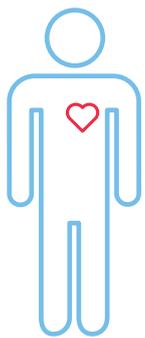


Secondary prevention of

# HEART ATTACK AND STROKE

# in Belgium

## MORE THAN



**405,000**

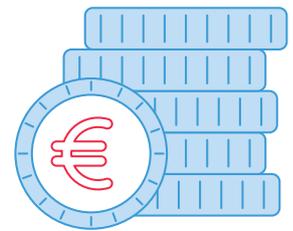
people are living with  
coronary heart disease<sup>1</sup>

**138,000**

people have survived  
a stroke<sup>1</sup>

## THE DIRECT COST

of coronary heart disease  
and cerebrovascular  
disease to the  
healthcare system is



**€792 m** per year<sup>2</sup>

People who experience  
heart attack or  
stroke often face  
an unnecessarily

## HIGH RISK OF REPEAT EVENTS



of heart attack patients  
in Belgium are  
readmitted to hospital  
within one year<sup>3</sup>

## MANY REPEAT HEART ATTACKS AND STROKES COULD BE AVOIDED.

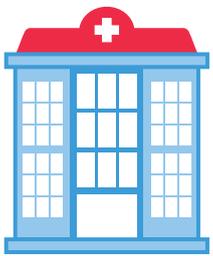
**Secondary prevention** can mitigate the risk of a subsequent heart attack or stroke through comprehensive risk factor management, combining rehabilitation, preventive medication and lifestyle change.<sup>4,5</sup> Long-term maintenance of risk factor control is key to achieving successful secondary prevention.

**Note:** Coronary heart disease is characterised by a build-up of plaque in the arteries that serve the heart. The most dangerous consequence of coronary heart disease is heart attack. Cerebrovascular disease is a collection of conditions which affect the blood vessels of the brain. The most common cerebrovascular disease is stroke, which is classified as a neurological disease. In this summary, we have used data specific to heart attack and stroke, where available.

# WHAT IS THE CURRENT SITUATION?



Secondary prevention for heart attack and stroke involves specialist acute care, structured rehabilitation and long-term management in primary care. Systemic gaps and inequalities in the availability of such care are putting people at an increased risk of repeat events.



## Acute stage interventions for secondary prevention are widely applied in heart attack but are less formalised in stroke

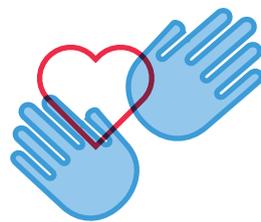
Heart attack and stroke patients should be treated in a specialist acute care setting. This helps ensure that secondary prevention is initiated while the person is still in hospital.



The majority of heart attack patients are prescribed the appropriate risk factor controlling medication at hospital discharge, with 96% given antiplatelets, 94% statins and 87% beta blockers.<sup>6</sup>



The lack of a formal accreditation process for stroke units means that it is unclear whether people who have had a stroke consistently receive guideline-recommended care.<sup>7</sup>



## Structured rehabilitation is underused

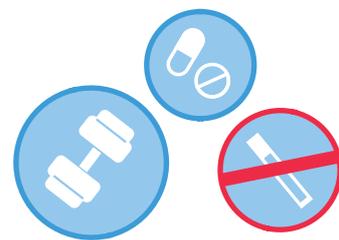
Secondary prevention should continue seamlessly following discharge from hospital. This is best achieved through a structured rehabilitation programme, such as cardiac rehabilitation.



More than 52,000 cardiac patients can miss out on cardiac rehabilitation each year due to a lack of facilities.<sup>8</sup>



A shortage of multidisciplinary rehabilitation teams in the community means that many stroke patients miss out on structured rehabilitation.<sup>7,9</sup>



## Risk factor control during long-term management does not meet guideline recommendations

After a heart attack or stroke, people require lifelong medication and lifestyle changes to lower their risk factors, such as high cholesterol and smoking.



43% of people had high blood pressure and 33% had high cholesterol more than six months after a heart attack.<sup>10</sup>



Only 50% of stroke patients received cholesterol-lowering medicines.<sup>11</sup>

### GOOD PRACTICE:

**Stroke Coach<sup>12</sup> is a nurse-led self-management programme developed to reduce the risk of repeat stroke. Using a digital platform, nurses provide advice on implementing a healthy lifestyle, acting as a personal coach. The goal of the programme is to improve risk factor control in the participants.**



## There is no **dedicated policy** addressing heart attack and stroke

Goal-oriented policies and strategies are vital to set clear targets and boost investment in best-practice secondary prevention.



There is no overarching national strategy for cardiovascular disease, nor for heart attack or stroke specifically.



## Advocacy for secondary prevention of heart attack and stroke is falling short on increasing national awareness

Advocacy efforts, such as targeted campaigns, help increase public and political awareness. They may stimulate action at the service delivery and policy levels.

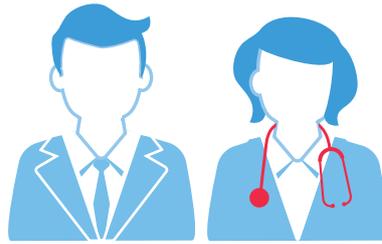


Public awareness of secondary prevention for heart attack and stroke is limited. Current efforts mainly focus on patient education.<sup>13-15</sup>



### **GOOD PRACTICE:**

In 2011, the Belgian Cardiology League ran a campaign called 'Heart attack: Take life to heart!'. The campaign raised awareness of critical care, rehabilitation and secondary prevention.<sup>16</sup>



## Clinical leadership is striving to improve clinical practice in secondary prevention

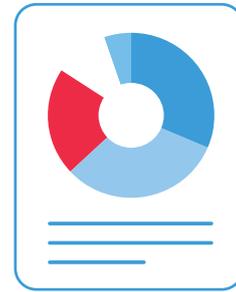
Clear, practice-oriented guidelines foster knowledge among healthcare professionals and implementation of best-practice care.



Endorsement of clinical guidelines varies among cardiac professionals, complicating care provision for secondary prevention along the pathway.<sup>17,18</sup>



The Belgian Stroke Council has published recommendations for stroke care. However, the quality control processes it recommends have not been legislated and there is currently no process to monitor guideline adherence.<sup>19-21</sup>



## There is a lack of **national registries** to collect comprehensive data on heart attack and stroke

Data on treatment, outcomes and quality of care after the acute phase are needed to monitor, plan and assess care services for secondary prevention.



In heart attack, a national acute care registry collects limited data relevant to secondary prevention,<sup>22</sup> and there is no comprehensive national registry covering the post-acute stage.



No national stroke registry exists, and there is no process to embed quality indicators in clinical practice and monitor service provision for secondary prevention.<sup>23</sup>

# WHAT ARE THE OPPORTUNITIES FOR IMPROVEMENT?

**Effective secondary prevention in heart attack and stroke requires a comprehensive package of interventions coordinated by a multidisciplinary team across all care settings.**

Currently, patients in Belgium face systemic barriers and inequalities in accessing secondary prevention at all stages of care, from acute care to long-term management.

Addressing these gaps represents a major opportunity to improve outcomes and potentially reduce national healthcare spending associated with repeat events.

**Increasing access to structured rehabilitation** is an area where significant improvements could be

made, with too few rehabilitation centres existing and limited service provision in the community. Considerable benefits could also be gained during long-term management by **bringing risk factor control in line with guidelines**. To take advantage of these opportunities, **national and regional plans for secondary prevention** will likely be needed to direct the standardisation of care. This will be aided by **improved data collection** to monitor and assess health service performance across the country. Encouragingly, clinical leadership has led to the development of some **good-practice models**, such as Stroke Coach, which could serve as templates for future improvement efforts.

To find out more about this project and read the full country profile on Belgium, please see <https://hpolicy.co/secondaryprevention>

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