

Chapter 1

Dashboards of health indicators

This chapter presents, for the first time, a set of dashboards which are designed to shed light on how well OECD countries do in promoting the health of their population and improving their health system performance. These dashboards do not have the ambition of identifying which countries have the best health system overall. They summarise some of the relative strengths and weaknesses of countries on a selected set of indicators on health and health system performance, to help identify possible priority areas for actions. These dashboards, which take the form of summary tables, highlight how well OECD countries are doing along five dimensions: 1) health status; 2) risk factors to health; 3) access to care; 4) quality of care; and 5) health care resources. For each of these five dimensions, a selected set of key indicators are presented. The selection of these indicators is based on three main criteria: 1) policy relevance; 2) data availability; and 3) data interpretability (i.e., no ambiguity that a higher/lower value means a better/worse performance). There is, however, one exception to the application of this third criterion: for the fifth dashboard on health care resources, more health spending or more human or physical resources does not necessarily mean better performance. This is why the ranking of countries is displayed differently.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Across the OECD, policy makers have a keen interest to understand how good the health of their people is, and how well their health systems are able to deliver good results. A look at indicators contained in this publication shows that much progress has already been achieved. People in OECD countries are living longer than ever before, with life expectancy now exceeding 80 years on average, thanks to improvements in living conditions and educational attainments, but also to progress in health care. In most countries, universal health coverage provides financial protection against the cost of illness and promotes access to care for the whole population. The quality of care has also generally improved, as illustrated by the reduction in deaths after heart attacks and strokes, and the earlier detection and improved treatments for serious diseases such as diabetes and cancer. But these improvements have come at a cost. Health spending now accounts for about 9% of GDP on average in OECD countries, and exceeds 10% in many countries. Higher health spending is not a problem if the benefits exceed the costs, but there is ample evidence of inequities and inefficiencies in health systems which need to be addressed. There is also a need to achieve a proper balance between spending on disease prevention and treatment.

Despite these improvements, important questions about how successful countries are in achieving good results on different dimensions of health system performance remain. What are the main factors explaining differences in health status and life expectancy across OECD countries? Is the increase in certain risk factors such as inactivity and obesity offsetting some of the gains from the reduction in other risk factors like smoking? To what extent do all citizens have adequate and timely access to care, and good financial protection against the cost of health care? What do we know about the quality and safety of care provided to people with different health conditions? What are the financial, human and technical resources allocated to health systems in different countries? And how does this translate into beneficial activities and better health outcomes?

Answering these questions is by no mean an easy task. But the dashboards presented in this chapter can help shed light on how well countries do in promoting the health of their population and on several dimensions of health system performance. These dashboards do not have the ambition of identifying which countries have the best health system overall. However, they summarise some of the relative strengths and weaknesses of OECD countries on a selected set of indicators on health and health system performance, and can be useful to identify possible priority areas for actions.

These dashboards, which take the form of summary tables, highlight how well OECD countries are doing along five dimensions: 1) health status; 2) risk factors to health; 3) access to care; 4) quality of care; and 5) health care resources. For each of these five dimensions, a selected set of key indicators (ranging from 4 to 7) are presented in a summary table. The selection of these indicators is based on three main criteria: 1) policy relevance; 2) data availability; and 3) data interpretability (i.e., no ambiguity that a higher/lower value means a better/worse performance). There is, however, one notable exception to the application of this third criterion: for the fifth dashboard on health care resources,

more health spending or more human or physical resources does not necessarily mean better performance. This is why the ranking of countries is displayed differently (through different colours) in this last dashboard. Box 1.1 at the end of this chapter summarises some of the main limitations in interpreting these dashboards.

In most of the dashboards, countries are classified in three groups: 1) top third performer; 2) middle third performer; and 3) bottom third performer. In addition, the specific ranking of countries is indicated in each cell to provide further information on how close countries may be to the other group. The ranking is based on the number of countries for which data are available for each indicator (with a maximum of 34, when all countries are covered), with countries separated in three equal groups. For the first indicator related to access to care (the percentage of the population with health coverage), the grouping of countries is based on a different method because most countries are at or close to 100% coverage: the top countries are defined as those with a population coverage rate between 95% and 100%, the middle countries with a coverage between 90% and 95%, and the bottom countries with a coverage of less than 90%. The availability of comparable data is also more limited for indicators of access to care, either because of a lack of harmonisation in survey instruments (for indicators related to unmet care needs) or limitations in administrative data (for indicators on waiting times).

Health status

The broad measures of population health status shown in Table 1.1, such as life expectancy at various ages, are not only related to health spending and the performance of health systems, but also to a wide range of non-medical determinants of health (with some of the lifestyle and behavioural factors presented in Table 1.2). Countries that perform well on life expectancy at birth for men and women usually also tend to do well on life expectancy at older ages, and typically have lower rates of mortality from cardiovascular diseases (the main causes of death in nearly all OECD countries).

Japan, Spain, Switzerland, Italy and France are among the countries that have the highest life expectancy at birth and at older ages, although France does not perform so well in terms of life expectancy at birth for men, reflecting higher mortality rates among younger and middle-aged men.

Mexico, Hungary, the Slovak Republic and Turkey have the lowest life expectancy at birth and older ages, although Turkey has achieved huge gains in longevity over the past few decades and is quickly moving towards the OECD average (see the first indicator on life expectancy in Chapter 3 for trends over time).

While higher health spending per capita is generally associated with higher life expectancy, this relationship is less pronounced in countries with the highest health spending per capita. Japan, Spain and Korea stand out as having relatively high life expectancies, and the United States relatively low life expectancies, given their levels of health spending (see Table 1.5). Life expectancy in the United States is lower than in most other OECD countries because of higher mortality rates from various health-related behaviors (including higher calorie consumption and obesity rates, higher consumption of legal and illegal drugs, higher deaths from road traffic accidents and homicides), adverse socio-economic conditions affecting a large segment of the US population, and poor access and co-ordination of care for certain population groups.

Risk factors to health

Most countries do not perform well for at least one or more indicators of risk factors to health, whether that is the proportion of their population smoking tobacco, alcohol consumption, or overweight and obesity among children and adults (Table 1.2). This highlights the importance of countries putting a higher priority on health promotion and disease prevention policies to reduce modifiable risk factors to health and mortality from related diseases.

The United States, Canada, Australia and Mexico have achieved remarkable progress over the past few decades in reducing tobacco smoking among adults and have very low rates now, but they face the challenge of tackling relatively high rates of overweight and obesity among children and adults. Some countries like Italy and Portugal currently have a relatively low rate of obesity among adults, but the current high rate of overweight and obesity among children is likely to translate into higher rates among adults in the future. Other countries like Turkey and Greece have relatively low levels of alcohol consumption, but still have a way to go to reduce tobacco smoking. Alcohol consumption remains high in Austria, Estonia, the Czech Republic, Hungary, France and Germany, although the overall level of consumption has come down in many of these countries over the past few decades (see the indicator on alcohol consumption in Chapter 4).

Access to care

Most OECD countries have achieved universal (or near-universal) coverage of health care costs for a core set of services, with the exception of Greece, the United States and Poland, where a sizeable proportion of the population is still not covered (Table 1.3). In the United States, the percentage of the population uninsured has started to decrease significantly in 2014, following the implementation of the Affordable Care Act which is designed to expand health insurance coverage. In Greece, the response to the economic crisis has reduced health insurance coverage among people who have become long-term unemployed, and many self-employed workers have also not renewed their health insurance plans because of reduced disposable income. However, since June 2014, uninsured people are covered for prescribed pharmaceuticals and for services in emergency departments in public hospitals, as well as for non-emergency hospital care under certain conditions.

The financial protection that people have against the cost of illness depends not only on whether they have a health insurance, but also on the range of goods and services covered and the extent to which these goods and services are covered. In countries like France and the United Kingdom, the amount that households have to pay directly for health services and goods as a share of their total consumption is relatively low, because most such goods and services are provided free or are fully covered by public and private insurance, with only small additional payments required. Some other countries, such as Korea and Mexico, have achieved universal (or quasi-universal) health coverage, but a relatively small share of the cost of different health services and goods are covered, leaving a significant amount to be paid by households. Direct out-of-pocket payments can create financial barriers to health care, dental care, prescribed pharmaceutical drugs or other health goods or services, particularly for low-income households. The share of household consumption spent on direct medical expenditure is highest in Korea, Switzerland, Portugal, Greece and Mexico, although some of these countries have put in place proper safeguards to protect access to care for people with lower income.

Access to health care may be restricted not only because of financial reasons, but also because of geographic barriers, waiting times and other reasons. In Europe, around 3% of the population on average in countries that are OECD members reported unmet needs for medical examination due to cost, travel distance or waiting lists in 2013, according to the EU-SILC survey. The share of the population reporting such unmet medical care needs was highest in Greece and Poland, and lowest in the Netherlands and Austria. In nearly all countries, a higher proportion of the population reports some unmet needs for dental care, reflecting that public coverage for dental care is generally lower. People in Portugal, Iceland, Italy and Greece reported the highest rates of unmet needs for dental care among European countries that are OECD members in 2013.

Waiting times for different health services indicate the extent to which people have timely access to care for specific interventions such as elective surgery. Denmark, Canada and Israel have relatively low waiting times for interventions such as cataract surgery and knee replacement among the limited group of countries that provide these data, while Poland, Estonia and Norway have relatively long waiting times.

Quality of care

Improving quality of care is a high priority in most OECD countries. Based on the available data, no country consistently performs in the top group on all indicators of quality of care (Table 1.4), even those that spend much more on health. This suggests that there is room for improvement in all countries in the governance of health care quality and prevention, early diagnosis and treatment of different health problems.

The United States is doing well in providing acute care for people having a heart attack or a stroke and preventing them from dying, but is not performing very well in preventing avoidable hospital admissions for people with chronic conditions such as asthma and diabetes. The reverse is true in Portugal, Spain and Switzerland, which have relatively low rates of hospital admissions for certain chronic conditions, but relatively high rates of mortality for patients admitted to hospital for a heart attack or stroke.

Finland and Sweden do relatively well in having high survival of people following diagnosis for cervical, breast or colorectal cancer, while the survival for these types of cancer remains lower in Chile, Poland, the Czech Republic, the United Kingdom and Ireland. An important pillar to achieve progress in the fight against cancer is to establish a national cancer control plan to focus political and public attention on performance in cancer prevention, early diagnosis and treatment.

Health care resources

Higher health spending is not always closely related to a higher supply of health human resources or to a higher supply of physical and technical equipment in health systems.

The United States continues to spend much more on health per capita than all other OECD countries, but is not in the top group in terms of the number of doctors or nurses per population. Following the United States, the next biggest spenders on health are Switzerland, Norway, the Netherlands and Sweden, whereas the lowest per capita spenders are Mexico and Turkey (Table 1.5). Health spending per capita is also relatively low in Chile, Poland and Korea, although it has grown quite rapidly over the past decade.

Greece, Austria and Norway have the highest number of doctors per capita, while Switzerland, Norway and Denmark have the highest number of nurses. The mix between different categories of health workers varies widely, with some countries choosing to have

relatively more doctors (such as Greece and Austria) and others opting to rely more on nurses and other health care providers to deliver some services (such as Finland and the United States).

Some Central and Eastern European countries such as Hungary, Poland and the Slovak Republic continue to have a relatively high number of hospital beds, reflecting an excessive focus of activities in hospital. The number of hospital beds per capita is lowest in Mexico, Chile, Sweden, Turkey, Canada and the United Kingdom. Relatively low number of hospital beds may not create any capacity problem if primary care systems are sufficiently developed to reduce the need for hospitalisation.

The availability of expensive technological equipment such as MRI and CT scanners is highest in Japan and the United States, and much lower in Mexico, Hungary, Israel and the United Kingdom. There is no ideal number of MRI units or CT scanners per population, and there is also evidence in many countries of inappropriate and excessive use of these expensive diagnostic technologies.

Higher health spending and other human or technical resources are not always correlated with greater access to care or higher quality of care, as shown by the lack of any consistent correlation in countries' relative position between health spending and various indicators of access or quality of care. For example, Norway has high levels of health spending and also relatively high numbers of doctors and nurses, and does generally well on many indicators of quality of care, but still faces some persisting issues in terms of access to care, for instance, on waiting times for elective surgery. On the other hand, the Czech Republic spends much less on health and is achieving good results for several indicators on access to care, but could improve public health and prevention programmes and improve the quality of care for people who have chronic diseases such as diabetes. The performance of health systems in achieving the key policy goals of universal access and quality depends not only on allocating more money on health care, but also on making a more rational use of resources and providing the right incentives to ensure the best value for money spent.

Table 1.1. **Health status**

■ Top third performers
■ Middle third performers
■ Bottom third performers

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For the mortality indicator, the top performers are countries with the lowest rates.

Indicator	Life expectancy at birth - Men	Life expectancy at birth - Women	Life expectancy at 65 - Men*	Life expectancy at 65 - Women*	Mortality from cardiovascular diseases**
Australia	8	7	3	7	7
Austria	18	13	16	13	26
Belgium	22	19	23	14	15
Canada	13	17	10	10	5
Chile	27	27	27	28	16
Czech Rep.	28	28	29	30	31
Denmark	21	25	25	26	10
Estonia	32	26	31	27	32
Finland	23	8	20	9	24
France	15	3	2	2	2
Germany	18	19	16	22	25
Greece	17	9	13	11	27
Hungary	33	33	34	34	33
Iceland	2	16	10	20	23
Ireland	15	23	19	24	21
Israel	3	11	3	17	3
Italy	3	4	8	4	17
Japan	5	1	6	1	1
Korea	20	5	20	5	4
Luxembourg	9	11	6	8	12
Mexico	34	34	28	32	22
Netherlands	11	19	16	20	8
New Zealand	11	19	8	17	18
Norway	9	13	15	14	11
Poland	30	29	30	28	30
Portugal	24	9	23	11	14
Slovak Rep.	31	31	33	31	34
Slovenia	25	17	26	14	28
Spain	5	2	3	3	6
Sweden	5	13	10	17	19
Switzerland	1	6	1	5	13
Turkey	29	32	32	33	29
United Kingdom	14	24	14	23	9
United States	26	29	22	25	20

* Life expectancy at 65 is not presented in chapter 3 on health status, but rather in chapter 11 on ageing and long-term care.

** Mortality from cardiovascular diseases includes deaths from ischemic heart diseases and cerebrovascular diseases shown in Chapter 3, as well as other cardiovascular diseases.

Source: *Health at a Glance 2015*.

StatLink  <http://dx.doi.org/10.1787/888933281467>

Table 1.2. Risk factors

■ Top third performers
■ Middle third performers
■ Bottom third performers

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available.

Indicator	Smoking in adults	Alcohol consumption	Obesity in adults*	Overweight and obesity in children**
Australia	4	22	30*	20
Austria	26	34	8	14
Belgium	15	20	9	5
Canada	6	11	29*	21
Chile	33	10	28*	28
Czech Rep.	25	32	20*	5
Denmark	12	17	10	23
Estonia	31	33	18	7
Finland	10	14	26	17
France	30	30	11	13
Germany	23	28	25*	3
Greece	34	7	19	33
Hungary	32	30	31*	24
Iceland	2	6	21	9
Ireland	16	26	24*	11
Israel	11	2	13	18
Italy	24	4	4	31
Japan	17	7	1*	15
Korea	19	12	2*	16
Luxembourg	9	29	23*	19
Mexico	3	3	33*	30
Netherlands	13	14	6	7
New Zealand	8	16	32*	27
Norway	7	5	3	1
Poland	27	27	14	2
Portugal	14	25	12	25
Slovak Rep.	18	22	16*	3
Slovenia	22	17	17	22
Spain	29	20	15	26
Sweden	1	7	7	9
Switzerland	21	22	4	11
Turkey	27	1	22*	n.a.
United Kingdom	20	19	27*	32
United States	5	13	34*	29

* Data on obesity in adults are based on measured height and weight for all the countries marked with an *. These result in more accurate data and higher obesity rates compared with all other countries that are providing self-reported height and weight.

** Data on overweight or obesity in children are all based on measured data, but refer to different age groups across countries.

Source: *Health at a Glance 2015*.

StatLink  <http://dx.doi.org/10.1787/888933281473>

Table 1.3. Access to care

- Top third performers (or between 95% and 100% for health care coverage)
- Middle third performers (or between 90% and 95% for health care coverage)
- Bottom third performers (or less than 90% for health care coverage)

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For out-of-pocket medical expenditure, unmet care needs and the waiting times indicators, the top performers in terms of access are countries with the lowest expenditure as a share of household consumption, the lowest unmet care needs or lowest waiting times.

Indicator	Health care coverage	Share of out of pocket medical expenditure in household consumption	Unmet medical care needs*	Unmet dental care needs*	Waiting times for cataract surgery - median	Waiting times for knee replacement - median
Australia	1	22	n.a.	n.a.	8	12
Austria	1	18	1	2	n.a.	n.a.
Belgium	1	20	11	8	n.a.	n.a.
Canada	1	11	n.a.	n.a.	2	4
Chile	1	28	n.a.	n.a.	13	8
Czech Rep.	1	7	5	4	n.a.	n.a.
Denmark	1	14	7	10	4	1
Estonia	2	12	21	19	9	13
Finland	1	18	19	11	10	7
France	1	3	15	15	n.a.	n.a.
Germany	1	5	9	5	n.a.	n.a.
Greece	3	32	23	20	n.a.	n.a.
Hungary	1	30	14	9	1	6
Iceland	1	21	18	22	n.a.	n.a.
Ireland	1	22	17	17	n.a.	n.a.
Israel	1	16	n.a.	n.a.	3	3
Italy	1	22	20	21	n.a.	n.a.
Japan	1	9	n.a.	n.a.	n.a.	n.a.
Korea	1	34	n.a.	n.a.	n.a.	n.a.
Luxembourg	1	5	4	3	n.a.	n.a.
Mexico	1	30	n.a.	n.a.	n.a.	n.a.
Netherlands	1	2**	1	1	n.a.	n.a.
New Zealand	1	9	n.a.	n.a.	7	5
Norway	1	16	8	15	12	10
Poland	2	13	22	13	14	14
Portugal	1	29	16	23	6	11
Slovak Rep.	2	22	11	6	n.a.	n.a.
Slovenia	1	7	n.a.	n.a.	n.a.	n.a.
Spain	1	26	3	18	11	9
Sweden	1	26	11	14	n.a.	n.a.
Switzerland	1	33	6	12	n.a.	n.a.
Turkey	1	1	n.a.	n.a.	n.a.	n.a.
United Kingdom	1	3	9	7	4	2
United States	3	14	n.a.	n.a.	n.a.	n.a.

* Unmet medical or dental care needs may be for financial reasons, waiting times or long distance to travel to get access to services. The data only cover European countries because they are based on the EU-SILC survey.

** The ranking for the Netherlands is overrated as it excludes compulsory co-payments to health insurers (if these were included, this would move the Netherlands in the middle third category).

Source: Health at a Glance 2015.


StatLink  <http://dx.doi.org/10.1787/888933281483>

Table 1.4. Quality of care

■ Top third performers
■ Middle third performers
■ Bottom third performers

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For the indicators of avoidable hospital admissions and case-fatality rates, the top performers are countries with the lowest rates.

Indicator	Asthma and COPD hospital admission	Diabetes hospital admission	Case-fatality for AMI (admission-based)	Case-fatality for ischemic stroke (admission-based)	Cervical cancer survival	Breast cancer survival	Colorectal cancer survival
Australia	29	17	1	20	11	5	3
Austria	28	29	27	8	19	19	7
Belgium	16	20	19	20	16	12	4
Canada	18	10	11	26	12	8	13
Chile	6	27	31	16	25	23	n.a.
Czech Rep.	12	23	11	22	13	22	21
Denmark	26	14	7	17	5	11	18
Estonia	27	n.a.	28	29	8	25	22
Finland	10	15	9	4	6	4	7
France	7	21	17	13	n.a.	n.a.	n.a.
Germany	21	25	25	8	15	15	10
Greece	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	31	11	30	22	n.a.	n.a.	n.a.
Iceland	14	4	15	14	7	10	n.a.
Ireland	32	16	8	24	20	20	19
Israel	19	9	11	6	10	7	2
Italy	2	1	5	7	3	15	12
Japan	1	18	29	1	4	9	4
Korea	24	30	24	2	2	14	1
Luxembourg	9	19	16	17	n.a.	n.a.	n.a.
Mexico	5	31	32	31	n.a.	n.a.	n.a.
Netherlands	11	6	20	12	16	16	11
New Zealand	30	22	10	14	14	12	15
Norway	17	7	11	5	1	2	13
Poland	20	28	3	n.a.	24	24	23
Portugal	3	8	26	27	18	6	16
Slovak Rep.	23	26	17	28	n.a.	n.a.	n.a.
Slovenia	8	13	4	30	23	18	17
Spain	15	3	23	24	n.a.	n.a.	n.a.
Sweden	13	12	2	8	9	1	6
Switzerland	4	2	22	11	n.a.	n.a.	n.a.
Turkey	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
United Kingdom	22	5	20	19	22	21	20
United States	25	24	5	3	21	2	9

Source: Health at a Glance 2015.

StatLink  <http://dx.doi.org/10.1787/888933281494>

Table 1.5. Health care resources


Top third in health spending or resources
 Middle third in health spending or resources
 Bottom third in health spending or resources

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. Although countries are ranked from highest health spending or availability of resources to lowest, this does not necessarily mean better performance.

Indicator	Health expenditure per capita	Doctors per capita (active)	Nurses per capita (active)	Hospital beds per capita	MRI units per capita*	CT scanners per capita*
Australia	13	14	10	18	12*	2*
Austria	8	2	21	4	9	10
Belgium	11	21	15	9	19*	11*
Canada	10	28	16	29	22	23
Chile	30	33	27	32	26	26
Czech Rep.	27	10	20	7	24	22
Denmark	7	11	3	23	10	5
Estonia	31	18	23	12	17	15
Finland	17	20	5	13	6	13
France	12	16	17	8	21	24
Germany	6	5	6	3	15*	16*
Greece	25	1	32	14	5	8
Hungary	29	19	22	5	31*	31*
Iceland	15	11	4	21	7	4
Ireland	16	25	7	26	13	17
Israel	24	13	31	22	30	29
Italy	20	8	24	19	3	9
Japan	14	29	13	1	1	1
Korea	26	31	29	2	4	6
Luxembourg	9	22	9	11	14	12
Mexico	33	32	33	33	32	32
Netherlands	4	17	8	n.a.	16	28
New Zealand	18	22	14	26	18	20
Norway	3	3	2	17	n.a.	n.a.
Poland	32	30	28	6	28	19
Portugal	22	4	25	20	27*	14*
Slovak Rep.	28	14	26	10	25	21
Slovenia	23	26	18	16	23	27
Spain	21	9	30	24	11	18
Sweden	5	7	11	31	n.a.	n.a.
Switzerland	2	6	1	15	8*	7
Turkey	34	34	34	30	20	25
United Kingdom	19	24	19	26	29	30
United States	1	27	12	25	2	3

* Data for most countries marked with an * do not include MRI units and CT scanners installed outside hospitals, leading to an under-estimation. In Australia and Hungary, the data only include MRI units and CT scanners eligible for public reimbursement, also leading to an under-estimation.

Source: Health at a Glance 2015.

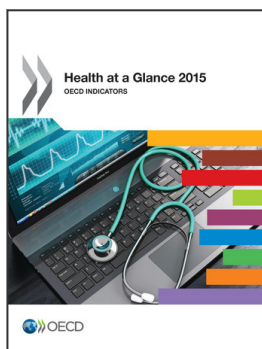
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Box 1.1. Limitations in the interpretation and use of the dashboards

The previous dashboards should be interpreted and used with caution for several reasons:

- Due to limitations in data availability, the indicators selected on each topic do not generally provide a complete coverage of all important aspects related to this topic. For instance, the indicators of health status relate solely to mortality because mortality data are more widely available and comparable across countries than morbidity data. While life expectancy undoubtedly is a key indicator of health status, the lack of indicators about the physical and mental health status of people while they are alive is an important limitation. The same limitations also apply to the dashboards on risk factors (which only include some risk factors to health), access to care and quality of care.
- There are limitations in data comparability for some indicators which should be kept in mind in interpreting the ranking of countries. One notable example is the indicator on obesity rates among adults, which in several countries are based on self-reported height and weight, resulting in an under-estimation compared to those countries that provide more reliable data based on measured obesity.
- The grouping of countries in three groups (tertiles) is based on a simple method using only the point estimates of each country and dividing them in three equal groups. It does not take into account the distribution of the data around the OECD average, nor the confidence intervals for those indicators where these have been calculated (notably for several indicators of quality of care).
- These dashboards only present the current situation and in this respect may hide the progress that some OECD countries might have achieved over time and the fact that they may be moving quickly towards the OECD average. These key trends are discussed in the publication.

Because of these limitations in data availability, comparability and statistical significance, there is no attempt to calculate any summary indicator of performance for each of the dimensions or across dimensions. These dashboards should be used to get a first impression on the relative strengths and weaknesses of different OECD countries on the set of indicators selected. It should be complemented by a more in-depth review of the data and the factors influencing the cross-country variations presented in the following chapters of this publication.



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