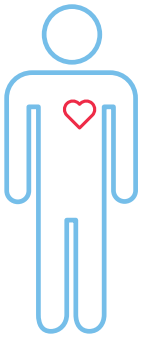
The Health Policy Partnership

Secondary prevention of

HEART ATTACK AND STROKE in Spain

MORE THAN



1.5 million

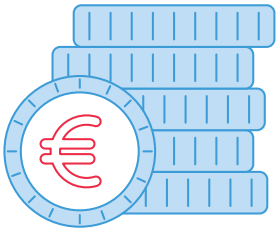
people are living with coronary heart disease[1]

550,000

people have survived a stroke[1]

THE DIRECT COST

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



€2.76 bn per year[2]

INPATIENT CARE

for cardiac patients alone currently accounts for

of hospitals' capacity[3]

Heart attack and stroke are the

two highest

causes of death in Spain[4]

People who survive a heart attack or stroke often face an unnecessarily

HIGH RISK OF REPEAT EVENTS

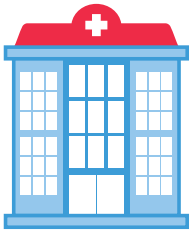
MANY REPEAT HEART ATTACKS AND STROKES COULD BE AVOIDED.

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?

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.



Specialist acute care is not available for all 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.

Specialist cardiovascular care units are not available in 64% of teaching hospitals with cardiology departments.[7]

Only 11 of 17 regions have stroke units, and even in these regions access can be limited.[8 9]

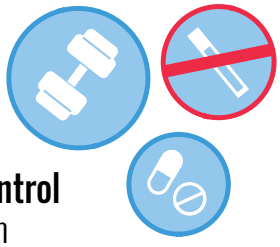
Structured rehabilitation is underused for heart attack, but availability appears to be relatively good for stroke

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

More than 165,000 people who need cardiac rehabilitation are estimated to miss out each year due to a lack of facilities.[10]

The 2008 National Stroke Strategy estimated that 61% of stroke patients were followed up by a nurse-led, home-based care programme.[8]

GOOD PRACTICE:
The MasXMenos (More 4 Less) study[11] is testing the effectiveness of cardiac rehabilitation run at a higher intensity and for shorter periods than regular programmes. It is hoped that this will result in better patient outcomes and be more cost-effective.



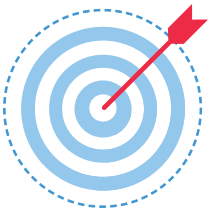
Risk factor control during long-term management does not fully meet guideline recommendations

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

One year after a heart attack, only 29% of patients met guideline-recommended cholesterol targets. Only 62% had adequate blood pressure control and 40% of previous smokers continued to smoke.[12]

In primary care, despite improvements in blood pressure control, 34% of post-stroke patients do not achieve their blood pressure targets. Further, 59% do not reach cholesterol targets and 24% do not quit smoking.[13]

GOOD PRACTICE:
Proyecto ACER-C-AP[14] aims to strengthen integration of secondary prevention into primary care to improve long-term patient support. Its programmes have successfully addressed risk factor control in high-risk groups.



Dedicated policies addressing heart attack and stroke need to be updated

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

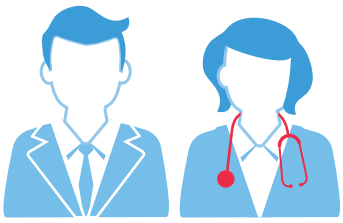
Spain has national strategic plans covering secondary prevention for heart attack[15] and stroke.[8] These have not been updated in recent years and their impact is rarely evaluated.[16]

GOOD PRACTICE:
The Stroke Strategy of the Balearic Islands *(Estrategia de Ictus de las Islas Baleares 2017–2021)*[17] highlights the importance of implementing patient-centred secondary prevention.

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 efforts to increase awareness around secondary prevention of heart attack and stroke appear to be extremely limited. There are no campaigns specific to secondary prevention or awareness-raising activities on a national scale.

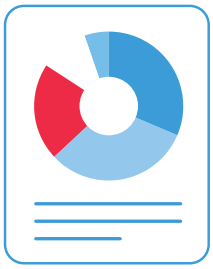


Clinical leadership is striving to improve clinical practice for secondary prevention, but greater efforts may be needed

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

Spanish cardiac and allied societies have made significant progress in developing guidelines covering secondary prevention of heart attack.[18 19] European guidelines have been adapted to the national context,[20-22] but only a third of primary care professionals used them in their daily practice.[21]

The Ministry of Health has developed national guidelines for secondary prevention of stroke, but they are now out of date and require revision.[23 24]



There are efforts to improve **national registries** and the collection of 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 range of indicators to measure performance and outcomes in cardiac care have been developed, but data collection in clinical practice still needs to be improved.[25]

The national stroke registry by the Spanish Society aims to provide a common database with shared and standardised criteria for Spanish hospitals.[26]

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 Spain 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 supply of specialist heart attack and stroke units**, along with facilities for structured rehabilitation, represents a significant opportunity to improve care. There are also considerable opportunities for improvement during long-term management, particularly the benefits that could be gained by **bringing risk factor control in line with guidelines**. To take advantage of these opportunities, both national and regional leadership will likely be needed. **Updates to the national strategic plans** covering secondary prevention may be required to encourage the development of regional policy and, in turn, address the significant regional differences in care standards.

To find out more about this project and read the full country profile on Spain, 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.