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Cardiovascular disease in the Netherlands, 1975 to 1995: decline in mortality, but increasing numbers of patients with chronic conditions

J B Reitsma, J A A Dalstra, G J Bonsel, J H P van der Meulen, R W Koster, L J Gunning-Schepers, J G P Tijssen

Abstract

Objective—To examine the relation between trends over time in mortality and hospital morbidity caused by various cardiovascular diseases in the Netherlands.

Design—Trend analysis by Poisson regression of national data on mortality and hospital admissions from 1975 to 1995.

Subjects—The Dutch population.

Results—All cardiovascular diseases combined were responsible for 39% of all deaths and 16% of all hospital admissions in 1995. From 1975 to 1995, age adjusted cardiovascular mortality declined by an annual change of −2.0% (95% confidence intervals (CI) −2.1% to −1.9%), while in the same period age adjusted discharge rates increased annually by 1.3% (95% CI 1.1% to 1.5%). Around 60% of the gain in life expectancy in this period was related to lower cardiovascular mortality. For mortality, major reductions were seen in coronary heart disease (annual change −2.9%) and in stroke (−2.1%), whereas the increase in hospital admissions was mainly caused by chronic manifestations of coronary heart disease (5.1%), heart failure (2.1%), and diseases of the arteries (1.8%).

Conclusions—Our findings of a decrease in cardiovascular mortality and an increase in admission rates for chronic conditions such as heart failure, chronic coronary syndromes, and diseases of the arteries, support the hypothesis that the longer survival of many patients with heart diseases is leading to a growing pool of patients at increased risk for subsequent cardiovascular complications in Western countries.

Keywords: epidemiology; time trends; mortality; hospital admissions; Netherlands

Methods

Data on the number of deaths in the Netherlands from 1975 to 1995 inclusive were obtained from Statistics Netherlands in Voorburg. Mortality data were grouped by five year age categories, sex, and primary cause of death. The eighth version of the International Classification of Diseases (ICD) was used for the years 1975 to 1978 and the ninth version thereafter. The total group of CVD consisted of all codes from group VII of the ICD classification (diseases of the circulatory system), together with ICD codes identifying congenital anomalies of the circulatory system (in ICD-8 codes 746 and 747; in ICD-9 codes 745–747). The following diseases were analysed separately: coronary heart disease (a combination of ICD codes 410–414), stroke (codes 430–438), and diseases of the arteries (codes 440–448).

The number of hospital admissions for CVD was derived from the central database of hospital admissions in the Netherlands called the National Medical Register. This database is maintained by SIG Health Care Information. In 1975, 83% of all hospital admissions in the Netherlands was recorded in this database. Cover had grown to 95% in 1980, and was complete from 1986 onwards. These percent-
Table 1 Some major causes of death in the Netherlands (1995)

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Men</th>
<th>Women</th>
<th>Men and women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the circulatory system*</td>
<td>25635 (38%)</td>
<td>26694 (40%)</td>
<td>52329 (39%)</td>
</tr>
<tr>
<td>Cancer</td>
<td>20435 (30%)</td>
<td>16054 (24%)</td>
<td>36489 (27%)</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>6970 (10%)</td>
<td>5674 (8%)</td>
<td>12644 (9%)</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>2101 (3%)</td>
<td>2943 (4%)</td>
<td>5044 (4%)</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>3033 (4%)</td>
<td>2140 (3%)</td>
<td>5173 (4%)</td>
</tr>
<tr>
<td>Other</td>
<td>10062 (15%)</td>
<td>13934 (21%)</td>
<td>23996 (18%)</td>
</tr>
<tr>
<td>All cause mortality</td>
<td>68236</td>
<td>67439</td>
<td>135675</td>
</tr>
</tbody>
</table>

Source: Statistics Netherlands.

*Including coronary heart disease, stroke, diseases of the arteries, and congenital heart disease.

Cardiovascular disease in the Netherlands

<table>
<thead>
<tr>
<th>Proportionate mortality</th>
<th>Age groups (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0–4</td>
</tr>
<tr>
<td>25%</td>
<td>5–9</td>
</tr>
<tr>
<td>50%</td>
<td>10–14</td>
</tr>
<tr>
<td>75%</td>
<td>15–19</td>
</tr>
<tr>
<td>100%</td>
<td>20–34</td>
</tr>
</tbody>
</table>

Figure 1 Proportionate mortality by age in the Netherlands in 1995. Men and women combined. Source: Statistics Netherlands.

Results

ALL CVD COMBINED: PRESENT BURDEN AND TRENDS

The total group of CVD was responsible for the deaths of 52 329 men and women in 1995, which is equivalent to 39% of all deaths in the Netherlands (table 1). All cancers combined caused 36 489 deaths in 1995, corresponding to 27% of all deaths. Proportionate mortality by age for the main causes of death is shown in fig 1. Figure 1 can be divided into four main segments, each linked with a predominant cause of death: from birth to 5 years, perinatal conditions and congenital diseases; from 5 to 34 years, injuries and suicide; from 35 to 64 years, cancer and to a lesser degree CVD; and 65 years and older, CVD and to a lesser degree cancer.

Age adjusted mortality from all CVD in the Netherlands decreased steadily from 419 per 100 000 in 1975 to 283 per 100 000 in 1995. In the same period, all cause mortality dropped from 934 per 100 000 to 760 per 100 000. As a result, life expectancy at birth for men in this period rose by 3.1 years to 74.6 years in 1995, and for women by 2.7 years to 80.5 years. Fifty four per cent of the gain in life expectancy for men and 63% for women could be explained by the lower mortality from CVD.

In contrast to the decline in mortality with an annual change of −2.0% (95% confidence interval (CI) −2.1% to −1.9%), there was a constant increase in age adjusted discharge rates for CVD with an annual growth of 1.3% (95% CI 1.1% to 1.5%). The absolute number of hospital admissions for CVD nearly doubled from 142 522 in 1975 (10% of all hospital admissions in the Netherlands) to 248 308 in 1995 (16% of all hospital admissions).

TIME TRENDS FOR DIFFERENT CVD

Figure 2 combines the trends in age adjusted mortality and discharge rates for several CVD. For mortality, major reductions were seen for coronary heart disease (annual change of −2.9%; 95% CI −3.0% to −2.8%) and stroke (−2.1%; 95% CI −2.3% to −2.0%), whereas mortality from arterial diseases remained more or less stable (0.3%; 95% CI 0.0% to 0.6%). Although the relative decline in mortality from coronary heart disease and stroke over the whole study period was similar in magnitude, trends over time were different. During the first half of the study period (1975 to 1985), the rate of decline was faster for stroke (annual change of −3.0%; 95% CI −3.3% to −2.8%) than for coronary heart disease (−2.3%; 95% CI −2.4% to −2.1%). During the second half of the study period, coronary heart disease mortality continued to decline at an even higher rate of −3.7% (95% CI −3.9% to −3.4%), whereas...
mortality from stroke slowed down with an annual relative change of −1.0% (95% CI −1.3% to −0.7%).

For hospital admissions, striking increases were seen in admissions for coronary heart disease (annual growth of 2.6%: 95% CI 2.4% to 2.8%) with a remarkable difference between acute syndromes (0.7% growth) and chronic manifestations (5.1% annual growth), for heart failure (2.1% annual growth; 95% CI 2.0% to 2.3%), and for arterial diseases (1.8% annual growth; 95% CI 1.6% to 2.0%). Age adjusted hospital case fatality improved for all major CVD: hospital case fatality for coronary heart disease declined from 12.7% in 1975 to 4.2% in 1995, for stroke from 28.6% to 17.0%, and for arterial diseases from 9.4% to 5.4%.

Discussion
Our analysis showed that CVD are still the leading cause of death in the Netherlands, despite a 30% decline in age adjusted mortality during the past 20 years. Based on the death rates observed in 1995, the lifetime probability of dying from CVD is 40% for both men and women, although the mean age at which they die is higher in women than in men. The combined analysis of trends in mortality and morbidity caused by different CVD in the Netherlands revealed an ongoing decline in mortality from CVD, but a continuous increase in the number of hospital admissions for these diseases. It has been hypothesised that the link between the decrease in mortality and the increase in admission rates is the longer survival of patients with CVD, particularly those patients who have had an acute myocardial infarction. The longer survival of
Cardiovascular disease in the Netherlands

Survival mortality. The most important factor in the continuing decline in successive vascular events, causing more recent decline in coronary heart disease, especially in recent years. Firstly, there was a substantial decline in hospital case fatality for many CVD, especially for coronary heart disease. Secondly, time trends for recent years (from the mid-1980s) were different for various CVD. The annual relative decline in mortality from coronary heart disease increased even further, whereas the decline in mortality from stroke and diseases of the arteries slowed down.

Longer survival but more patients with chronic conditions

It has been hypothesised that the longer survival of patients with coronary heart disease will lead to a growing group of patients at high risk from subsequent vascular events, causing an increase in the prevalence of chronic conditions. The remarkable growth in the number of hospital admissions for CVD and the type of diseases responsible for this increase are in line with this hypothesis. Major increases were seen for congestive heart failure, chronic coronary syndromes, and arterial diseases (fig 2). In the interpretation of the increase in hospital admissions it is important to recognise that multiple admissions of the same patient cannot be determined. In the case of chronic conditions like heart failure and arterial diseases, readmissions might be frequent. What proportion of the increase in hospital admissions is related to readmissions and how much to "new" patients remains unclear. We have already demonstrated that in heart failure patients multiple readmissions within a short period of time are common. An additional factor in the rise of the number of admissions for coronary heart disease is the intensive use of diagnostic and therapeutic procedures in patients with coronary syndromes.

Differences in time trends for mortality from coronary heart disease between men and women

A significant finding of this study is that the gap between men and women at risk of dying from coronary heart disease has become smaller in recent years for those aged 65 years and younger (fig 3). The reasons for this are not clear, but might be related to men having more benefit from recent advances in medical care or women adopting more unfavourable lifestyles. Several studies have demonstrated that women with coronary heart disease are treated differently from men. These differences include a lower use of invasive diagnostic testing in women, lower rates of revascularisation in women, and less likelihood of women being discharged with aspirin and β blocking agents. The fact that women with myocardial infarction are in general older and have more traditional risk factors such as hypertension, diabetes mellitus, and congestive heart failure than men at the time of admission, could not fully explain the lower use of thrombolysis in women.

Strengths and limitations of the study

This was a descriptive study, analysing only temporal relations in data from two national registries. The validity of this study depends strongly on the accuracy of the primary cause of death or the primary diagnosis at discharge. For mortality, discrepancies have been found between the judgment of physicians and subsequent findings at necropsy, and between physicians coding identical cases for research purposes. The use of broad categories of diseases, as has been done in this study, is known to lead to fewer discrepancies than analysing single disorders.

The use of hospital statistics data is limited by the inability to identify multiple admissions of the same patient. Furthermore, the number of hospital admissions is affected by changes in admission policy and by improvements in diagnostic capabilities. The significance of these factors will vary with the disease under study. They will be of minor importance for diseases like acute myocardial infarction, in which nearly all patients are hospitalised, but become more important for diseases like stroke (introduction of computed tomography) and heart failure (coding problems and admission policy). The lower hospital case fatality could have been influenced by more admissions for milder forms, by more frequent readmissions, and by more admissions for diagnostic purposes.
This study underlines the dynamic and complex interactions that exist between morbidity and mortality caused by different CVD. Studies with a limited time of follow up or trials dealing with selected patients will reveal only part of the total picture important from a public health point of view. More attention needs to be given to the exact benefits, both short and long term, of new additions to the treatment of heart patients and to differences in medical care and outcomes between men and women. The shift from acute and fatal to more chronic conditions. These growing numbers of patients, coupled with the increased aging of many European populations, will increase the reference in mortality and morbidity caused by diabetes and heart disease: the Framingham heart study. N Engl J Med 1990; 322:1635–41.


