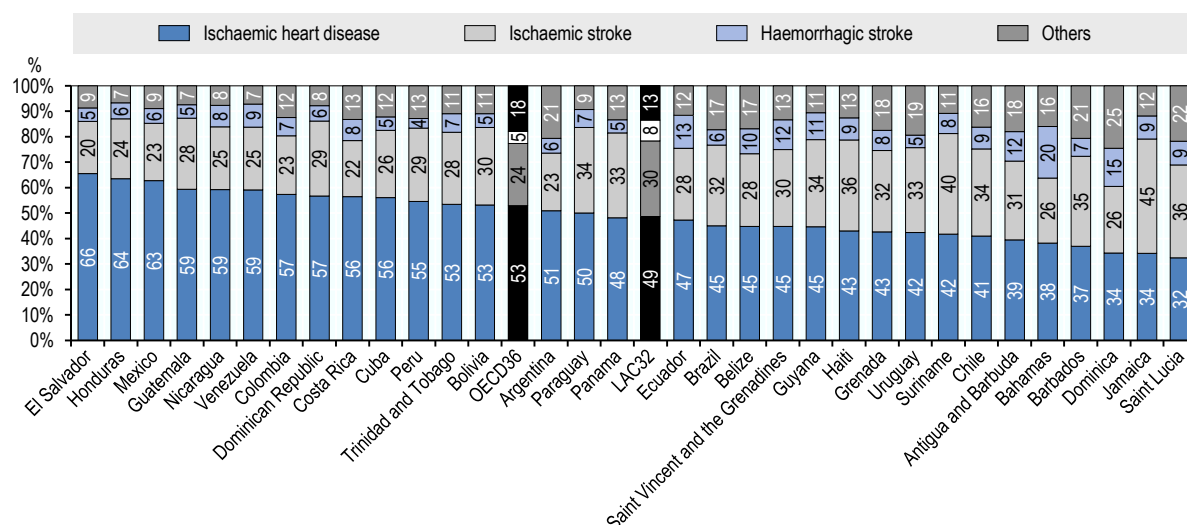
Figure 3.12. Cardiovascular disease, estimated mortality rates, by sex, 2017 (or nearest year)



Source: Global Burden of Disease (2019), IHME.

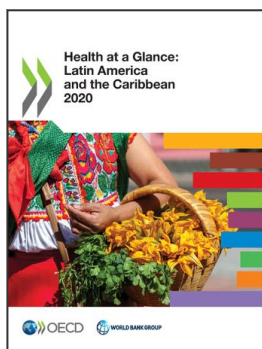
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Figure 3.13. Proportions of deaths per type of cardiovascular disease, 2017 (or nearest year)



Source: Global Burden of Disease (2019), IHME.

StatLink <https://stat.link/oxk94a>



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