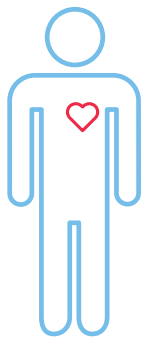


Secondary prevention of

HEART ATTACK AND STROKE

in Poland

MORE THAN



1.5 million

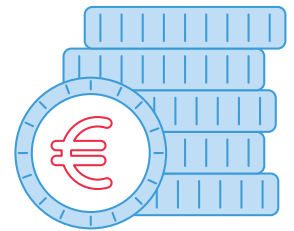
people are living with
coronary heart disease¹

620,000

people have survived
a stroke¹

THE DIRECT COST

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



€1.39 bn per year²

The number of people
affected by heart attack
and stroke in
Poland is rising.

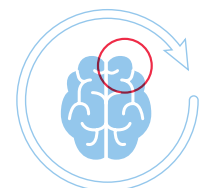
**CARDIAC DISEASE
IS PREDICTED
TO INCREASE** by

13%
by 2025³

People who experience heart attack or stroke often face
an unnecessarily high risk of repeat events.

In 2015 in the Silesian province,

20.1%



of all stroke hospitalisations were for a repeat stroke⁴

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.^{5,6} 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?

Poland

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.



Although heart attack patients usually receive **specialist acute care**, this is not the case for stroke patients

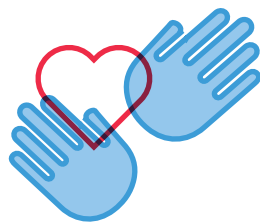
Heart attack and stroke patients should be treated in a specialist acute care setting. This helps ensure that secondary prevention is initiated while the person is still in hospital.



The mortality rate for heart attack patients has significantly improved over the past two decades, and most are treated in cardiac care units.^{3,7}



30% of stroke patients do not receive specialist care in a stroke unit.^{8,9}



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.



Approximately 216,000 people who need cardiac rehabilitation may miss out each year due to a lack of facilities.¹⁰ Access varies widely across regions.^{11,12}



Only 25% of stroke patients are referred to rehabilitation.¹³

GOOD PRACTICE:

In Kraków, cardiac patients received continual education on risk-factor management. This was done through the Patient Club programme initiated in 2014,¹⁴ which was run in addition to regular cardiac rehabilitation. Participation was shown to improve dietary habits, physical activity levels and risk factor control.



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.



Data from five hospitals in southern Poland found that recommended targets for key risk factors 6–18 months after a heart attack were not achieved in 43–79% of people.¹⁵



Data from a hospital in Warsaw showed that a number of patients admitted with a second or subsequent stroke had not been receiving guideline-recommended medications. Medications to lower cholesterol and reduce the formation of blood clots had not been received by 41% and 21% of patients, respectively.¹⁶

GOOD PRACTICE:

'After the heart attack'¹⁷ is a comprehensive online platform for people who have had a heart attack. It explains how to keep risk factors under control and signposts users to sources of support.



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.



A number of national heart attack registries exist,¹⁸⁻²⁰ but they focus on acute care outcomes and do not comprehensively monitor secondary prevention.



The national stroke registry collects only limited data related to secondary prevention.²¹

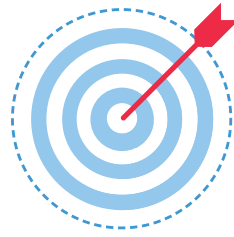


Advocacy for secondary prevention of heart attack and stroke is falling short on increasing national awareness

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



Advocacy around secondary prevention of heart attack and stroke is limited. Current efforts mainly focus on patient education.^{8 22}



Cardiovascular diseases have been **increasingly prioritised in health policy** in recent years

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

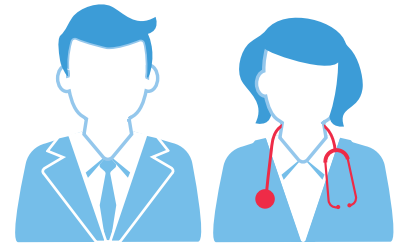


Policymakers have recognised the need for more concerted efforts in the prevention and management of cardiovascular diseases,²³ yet the national cardiovascular health programme for 2017–2020 primarily focuses on improving acute care.³



GOOD PRACTICE:

A government drive to improve care coordination in 2017 has resulted in the development of a fully reimbursed best-practice pathway to improve heart attack patients' post-discharge prognosis – the Managed post-AMI Care Programme (KOS-zawał).^{24 25} Early data suggest that it increases uptake of cardiac rehabilitation, improves follow-up care and reduces major adverse events.²⁴



Clinical leadership is striving to improve clinical practice for secondary prevention

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



The Polish Cardiac Society endorses European Society of Cardiology guidelines covering secondary prevention for heart attack. It aids uptake by translating the guidelines, adding context-specific commentary, and disseminating them among healthcare professionals.²⁶



International guidelines covering secondary prevention are translated, published and discussed by professional medical publications and online platforms.^{27 28}

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 Poland 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 the use of structured rehabilitation,

for example, represents a significant opportunity to improve care, as too few patients currently access such services. There are also significant opportunities for improvement during long-term management, particularly the benefits that could be gained by **bringing medication use for risk factor control in line with guidelines**. Encouragingly, a major new tool is now available to take advantage of these opportunities in the form of the Ministry of Health **best-practice pathway for post-discharge heart attack care (KOS-zawał)**. This may also provide a model for future developments in stroke.

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

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This summary is part of a larger project exploring secondary prevention of heart attack and stroke across Europe. The project was developed by The Health Policy Partnership and initiated and funded by Amgen (Europe) GmbH.