

Ischaemic heart diseases and stroke were two major causes of death in Latin America in 2017, accounting for 78% of all cardiovascular diseases (CVD) deaths in LAC countries combined, very similar to the 77% in OECD countries (see Chapter 3, 'Mortality from cardiovascular diseases'). Additionally, both are associated with significant health, economic, social and non-financial costs, because of the persistent disabilities suffered by many survivors. Treatment following acute myocardial infarction (AMI) and stroke has advanced greatly over the past decade. The introduction and diffusion of new technologies such as cholesterol and blood pressure lowering medications, thrombolysis and angioplasty over recent decades have had a marked effect on the quality of cardiovascular care (OECD, 2015[4]).

Case-fatality rate is a useful measure of acute care quality for both AMI and stroke. It reflects the processes of care, such as effective medical interventions, including early thrombolysis, angioplasty or treatment with aspirin when appropriate and co-ordinated and timely transport of patients, but may be also influenced by individual characteristics such as the severity of AMI and stroke. For AMI, age-sex standardised in-hospital case fatality rates within 30 days of admission was reported as very low in Costa Rica (0.3%), while the highest rates are in Mexico (28.1%) (Figure 7.4), much higher than the OECD average (6.9%).

For ischaemic stroke, the lowest case-fatality rates was reported in Costa Rica (2.7%), the only country below the OECD average of 7.7%. Mexico reported the highest rate of 19.2%, while Uruguay and Chile were also over the OECD average (Figure 7.5).

Fatality rates for haemorrhagic stroke are significantly higher than for ischaemic stroke, and countries that achieve better survival for one type of stroke also tend to do well for the other. Again, the lowest case-fatality rates for haemorrhagic stroke were reported in Costa Rica (1.6%) with Mexico and Uruguay reporting the highest rate: 29.9% and 30.5%, respectively (Figure 7.6). Chile, with a fatality-rate of 21.3%, was below the average of 24% in OECD countries.

Since very few countries in the region can report this type of quality of care data, efforts can be put in place to develop their health system information infrastructure, along with capacity building to produce and use the information. In terms of policies, while the promotion of healthier lifestyles to reduce CVD burden is a priority,

efforts can be also done to improve care for patients with CVD. For instance, ensuring primary care is financially accessible to everyone and the gap between recommended care and care provided in practice is closed, while improving accountability and transparency of primary care performance is key. In addition, establishing a national framework to improve quality of acute care of CVD and set national standards for the measurement and continuous quality improvement of emergency services and care provided in hospitals can help to address the complexity of treating CVD (OECD, 2015[4]).

Definition and comparability

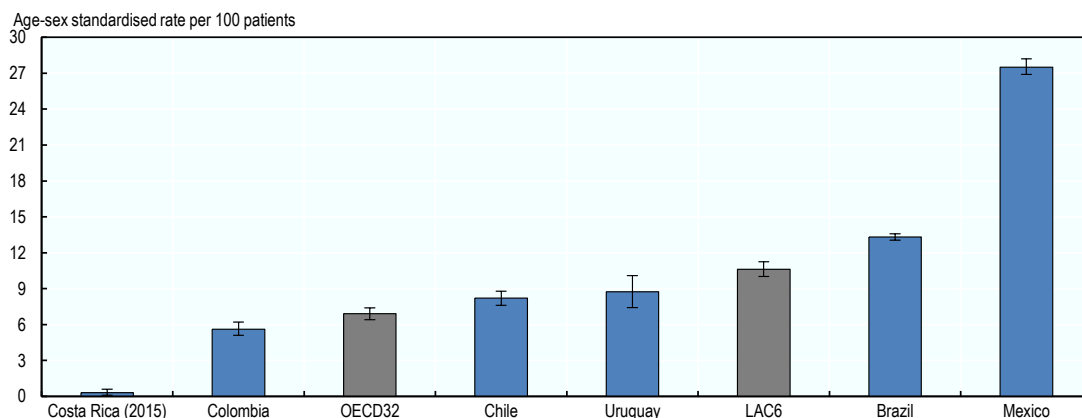
The in-hospital case-fatality rate following AMI, ischemic and haemorrhagic stroke is defined as the number of people who die within 30 days of being admitted to hospital. This indicator is based on unique hospital admissions and restricted to mortality within the same hospital, differences in practices in discharging and transferring patients may influence the findings. Standardised rates adjust for differences in age (45+ years) and sex and facilitate more meaningful international comparisons.

Data presented here do not take account of patients that are transferred to other hospitals during their care or reflect patients who died out of hospitals within 30 days. Using a unique patient identifier patient data can be linked across hospitals and with death registers to generate more robust indicators for national monitoring and international comparison. Currently, very few countries in Latin America and the Caribbean can track patients in this way and hence this form of indicator is not shown here.

References

- [4] 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>.

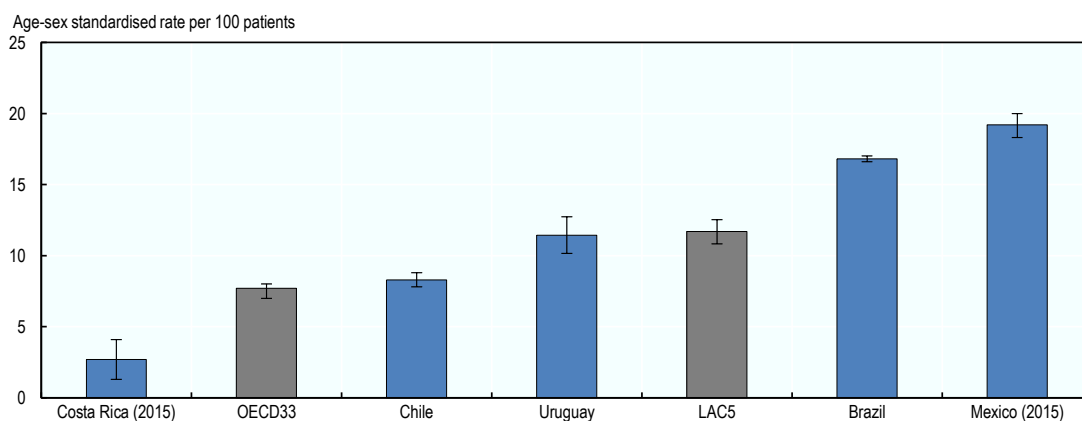
Figure 7.4. In-hospital case-fatality rates within 30 days after admission for AMI, patients 45 years old and over, 2017



Source: OECD Health Statistics 2019 and Ministries of Health of Brazil and Uruguay.

StatLink  <https://stat.link/myp8f4>

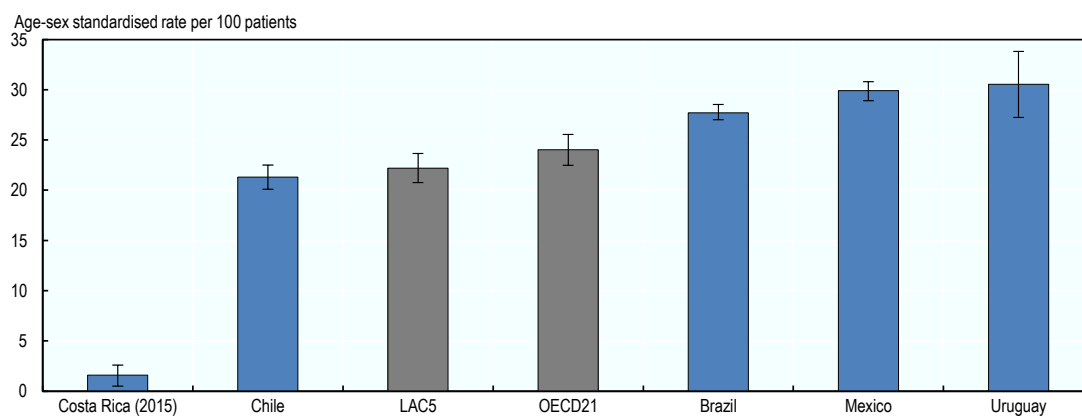
Figure 7.5. In-hospital case-fatality rates within 30 days after admission for ischemic stroke, patients 45 years old and over, 2017 (or nearest year)



Source: OECD Health Statistics 2019 and Ministries of Health of Brazil and Uruguay.

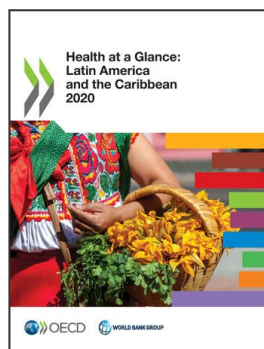
StatLink  <https://stat.link/y9m6zs>

Figure 7.6. In-hospital case-fatality rates within 30 days after admission for haemorrhagic stroke, patients 45 years old and over, 2017 (or nearest year)



Source: Health Statistics 2019 and Ministries of Health of Brazil and Uruguay.

StatLink  <https://stat.link/mv91rj>



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