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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%). In recent years, the gap between men and women at risk of dying from coronary heart disease became smaller for those aged <65 years.

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.

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 were 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>135765</td>
</tr>
</tbody>
</table>

Source: Statistics Netherlands.

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

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

Figure 2 combines the trends in age adjusted 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%.

CVD: DIFFERENCES BY SEX AND AGE

If we subject a hypothetical cohort of 100 000 men and 100 000 women to the age specific mortality risks of CVD as measured in 1995, eventually 38 569 men (lifetime probability of 0.39) and 40 761 women (lifetime probability of 0.41) will die from CVD. Although the lifetime probability of dying from CVD is higher in women than in men, the age at which they die is very different. Of all 40 761 women that would die from CVD, the mean age at death would be 82.3 years, with 82% of these women dying after age 75. For men the mean age at death would be 76.4 years, with 61% dying after age 75.

The rate of decline in mortality from CVD varied among different age groups. In general, the rate of decline was faster in younger age groups. For instance, the relative decline in CVD mortality for those younger than 75 years was \(-2.4\%\) (95% CI \(-2.5\%\) to \(-2.3\%\)) compared with \(-1.8\%\) (95% CI \(-1.9\%\) to \(-1.6\%\)) for those 75 years and older. The annual increase in discharge rates was in general more pronounced in older age groups. The annual growth in the age groups above 75 years was 2.0% (95% CI 1.9% to 2.1%) compared with 1.1% annual growth (95% CI 0.9% to 1.4%) in the age groups younger than 75 years.

Generally, trends in mortality from different CVD showed similar patterns among men and women. Only for mortality from diseases of the arteries were trends in the opposite direction observed, with men having an annual increase of 1.3% (95% CI 1.0% to 1.6%) and women an annual decline of \(-1.0\%\) (95% CI \(-1.3\%\) to \(-0.6\%\)). In recent years, different trends by sex and age were observed for coronary heart disease mortality. Figure 3 presents the age specific sex ratios for coronary heart disease mortality. The following observations can be made. Firstly, in all age groups sex ratios were above 1, indicating that men had a higher rate of mortality than women. Secondly, sex ratios became smaller with increasing age. Thirdly, sex differences in the age groups below 65 years of age were severely reduced in recent years, whereas sex differences in the older age groups remained more or less stable.

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.8–11 The longer survival of
heart patients will lead to a growing pool of individuals at high risk for subsequent events or diseases, such as recurrent coronary artery stenosis, stroke or congestive heart failure. Before looking at our results in more detail to see if they support this hypothesis, we will first review the literature for the evidence of a longer survival of patients with coronary heart disease.

DECLINE IN MORTALITY FROM CORONARY HEART DISEASE: LOWER INCIDENCE AND LONGER SURVIVAL
Several studies have tried to determine how much of the decline in mortality from coronary heart disease has been caused by a lower incidence of coronary heart disease (primary prevention) and how much by a longer survival (secondary prevention, improvements in medical care). Estimates of the importance of a lower incidence varied between 30% and 80% for the different studies analysing the decline in mortality in the 1970s and '80s. Important lifestyle factors that have led to a lower incidence are a reduction in the number of people who smoke, the treatment of hypertension, and a reduction in the prevalence of hypercholesterolaemia. Studies focusing on the more recent decline in coronary heart disease point to a longer survival among patients with established (coronary) heart disease as an important factor in the continuing decline in mortality. The following factors were specifically mentioned: coronary bypass surgery, coronary angioplasty, thrombolysis in acute coronary syndromes, and secondary medical prevention in patients with myocardial infarction (antiplatelet agents, anticoagulants, and β blockers) to prevent vascular events.

Several findings from our study also indicate a longer survival among patients with 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 fail to 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 should lead to more attention being focused on the reasons for and prevention of readmissions in patients with chronic disorders.

To summarise, CVD are still the leading cause of death among men and women in the Netherlands, despite a major decline in age adjusted mortality of more than 30% in both men and women. This decline was the major reason behind the gain in life expectancy. In the same period that mortality declined, the number of hospital admissions for CVD rose steadily. This increase was mainly caused by diseases related to non-acute syndromes of coronary heart disease, heart failure, and arterial diseases. These findings support the hypothesis that improvements in medical care have resulted in a longer survival of many heart disease patients, and led to a growing prevalence of patients with chronic cardiovascular conditions. These growing numbers of patients, coupled with the increased aging of many European populations, will increase the strain on forthcoming health care budgets even further. The reduced difference in mortality from coronary heart disease between men and women aged 65 years and younger might suggest that men have had more benefit from the introduction of thrombolysis, but other factors explain changes in mortality from ischaemic heart disease in Finland. We are indebted to the members of this committee for their help in the preparation of the paper.