Quality of health care

Every day, health care providers have to deal with an array of health problems, including infectious diseases, chronic diseases, and life-threatening diseases and injuries. Some of the most frequent and serious health problems in OECD countries are cardiovascular diseases (including heart attacks, strokes and other diseases) and different types of cancer. These are, by far, the two main causes of death in OECD countries, with all cardiovascular diseases accounting for about one-third of all deaths and all types of cancer for about one-fourth of all deaths. While the occurrence of cardiovascular problems and cancers might be reduced through greater prevention efforts (e.g., reductions in tobacco smoking), health care systems have a major role to play in the early detection of these health problems and providing effective and timely treatments when these problems are diagnosed.

A good indicator of the quality of acute care for people having an acute myocardial infarction (AMI or heart attack) is the 30-day case-fatality rate after their admission to hospital. This measure reflects the processes of care, such as timely transport of patients to hospital and effective medical interventions and it varies from a low of about 4% in Australia and Sweden, to a high of 28% in Mexico.. In most countries (with the exception of Mexico), AMI case-fatality rates have come down over the past decade, reflecting improvements in emergency services before patients reach the hospital and immediately after their admission. On average across OECD countries, the case-fatality rate has decreased by over 25% over the past decade.

After lung cancer, breast cancer is the second most common cause of death from cancer for women. Mortality from breast cancer can be reduced through earlier diagnosis and the provision of more effective treatments. Most OECD countries have organised breast cancer screening programmes for women after a certain age (often after age 50) to promote early diagnosis. The proportion of women aged 50-69 screened over the past two to three years has increased in most OECD countries during the past decade, but remains low in several countries. In 2014, more than 80% of women aged 50-69 had recently been screened in Portugal, Denmark, Finland, Slovenia and the United States. In Mexico and the Slovak Republic, less than 30% of women aged 50-69 had recently been screened in 2014, but still, there was a substantial improvement compared to a decade earlier. In Korea and Japan also, there has been a substantial increase in the proportion of women screened for breast cancer.

Over the same period, breast cancer mortality rates have also decreased by around 3.5 p.p on average in OECD countries. This reduction is a reflection of improvements in early detection and treatment of breast cancer. Reductions in mortality have been substantial in the Czech Republic, the Netherlands and New Zealand with a decline of over 6 p.p in a decade. Denmark also reported a considerable decline, but its mortality rate was still the highest in 2014. On the other hand, in Korea, Turkey and Japan, the mortality rate from breast cancer increased over the past decade, although it remains among the lowest rates across OECD countries.

Methodology and definitions

The case-fatality rate for AMI measures the percentage of people aged 45 and over who die within 30 days following admission to hospital. Rates based on admission data refer to the deaths that occurred in the same hospital as the initial admissions. Admissions resulting in a transfer were excluded for all countries except Australia, Belgium, Denmark, Hungary, Ireland, Israel, Japan, Luxembourg, Mexico, Netherlands, Slovak Republic and Sweden. This exclusion generally increases the rate compared with those countries which do not exclude these transfers. Rates are age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI.

Screening rates are based on surveys or programme data, which may influence the results. Survey-based results may be affected by recall bias. Programme data are often calculated for monitoring national screening programmes and differences in target population and screening frequency may also lead to variations in screening coverage across countries. Mortality rates come from crude data extracted from the WHO Mortality Database in June 2016 and have been age-standardised to the 2010 OECD population structure to remove variations due to differences in population structures across countries and over time.

Additional data on mortality rates from Acute Myocardial Infarction and Cerebrovascular diseases are available online (see annex F).

Further reading

OECD (2013), Cancer Care: Assuring Quality to Improve Survival, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264181052-en*.

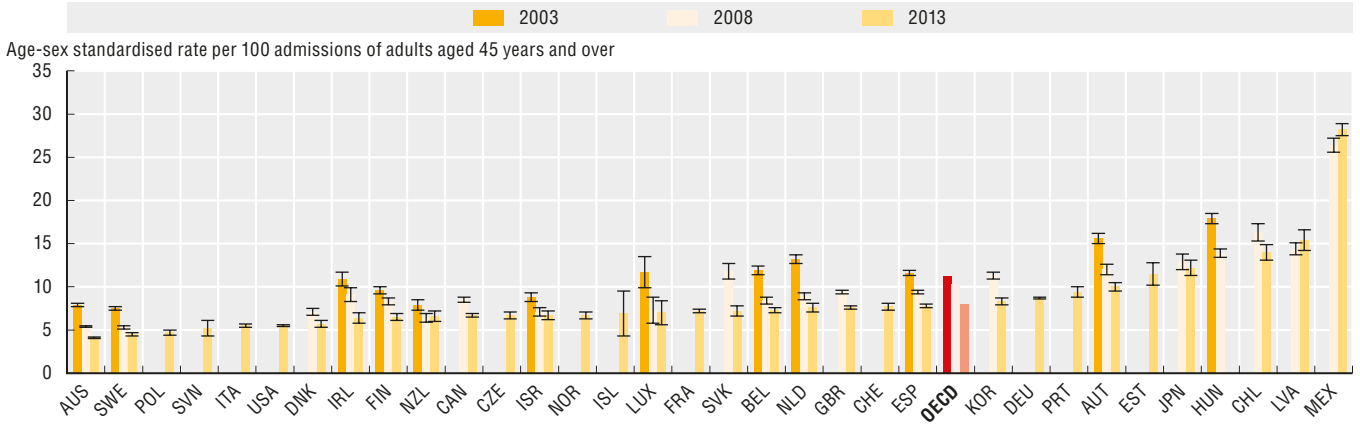
Figure notes

14.27. Admissions resulting in a transfer are included. 95% confidence intervals represented by H. Three-year average for Iceland and Luxembourg.

14.28. and 14.29. For detailed figure notes see Statslinks.

Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

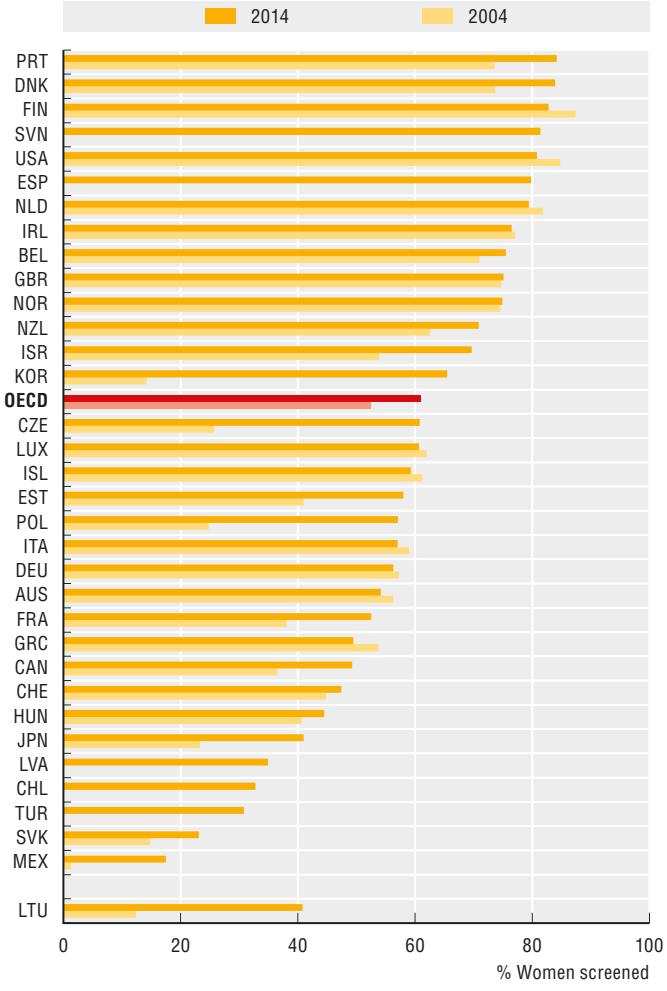
14.27. Thirty-day mortality after admission to hospital for AMI, 2003, 2008 to 2013 (or nearest years)



Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en

StatLink http://dx.doi.org/10.1787/888933534252

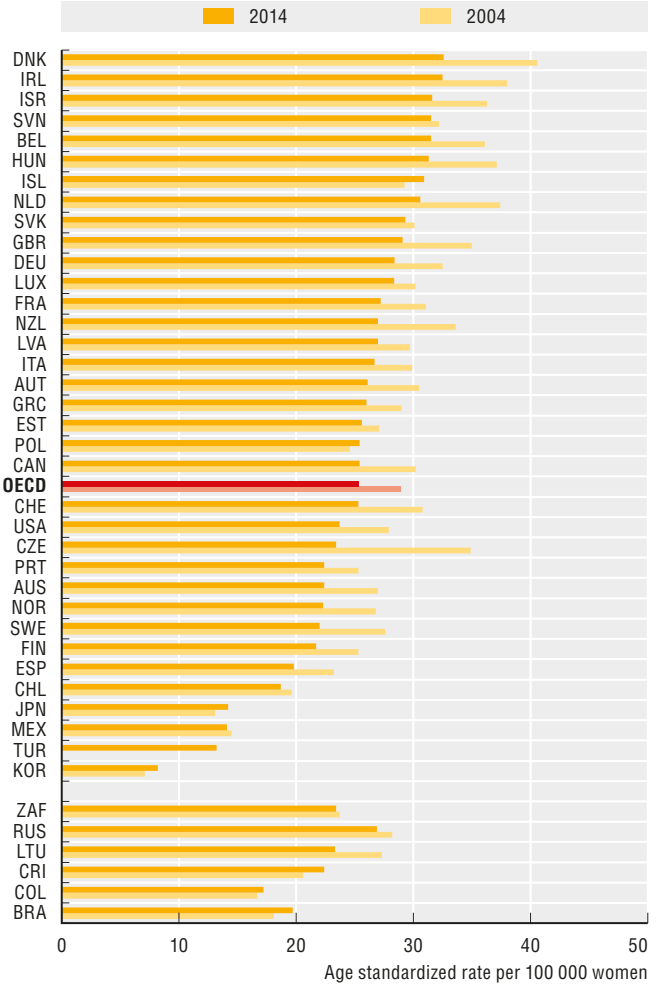
14.28. Mammography screening in women aged 50- 69, 2004 to 2014 (or nearest years)



Source: OECD Health Statistics 2016 (database)

StatLink http://dx.doi.org/10.1787/888933534271

14.29. Breast cancer mortality in women, 2004 to 2014 (or nearest years)



Source: OECD Health Statistics 2015 and World Health Organization database, 2016

StatLink http://dx.doi.org/10.1787/888933534290

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