1.1.3 Healthy life years (HLY) at birth, 2005-07 and health spending per capita, 2007

\[ R^2 = 0.33 \]

Source: European Health and Life Expectancy Information System (EHLEIS); OECD Health Data 2010; Eurostat Statistics Database; WHO.
Average OECD health expenditure
Growth rates in real terms, 2000 to 2010, public and total

Source: OECD Health Data 2012
Average annual growth in health spending
Real terms, 2000-2010

Note: Growth rates for 2009/10 are not available for Australia, Japan, Luxembourg, Israel, Spain and Turkey.

Source: OECD Health Data 2012.
Most recent Health Statistics OECD

Slow recovery in health spending in many countries after a period of decline

Average OECD health expenditure growth rates in real terms, 2000 to 2012, public and total

Source: OECD Health Statistics 2014.
Quality of health care services is seen in the overall context of health system performance, population health and health system development.

The performance of the health care system is one of the determinants of population health alongside non-medical determinants of health such as behavioural and environmental factors.

In OECD reports quality has 3 components; effectiveness, safety and person centeredness.

It is used alongside the domains access and costs/expenditure and the cross cutting domains efficiency and equity.
This conceptual thinking is reflected in the framework used for reporting statistics in OECD’s Health at a Glance.
The OECD Health Data Questionnaire collects data on a range of variables related to health status, non-medical determinants of health, the pharmaceutical market, waiting times, long-term care resources and utilisation, and public and private health insurance coverage.

The OECD/Eurostat/WHO-Europe Joint Questionnaire on Non-Monetary Health Care Statistics collects data on health care resources (human and technical) and health care activities.

The OECD/Eurostat/WHO Joint Health Accounts Questionnaire collects data on health expenditure by function, provider and financing scheme, based on the System of Health Accounts.

The OECD/Eurostat Purchasing Power Parity (PPP) Questionnaire collects data on the prices of a selected set of health services and goods (for the purpose of developing health-specific and economy-wide PPP indices).

The OECD Health Care Quality Indicators Questionnaire collects data on quality of care (including health outcomes and patient safety).
Where we come from

- Start Health Care Quality Indicator (HCQI) work in 2002 (with input from CWF and Nordic Council)
  - A conceptual framework for the OECD Health Care Quality Indicators Project
  - OECD Health Care Quality Indicator Project. The expert panel on primary care prevention and health promotion
- Work on indicators on acute care, primary care, cancer and infectious diseases
  - Publication in OECD Health at a Glance (HAG) since 2007
- Work on patient safety indicators
  - Publication in OECD HAG since 2011
  - International comparability of patient safety indicators in 15 OECD member countries: a methodological approach of adjustment by secondary diagnoses
- Work on mental health and patient experience indicators
  - Publication in OECD HAG since 2013
- Revision of framework and set of HCQI in 2013
  - Towards actionable international comparisons of health system performance: expert revision of the OECD framework and quality indicators
- Work on health information infrastructure since 2011
This conceptual thinking is reflected in the framework used for reporting statistics in OECD’s Health at a Glance.

Health system performance assessment framework

Healthcare System Performance

<table>
<thead>
<tr>
<th>Health care needs</th>
<th>Quality</th>
<th>Access</th>
<th>Expenditure</th>
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<tbody>
<tr>
<td>Staying healthy</td>
<td>Effectiveness</td>
<td>Responsiveness/Patient centered</td>
<td>Accessibility</td>
</tr>
<tr>
<td>Getting better</td>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with illness or disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping with end of life</td>
<td></td>
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Current focus of HCQI Project

Health system design, policy and context
WHO Framework 2007  

SYSTEM BUILDING BLOCKS

SERVICE DELIVERY
HEALTH WORKFORCE
INFORMATION
MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES
FINANCING
LEADERSHIP / GOVERNANCE

OVERALL GOALS / OUTCOMES

ACCESS
IMPROVED HEALTH (LEVEL AND EQUITY)

COVERAGE
RESPONSIVENESS

QUALITY
SOCIAL AND FINANCIAL RISK PROTECTION

SAFETY
IMPROVED EFFICIENCY
1. Preventing people from dying prematurely

**Overarching indicators**
- Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
  - Adults: Children and young people
  - Life expectancy at 75

**Improvement areas**
- Reducing premature death in the major causes of death
  - Under 75 mortality rate from cardiovascular disease
  - Under 75 mortality rate from respiratory disease
  - Under 75 mortality rate from liver disease
- Under 75 mortality rate from cancer (PHOF 4.5**)
- One- and five-year survival from all cancers
- One- and five-year survival from breast, lung and colorectal cancer
- Five-year survival from all cancers
- Excess under 75 mortality rate in adults with common mental illness (PHOF indicator 4.1**)
- Excess under 75 mortality rate in adults with a learning disability (PHOF indicator 4.10**)”
- Excess under 75 mortality rate in adults with mental illness

2. Enhancing quality of life for people with long-term conditions

**Overarching indicators**
- Health-related quality of life for people with long-term conditions
- Ensuring people feel supported to manage their condition
- Improving functional ability in people with long-term conditions
- Employment of people with long-term conditions
- Reducing time spent in hospital by people with long-term conditions
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 18s
- Alcohol-related hospital admissions (PHOF 2.18*)

**Improvement areas**
- Enhancing quality of life for carers
- Health-related quality of life for carers
- Enhancing quality of life for people with mental illness
- Employment of people with mental illness
- Health related quality of life for people with mental health problems
- Enhancing quality of life for people with dementia
- Estimated diagnosis rate for people with dementia
- A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life
- Dental Health
  - Decaying teeth
  - Under 10 tooth extractions in secondary care

3. Helping people to recover from episodes of ill health or following injury

**Overarching indicators**
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency readmissions within 30 days of discharge from hospital

**Improvement Areas**
- Improving outcomes from planned treatments
  - Total health gain as assessed by patients for elective procedures
  - Physical Health-related procedures
  - Mental Health-related procedures
  - Recovery in Quality of life for patients with mental health problems
- Preventing lower respiratory tract infections (LRTI) in children from becoming serious
- Emergency admissions for children with LRTI
- Improving recovery from injuries and trauma
- Survival from major trauma
- Improving recovery from stroke
  - Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
  - Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 30 and 120 days
- Helping older people to recover their independence after illness or injury
  - Proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation service
  - ASCOF 2B(1)
  - Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B(2)

4. Ensuring that people have a positive experience of care

**Overarching indicators**
- Patient experience of primary care
- GP services
- GP Out-of-hours services
- NHS dental services
- Patient experience of hospital care

**Improvement areas**
- Improving people’s experience of outpatient care
- Improving people’s experience of accident and emergency services
- Patient experience of A&E services
- Improving access to primary care services
- Access to GP services and NHS dental services
- Improving women and their families’ experience of maternity services
- Women’s experience of maternity services
- Improving the experience of care for people at the end of their lives
- Bereaved carers’ views on the quality of care in the last 3 months of life
- Improving experience of healthcare for people with mental illness
- Patient experience of community mental health services
- Improving children and young people’s experience of healthcare
- Children and young people’s experience of outpatient services
- Improving people’s experience of integrated care
- People’s experience of integrated care

5. Treating and caring for people in a safe environment and protecting them from avoidable harm

**Overarching indicators**
- (previously 5c) Deaths attributable to problems in healthcare
- 5b. Severe harm attributable to problems in healthcare

**Improvement areas**
- Reducing the incidence of avoidable harm
- Deaths from venous thromboembolism (VTE) related events
- Incidence of healthcare associated infection (HCAI)
- MRSA
- C. difficile
- Proportion of patients with category 2, 3 and 4 pressure ulcers
- Hip fractures from falls during hospital care

**Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or Public Health Outcomes Framework (PHOF)**

- Indicator is shared
- ** Indicator is complementary

---

**Notes:**
- Identification
- Publications are available from: www.nhsoutcomesframework.org.uk

**NHS Outcomes Framework 2015/16 at a glance – DRAFT**
Fig. 1. Health system performance dimensions for Armenia

Health system functions
- Health management information system
- Development of health human resources
- Health system stewardship

Service delivery
- Health system efficiency
- Access to health care services
- Quality and safety of health care services
- Risk factors, health promotion and disease prevention

Improvement in health status and distribution
- Health system responsiveness

Equity in financing and financial protection

Source: Armenia health system performance assessment 2009 (3)
Fig. 7. Framework for health system and programme monitoring and evaluation in Kyrgyzstan, illustration of health status improvement

<table>
<thead>
<tr>
<th>Component</th>
<th>Subcomponent</th>
<th>Output</th>
<th>Outcome/impact</th>
<th>Sector performance goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health financing</td>
<td>Policy</td>
<td>Funds pooling</td>
<td>Reduced financial barriers to access</td>
<td>Health status improvement (level and distribution)</td>
</tr>
<tr>
<td></td>
<td>Purchasing</td>
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<td>Information systems</td>
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<td>FGP upgrade</td>
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<td>CRH/OMH</td>
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<tr>
<td></td>
<td>Balkhak hospitals</td>
<td></td>
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<tr>
<td></td>
<td>Human resources</td>
<td></td>
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<tr>
<td></td>
<td>Mental health</td>
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<td></td>
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</tr>
<tr>
<td>Delivery system restructuring</td>
<td>Education</td>
<td></td>
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<tr>
<td></td>
<td>Professional development</td>
<td></td>
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<tr>
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<td>Pharmaceutical quality</td>
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</tr>
<tr>
<td>Quality improvement</td>
<td>Health promotion</td>
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<tr>
<td></td>
<td>Health protection</td>
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</tbody>
</table>

Figure 6: Conceptual Framework for Portuguese HSPA Report

- **Demographic**
  - Functions that the system performs
    - Health system stewardship
    - Service delivery
    - Health financing
    - Resource generation

- **External context**
  - Economic
    - Intermediate objectives of the system
      - Improving access
      - Improving coverage
      - Delivering high-quality, safe health services
      - Promoting healthier behaviour
      - Improving efficiency
  - Legal and regulatory
    - Ultimate goals of the system
      - Improved health (level, distribution)
      - Responsiveness
      - Social and financial risk protection

- **Epidemiological**
- **Technological**
- **Political**
- **Socio-cultural**
Conceptual notions in the Health Care Quality Indicator program

• The 3 domains of quality (effectiveness, safety and person centeredness) are explored along 4 health care system functions; staying healthy, getting better, living with illness or disability and coping with the end of life (IoM)

• The HCQI program started in 2002, the framework was developed in 2004 and updated in 2013

• Quality Indicators have been reported on OECD countries since 2005 (at present 55 indicators and participation of 35 countries)
Types of Health Care Quality Indicators

- Infectious Diseases: vaccination rates children and flu-vaccination elderly
- Acute Care: 30-day case fatality rates AMI and Stroke
- Primary Care: hospital admission rates for chronic conditions (diabetes, asthma/COPD, Chronic Heart Failure) and prescribing rates antibiotics
- Cancer Care: screening, mortality and 5-year survival rates
- Mental Health: Excess Mortality persons with Severe Mental Health problems
- Patient Safety Indicators (PSI’s)
- Patient Experiences (respect, autonomy, communication)
An evolving view of outcomes

<table>
<thead>
<tr>
<th>From Deaths</th>
<th>Rationale, examples of measures and data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality and life-expectancy</strong>: classical parameters to measure health systems outcomes</td>
<td></td>
</tr>
<tr>
<td><strong>Look at outcome from a public health perspective</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Need good death registries as an information source</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To Diseases</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence and incidence of diseases are classical parameters to assess morbidity of diseases in a country</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Related outcome measures try to capture the reduction in morbidity and the outcomes of specific diseases (e.g. QALYs, SF36)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medical/clinical perspective is the dominant way of operationalizing outcome measures. Outcome measurement is dependent on clinical registries (such as on cancer and diabetes).</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Linking to costs (value) at system level (burden of diseases studies) and for specific services and interventions (cost-effectiveness studies)</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To Disability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Many chronic diseases come with long term disabilities and outcomes should also address the way a health system deals with disabilities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>At system level DALY (Disability Adjusted Life Expectancy) most well-known measure; at health services level various instruments available to assess disabilities and their outcomes (e.g. inter RAI initiative)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Administrative data-bases and surveys are the main data source</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To Discomfort</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increasingly outcomes experienced by citizens/patients seen as an important outcome</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PROMS (patient reported outcomes) mainly tested for clinical procedures and treatments and still under development for chronic conditions; EQ5D a more generic measure used.</strong></td>
<td></td>
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<tr>
<td><strong>PREMs with some limited international validation of instruments (CAHPS, Picker)</strong></td>
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</tr>
</tbody>
</table>
Data Sources for OECD’s HCQI

• Death registries
• Clinical Registries (cancer, diabetes)
• Administrative Data-Bases
• (Electronic) Health Records
• Surveys

• Key factor is the capacity for data-linkage
National record linkage projects are used for regular health care quality monitoring.

Source: OECD HCQI Questionnaire, Secondary Use of Health Data, 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Hospital in-patient data</th>
<th>Primary care data</th>
<th>Cancer registry data</th>
<th>Prescription medicines data</th>
<th>Mortality data</th>
<th>Formal long-term care data</th>
<th>Patient experiences survey data</th>
<th>Mental hospital in-patient data</th>
<th>Population health survey data</th>
<th>Population census or registry data</th>
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<td><strong>5</strong></td>
<td><strong>4</strong></td>
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### 25 countries participated in an HCQI survey that found…

<table>
<thead>
<tr>
<th>Progress</th>
<th>Europe (15)</th>
<th>Other (10)</th>
<th>Total (25)</th>
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<tbody>
<tr>
<td>70%+ of Doctors using EMRs</td>
<td>11</td>
<td>2</td>
<td>13</td>
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<tr>
<td>70%+ of Hospitals using EPRs</td>
<td>11</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>National plan to implement EHRs</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>Implementation started</td>
<td>12</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Exchange among doctors and hospitals including medications, lab tests and images</td>
<td>8</td>
<td>6</td>
<td>14</td>
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</table>

Countries reporting minimum data set elements

- Patient Unique identifiers (UPI)
- Diagnostic concerns (chronic conditions/allergies)
- Health care provider identifiers
- Patient demographic information
- Current medications
- Procedures (surgeries, screening tests, laboratory results)
- Behaviours (smoking, alcohol use)
- Physical characteristics (body mass)
- Patient socio-economic data
- Psychosocial or cultural issues
21 countries use clinical terminology standards for some elements

- Diagnosis
- Medications
- Laboratory test results
- Socio-economic information
- Medical image results
- Surgical procedures
- Physical characteristics
- Health behaviours
- Psychosocial or cultural issues

- All records
- Some records
Some have adopted international terminology standards

<table>
<thead>
<tr>
<th>International standard</th>
<th>Elements</th>
<th>Number of countries</th>
</tr>
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<td>ICD-10</td>
<td>Diagnosis</td>
<td>19</td>
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<td>ICD9-CM</td>
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<td>Medical images</td>
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<td>LOINC</td>
<td>Lab tests</td>
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<tr>
<td>WHO ATC</td>
<td>Medications</td>
<td>12</td>
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<tr>
<td>ICD-9 (CM)</td>
<td>Surgical procedures</td>
<td>6</td>
</tr>
<tr>
<td>SNOMED</td>
<td>Surgical procedures</td>
<td>4</td>
</tr>
</tbody>
</table>
Asthma and COPD hospital admission in adults, 2013 (or nearest year)

Note: Three-year average for Iceland and Luxembourg.
Major lower extremity amputation in adults with diabetes, 2013 (or nearest year)

Note: Three-year average for Iceland and Luxembourg.
Overall volume of antibiotics prescribed, 2013 (or nearest year)

1. Data refer to all sectors (not only primary care).

Thirty-day mortality after admission to hospital for AMI based on admission data, 2003 and 2013 (or nearest years)

Note: 95% confidence intervals represented by H. Three-year average for Iceland and Luxembourg.
1. Admissions resulting in a transfer are included.
Thirty-day mortality after admission to hospital for AMI based on patient data, 2003 and 2013 (or nearest years)

Note: 95% confidence intervals represented by H. Three-year average for Luxembourg.
Hip fracture surgery initiation after admission to hospital, 2013 (or nearest year)

Note: Three-year average for Iceland.
Postoperative pulmonary embolism or deep vein thrombosis in hip and knee surgeries, 2013 (or nearest year)

Note: Rates have not been adjusted by the average number of secondary diagnoses.
1. The average number of secondary diagnoses is < 1.5.
Inpatient suicide amongst patients with a psychiatric disorder, 2013 (or latest year)

Note: Three-year average for most countries.
StatLink  http://dx.doi.org/10.1787/888933281184
Excess mortality from schizophrenia, 2013 (or latest year)

Note: Excess mortality is compared to the mortality rate for the general population.
StatLink  http://dx.doi.org/10.1787/888933281184
Mammography screening in women aged 50-69, 2003 and 2013 (or nearest years)


Breast cancer five-year relative survival, 1998-2003 and 2008-2013 (or nearest years)

1. Period analysis. 2. Cohort analysis. 3 Different analysis methods used for different years. * Three-period average. 95% confidence intervals represented by H.

Breast cancer mortality in women, 2003 and 2013 (or nearest years)

*Three-year average.
Doctor spending enough time with patient in consultation, 2013 (or nearest year)

Note: 95% confidence intervals represented by H.
1. National sources. 2. Data refer to patient experiences with regular doctor.
Source: Commonwealth Fund International Health Policy Survey 2013 and other national sources.

StatLink  http://dx.doi.org/10.1787/888933281241
Canada compared with HCQI from a selected group of OECD countries

Source: Canadian Institute for Health Information, 2014
### Reporting on Hospital Performance (England)

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Care Quality Commission Inspection Results</th>
<th>A&amp;E Performance</th>
<th>Mortality Rate</th>
<th>Recommended by Staff</th>
<th>Infection Control and Cleanliness</th>
<th>Number of Patients Waiting More Than 52 Weeks</th>
<th>Friends and Family Test Score: Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Royal Surrey County Hospital</strong></td>
<td><a href="http://www.nhs.uk/Service-Search/Perf">Icon</a></td>
<td><strong>96.6%</strong></td>
<td><strong>OK</strong></td>
<td><strong>OK</strong></td>
<td><strong>OK</strong></td>
<td><strong>93%</strong></td>
<td><strong>Good Rated on 18 December 2013. Visit CQC profile</strong></td>
</tr>
</tbody>
</table>

- **Royal Surrey County Hospital**, Egerton Road, Guildford, Surrey, GU2 7XX
- **Tel:** 01483 571122
- **1.61 miles away**
- **Add to shortlist**
병원평가정보

병원에서 실시한 수술과 처방의 평가결과를 제공해 드립니다.

요양병원/광주/요양병원으로 12개의병원이 검색되었습니다. [다시검색하기]

요양병원(12)

표시를 클릭하시면 병원명과 병원명을 추가하실 수 있습니다.
Results

Reports distribution by country
Total: 163

Report distribution by level of reporting
Total: 163

- National Reports 70%
- Regional Reports 30%
Hospitals quality performance in care of AMI patients on empirical Bayes estimates of random coefficients

Stockholm 8.04.2014 EUROHOPE project
• Performance reporting on health systems and services is popular
• Dependence on information infrastructure (linkage/EHR)
• R&D on international comparisons essential
• Broadening from systems reporting to services reporting
• Broadening from hospital performance to all services
• Strengthening PROMS and PREMS