Benchmarking the quality of national health systems – the OECD indicators

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Qualitätsmanagement

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- health system quality
- administrative data
- quality indicators

International comparisons of health system performance as provided by multilateral organizations such as the Organization for Economic Co-operation and Development (OECD) meet a lot of interest [1]. Although the methodological challenges in providing comparative data are substantial, there is also a large potential for cross-national learning. Within the OECD, the scope on international health system comparisons has in the past mainly been on comparisons of the financing of health care (resulting in OECD's system of Health Accounts) and publication of comparative data on the structure of health care (numbers of physicians, institutions and technologies) and data on the health of populations (Health Data).

The publication Health at a Glance, released biannually and the various OECD websites, put the information in the public domain. Since 2002 this interest in international comparative data has broadened to the quality of health care. The Health Care Quality Indicator project has the objective of developing a set of indicators on health care quality that can be reliable reported on a regular basis across the 30 participating OECD countries.

After initial phases of constructing a conceptual framework for measuring health system quality, identifying through an elaborative panel process a potential list of indicators and pilot-testing of these indicators through national data collection rounds, in 2007 for the first time a chapter on quality of care appeared in Health at a Glance reporting on 20 indicators [2, 3]. These indicators cover acute conditions (i.e. 30 day case fatality rates for AMI and stroke), cancer care (5yr relative survival rates for breast, cervical and colo-rectal cancer, screening rates for breast and cervical cancer), care for chronic conditions (i.e. asthma mortality rates age 5–39) and prevention and communicable diseases (i.e. vaccination rates measles, pertussis, hepatitis B and influenza (people 65+)).

In addition to the systematic data collection on these initial indicators, research and development work is ongoing on additional indicators in the area's of mental health care, patient safety, primary care and responsiveness.

Although data for a large number of the present indicators is reported through (national) death registries, cancer registries and chronic disease registries, a lot of work is also done on the validation of quality indicators derived from administrative databases. Examples of the latter are the indicators on 30 day case fatality rates, patient safety indicators and indicators related to avoidable hospital admissions.

Several technical problems, such as the crosswalk of coding structures from ICD9 to ICD10 have been overcome. Other issues remain the focus of methodological debate such as the need for case mix adjustment and the representativeness, completeness and timeliness of the various (national) administrative data bases. Necessary developments to bring the use of administrative databases for cross national comparison of quality indicators forward, are the necessity of international standardised procedure codes, the necessity of registering whether certain conditions were present at admission (i.e. bedsores, infections) and the need to use unique patient identifiers to link hospital administrative data bases with other registries.

The presentation at the Potsdam conference will highlight the experiences gained in OECD's Health Care Quality Indicators program over the past six years and the various methodological and policy challenges for the near future.

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