OECD Reviews of Health Care Quality

Caring for Quality in Health

LESSONS LEARNT FROM 15 REVIEWS OF HEALTH CARE QUALITY

OECD

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OECD
BETTER POLICIES FOR BETTER LIVES

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Please cite this publication as:
OECD (2017), *Caring for Quality in Health: Lessons Learnt from 15 Reviews of Health Care Quality*, OECD Reviews of Health Care Quality, OECD Publishing, Paris.
http://dx.doi.org/10.1787/9789264267787-en

ISBN 978-92-64-26777-0 (print)
ISBN 978-92-64-26778-7 (PDF)

Series: OECD Reviews of Health Care Quality
ISSN 2227-0477 (print)
ISSN 2227-0485 (online)

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Foreword

This synthesis report draws on key lessons from the *OECD Health Care Quality Review* series. As health costs continue to climb, policy makers increasingly face the challenge of ensuring that substantial spending on health is delivering value for money. At the same time, concerns about patients occasionally receiving poor-quality health care have led to demands for greater transparency and accountability. Despite this, considerable uncertainty still remains over i) which policies work best in delivering safe, effective health care that provides a good patient experience, and ii) which quality-improvement strategies can help deliver the best care at the least cost.

The objective of this report is to summarise the main challenges and good practices so as to support improvements in health care quality and to help ensure that the substantial resources devoted to health are used effectively in supporting people to live healthier lives. The findings presented in this synthesis report were assembled through a systematic review of the policies and institutions described in each *OECD Health Care Quality Review*, to identify common challenges, responses and leading-edge practices. This material was complemented by OECD health statistics and other OECD reports where appropriate.

The overarching conclusion emerging across the *OECD Health Care Quality Review* series concerns transparency. Governments should encourage, and where appropriate require, health care systems and health care providers to be open about the effectiveness, safety and patient-centredness of care they provide. More measures of patient outcomes are needed (especially those reported by patients themselves), and these should underpin standards, guidelines, incentives and innovations in service delivery. Greater transparency can lead to optimisation of both quality and efficiency – twin objectives that reinforce, rather than subvert, each other. In practical terms, greater transparency and better performance can be supported by making changes in where and how care is delivered; by modifying the roles of patients and professionals, and by more effectively employing tools such as data and incentives. Key actions in these three areas are set out in the 12 lessons presented in this synthesis report.

Acknowledgements

This report was written and co-ordinated by Caroline Berchet and Ian Forde.

Other authors were Rie Fujisawa, Emily Hewlett and Carol Nader. We are grateful for comments on earlier drafts from Ian Brownwood, Niek Klazinga, Francesca Colombo, Mark Pearson and Stefano Scarpetta from the OECD Directorate of Employment, Labour and Social Affairs. Thanks also go to Marlène Mohier, Lucy Hulett and Alastair Wood for editorial input and to Duniya Dedeyn for logistical support.

In addition, we would like to thank delegates to the OECD Health Committee and OECD Health Care Quality Indicators Expert Group for detailed comments on two interim reports, on earlier drafts of this synthesis report and for suggestions throughout the course of the project, 2012–2016. We also reiterate our thanks to all of the national policy experts and data correspondents interviewed for the individual health care system quality reviews, listed in each publication.

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Acronyms and abbreviations

CME	Continuous medical education
CPD	Continuous professional development
EHR	Electronic health record
FFS	Fee-for-service
GP	General practitioner
ICP	Individual care plan
LTC	Long-term condition
NHS	National Health Service
P4P	Pay-for-performance
PCIC	Patient-centred integrated care
PCP	Primary care practitioner
PIP	Practice Incentives Programme
PREM	Patient-reported Experience Measure
PROM	Patient-reported Outcome Measure
PRIM	Patient-reported Incident Measure
QOF	Quality and Outcomes Framework
ULS	*Unidade Local de Saude*

Introduction

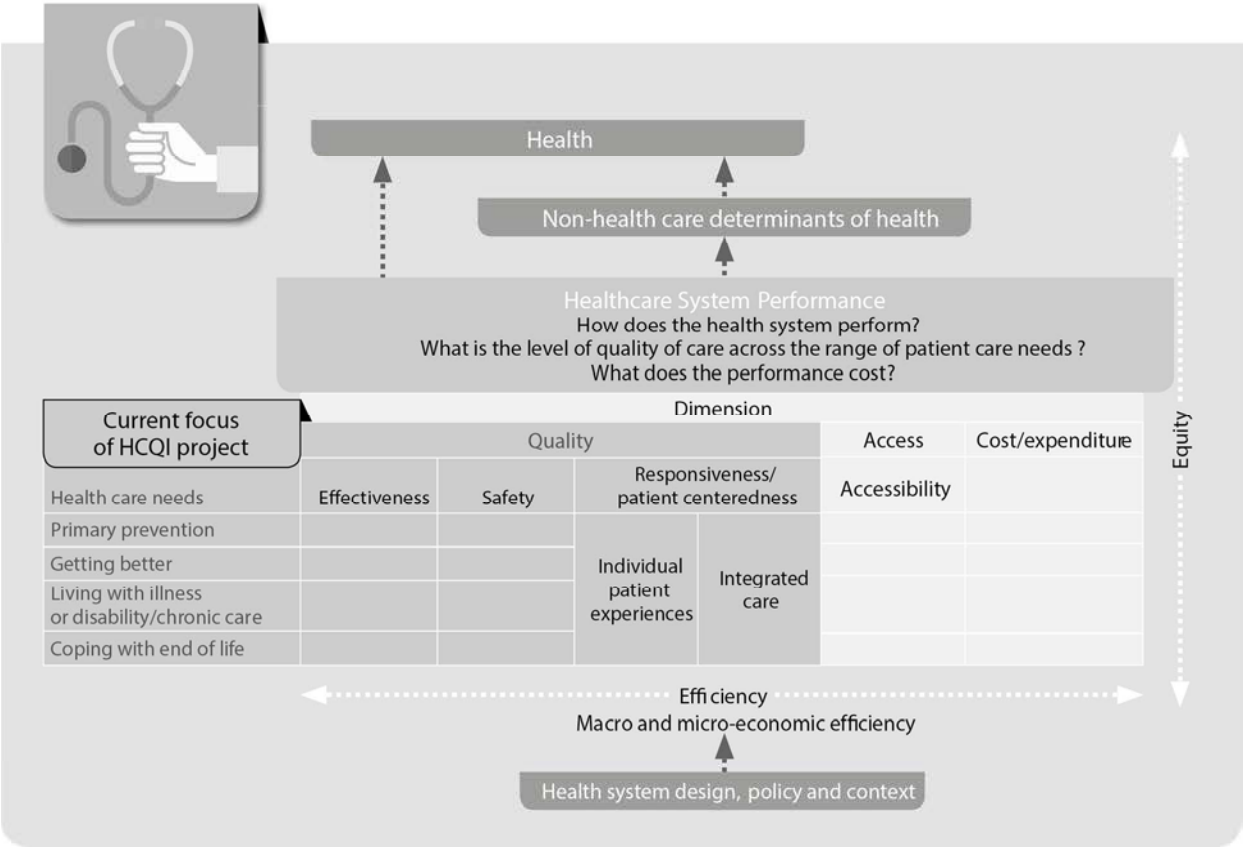
Between 2012 and 2016, the OECD conducted a series of in-depth reviews of the policies and institutions that underpin the measurement and improvement of health care quality in 15 different health care systems (Australia, Czech Republic, Denmark, England, Israel, Italy, Japan, Korea, Northern Ireland, Norway, Portugal, Scotland, Sweden, Turkey and Wales). The 15 settings examined are highly diverse, encompassing the high-tech, hospital-centric systems of Japan and Korea, the community-focussed Nordic systems, the unique challenges of Australia's remote outback, and the historically underfunded systems of Turkey and the Czech Republic, now undergoing rapid modernisation. What unites these and all other OECD health care systems, however, is that all increasingly care about quality.

In a time of multiple, unprecedented pressures on health care systems – many of which are beyond health care systems' control – central and local governments as well as professional and patient groups are renewing their focus on one issue that they can control and one priority that they equally share: health care quality and outcomes. In the OECD's work to measure and improve health care system performance, health care quality is understood to comprise three dimensions: effectiveness, safety and patient-centredness (or responsiveness). These dimensions are applied across the key stages of the care pathway: staying well (preventive care), getting better (acute care), living with illness or disability (chronic care) and care at the end of life (palliative care). This conceptual framework is illustrated in Figure 0.1.

To facilitate the provision of high-quality care, governments and professional and patient groups use a consistent set of tools (shown in Table 0.1), such as standardisation of clinical practices, monitoring of capabilities, reports on performance or accreditation of health care organisations. The way these tools are shaped and used varies, rightly, from system to system depending on local needs and traditions. In some systems, regulation is relatively light-touch; in others, regulatory activities such as accreditation and licensing follow lengthy and detailed protocols (see tables in Annex A).

Despite differences in health care system priorities, and in how quality-improvement tools are designed and applied, a number of common approaches emerged across the 15 *OECD Reviews* of *Health Care Quality* analysed. Likewise, a number of shared challenges became apparent. This report seeks to answer the question of what caring for quality means for a modern health care system by distilling 12 key lessons from the 15 reviews published over the last five years. The report identifies what policies and approaches work best in improving quality of care and provides guidance to policy makers on the actions that they can take to improve health care quality. A second, equally important purpose is to identify unresolved gaps and challenges in health care systems' progress towards continuous monitoring and improvement of quality across all sectors, for all patient groups.

Figure 0.1. OECD framework for health care system performance measurement



Source: Carinci, F. et al. (2015), "Towards Actionable International Comparisons of Health System Performance: Expert Revision of the OECD Framework and Quality Indicators", *International Journal for Quality in Health Care*, Vol. 27, No. 2, pp. 137-146, http://dx.doi.org/10.1093/intqhc/mzv004.

Table 0.1. Key policies and institutions that influence health care quality

Policy	Examples
Health system design	Accountability of actors, allocation of responsibilities legislation
Health system inputs (professionals, organisations, technologies)	Professional licensing, accreditation of health care organisations, quality assurance of drugs and medical devices
Health system monitoring and standardisation of practice	Measurement of quality of care, national standards and guidelines, national audit studies and reports on performance
Improvement (national programmes, hospital programmes and incentives)	National programme on quality and safety, pay for performance in hospital care, examples of improvement programmes within institutions

A key priority is to encourage, and where appropriate require, health care systems and health care providers to be open about the effectiveness, safety and patient-centredness of care they provide. Health care system governance should focus on using transparency to steer performance, through continuous plan-do-study-act cycles, at national as well as at local level. Greater focus on patient outcomes is particularly important, and this can

support optimisation of both quality and efficiency. Twelve policy actions or lessons illustrate how, in practical terms. The first four address the need for systemic changes on where and how care is delivered. The importance of placing the primary care sector at the forefront of the health care system to deliver pro-active, co-ordinated care, especially for patients living with one or more chronic conditions, is stressed. Lessons 5–8 explore the changing role of stakeholders, notably the role of the patients and of health professionals to deliver high-value and safe care. The final four lessons address the data and incentive structures that should be aligned to outcomes and quality of care to guarantee the accountability and transparency necessary for a more efficient health care system.

Approaches to quality monitoring and improvement are divergent. Some systems (the Czech Republic, England and Turkey, for example), while taking into account views of local stakeholders, emphasise quality management and quality control largely designed by central authorities. Other systems (Italy, Norway and Scotland, for example), prioritise quality-improvement activities, characterised by plan-do-study-act cycles at local level. The correct balance between top-down and bottom-up approaches will depend upon political traditions and priorities, and can be difficult to judge. In any arrangement, however, two key ingredients are needed to drive sustainable change.

The first is a quality culture among both clinicians and service managers, to encourage continuously better and safer care. Ways to encourage a culture of continuous quality improvement include educational measures, feedback on performance, and learning and sharing from good practices. This is essential to change behaviour and to seek opportunities for quality improvement. Such activities appeared weaker in some health care systems including the Czech Republic, Korea and Turkey, where demonstrations of quality monitoring and improvement were not as developed as in other OECD countries. In this case, it is essential to assure that the intent of quality initiatives is not punitive for health professionals, but rather to share knowledge and learn from experiences to then drive quality improvements. This is crucial to build a culture of quality.

The second ingredient is a clear accountability framework. This entails a role for central authorities to: set system-wide priorities; provide a nationally consistent approach to measure them; identify excellence; and support poor performers. Yet consistent steering from central authorities is lacking in some systems, such as Italy and Australia. The review of country experiences suggests that ambitious quality-improvement programmes can fail to deliver expected results in a system characterised by a weak accountability framework with fragmented leadership. At the same time, sufficient space for local innovations to improve care quality must be maintained.

SYSTEMIC CHANGES ON WHERE AND HOW HEALTH CARE IS DELIVERED WILL OPTIMISE BOTH QUALITY AND EFFICIENCY

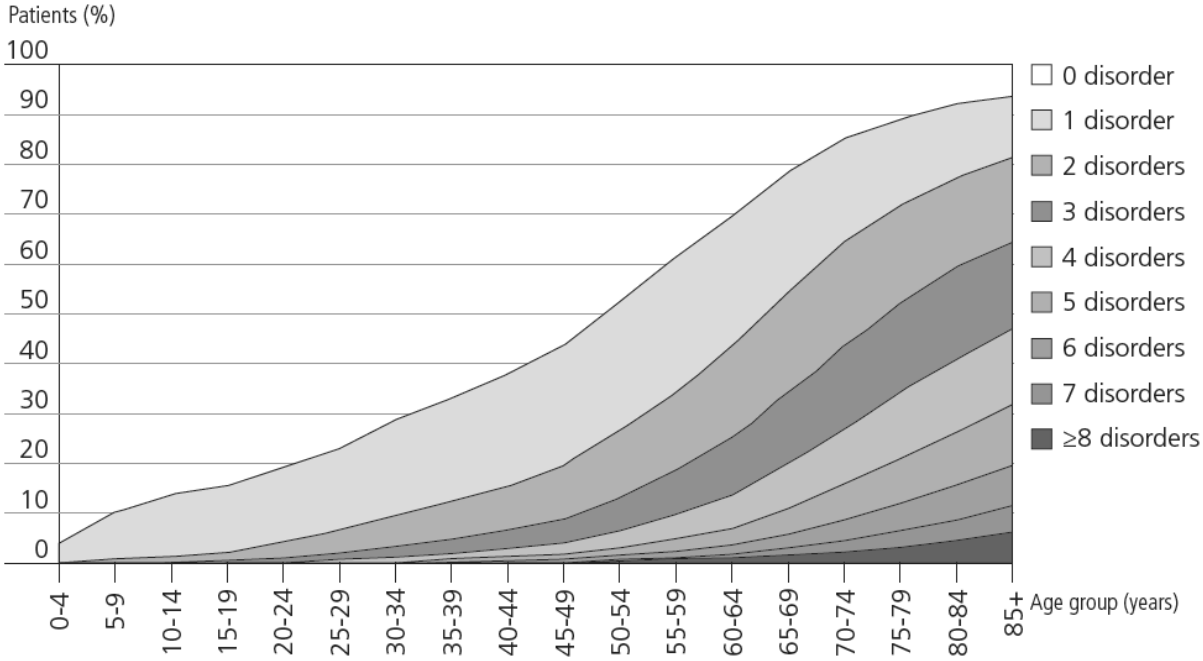
All OECD health care systems need to gear themselves for an ageing population, which is most often associated with an increased prevalence of long-term conditions (LTC) such as diabetes or hypertension. In many cases, the elderly population suffers from multiple chronic conditions simultaneously. Such socio-demographic and epidemiologic challenges place increasing pressure on the health sector, calling for better prevention and more effective management of chronic diseases. The transition towards chronic and LTCs also requires a comprehensive approach, supporting patient-centred integrated care (PCIC), which is a means to optimise both quality and efficiency. Strengthening primary care is a fundamental way of shifting the focus to PCIC, but it will also be a key element to improving quality care for mental health disorders, which often co-exist with other LTCs.

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.

Lesson 1. High-performing health care systems offer primary care as a specialist service that provides comprehensive care to patients with complex needs

Across OECD countries, the population aged over 65 years increased from less than 9% in 1960 to 16% in 2014; and it is expected to nearly double in the next four decades to reach 27% in 2050. At the same time, nearly 65% of those aged 65-84 are estimated to have more than one chronic condition, a prevalence that reaches 89% for those aged 85 and over (Figure 1.1). Given the growing ageing population and the rising prevalence of multimorbidities, it is widely accepted that hospitals are neither the best settings to provide preventive care nor from which to manage multiple and complex care needs. It makes clinical and economic sense for health care systems to rebalance services towards community-based primary care. Stronger primary care requires investing in key functions of primary care (comprehensiveness, care co-ordination and care continuity), shifting care out of costly inpatient services and developing a rich information infrastructure to underpin quality monitoring and improvement.

Figure 1.1. The prevalence of multimorbidity is increasing with age



Source: Adapted from Barnett, K. et al. (2012), "Epidemiology of Multimorbidity and Implications for Health Care, Research, and Medical Education: A Cross-sectional Study", *The Lancet*, Vol. 380, No. 9836, pp. 37-43.

Investing in key functions of primary care

Primary care is critical to provide effective, co-ordinated care for patients with multiple needs. While no one single dimension of primary care exists, a large body of evidence finds that comprehensiveness, care co-ordination and care continuity are essential functions to deliver high-quality and efficient health care (Kringos et al., 2015; Starfield, 1994, 2005). In practical terms, this means that primary care constitutes the first point of call, serving as a co-ordinating hub for complex patient care, with the ability to refer patients to secondary care when necessary. It also strives to provide care that is

person- rather than disease-focused, and entails a long-term clinical relationship with patients.

Delivering such a model of care is not an easy task. OECD countries have taken different paths to provide it (Table 1.1). Several OECD countries established a patient registration system to favour care continuity. In the Czech Republic, Denmark, Italy, Norway and Portugal, patients are required to register with a regular primary care practitioner (PCP). Some health care systems went a step beyond and introduced a gatekeeping or referral system to achieve greater care co-ordination. In Australia, Denmark, Israel, Italy, Norway, Portugal and the United Kingdom, access to a specialist is available only by referral from a PCP.

Investing in a specialist primary care workforce is also fundamental to developing a strong primary care system. In the context of population ageing, where a growing number of individuals have multiple and complex care needs, a specialist primary care sector with a comprehensive and patient-centred orientation is especially needed. Firm evidence suggests the benefits of having a specialist primary care workforce (Masseria et al., 2009). Not only does a specialist workforce promote the health and well-being of the population, it also contributes to better quality, co-ordination, responsiveness and cost-effectiveness of health care services, particularly with respect to the management of long-term conditions (LTCs) (Shi et al., 2002; Boerma et al., 1998; Kringos et al., 2010; Thorlby, 2013; Goodwin et al., 2011). Almost all health care systems reviewed have invested in a specialist primary care workforce (Table 1.1). In Turkey for example, the 2005 *Health Transformation Programme* reinvigorated the specialty of family medicine. Since then, nearly all Turkish medical schools include departments of family medicine that supervise specialty training over three years, leading to a post-graduate diploma in family medicine (OECD, 2014a). By contrast, Japan was lagging behind the other OECD countries, with no specialist training in general practice or family medicine. However, the Ministry of Health, Labour and Welfare is taking steps in the right direction. General practitioners are now recognised as primary care specialists and a distinct training in general practice will start from 2018.

The Czech Republic, Japan, Korea and Turkey demonstrate weaknesses in their current primary care arrangements. Common to these countries is a lack of strong primary care to be responsible for co-ordinating prevention, investigation and treatment of health care needs, and to steer demand for secondary care. By contrast, England, Norway and Denmark are internationally recognised for their strong primary care sectors, with care co-ordination a key function of general practice.

To build a strong primary health care foundation capable of delivering a wide range of pro-active and patient-centred health services, all OECD health care systems need to continue developing primary care as a specialist community-based service that offers comprehensiveness, continuity and co-ordination to patients with complex needs.

Table 1.1. Key functions of primary care

	Is gatekeeping or referral system to access most types of specialist care?	Do patients have to registered with PCPs or family physicians	Is there post training requirement to become GPs, family physicians or PCPs ?
Australia	Yes	Optional	Yes, there is postgraduate training programme in general practice.
Czech Republic	No	Required	Yes, there is postgraduate training programme in general practice.
Denmark	Yes	Required	Yes, there is postgraduate training programme in general practice.
Israel	Yes	Not required	Yes, there is a family practice residency programmes.
Italy	Yes	Required	Yes, there is a post-graduate programme of three years to achieve the speciality of general practice.
Japan	No	Not required	No, primary care has been delivered by a cadre of semi generalist/semi specialists with no compulsory training. The country, however, plan to introduce a new specialist training in general practice from 2018.
Korea	No	Not required	Yes, there is a specific specialisation in “family medicine”.
Norway	Yes	Required	Yes, here is specialist training in general practice (undergone by 60% of GPs in Norway).
Portugal	Yes	Required	Yes, there is a general practice and family medicine speciality.
Sweden	No	Optional	Yes, Swedish GPs are medical specialists in family medicine.
Turkey	No	Not required	Yes, family medicine is a post-graduate training programme since the Health Transformation Programme (with the family practitioner scheme)
United Kingdom	Yes	Not required	Yes, there is a post graduate specialty in the field of general practice.

Source: OECD Secretariat based on the series of *OECD Reviews of Health Care Quality.*

Shifting treatment towards primary and community care settings

Stronger primary care may be a means to contain health spending, by shifting care away from costly inpatient services. Many factors determine where care occurs. An important determinant (beyond patient preferences) is the availability of services in the community to prevent hospital admissions or to continue a patient’s care after discharge. Availability of co-ordinated and high-quality community care was reported to be poor or inconsistent in Japan, Korea, Portugal and Turkey. These countries have above-average acute care capacities and lag behind the OECD average with long average length of hospital stay or low discharge rates. They are pursuing policies to reduce dependence on the hospital sector but progress in this area is still slow.

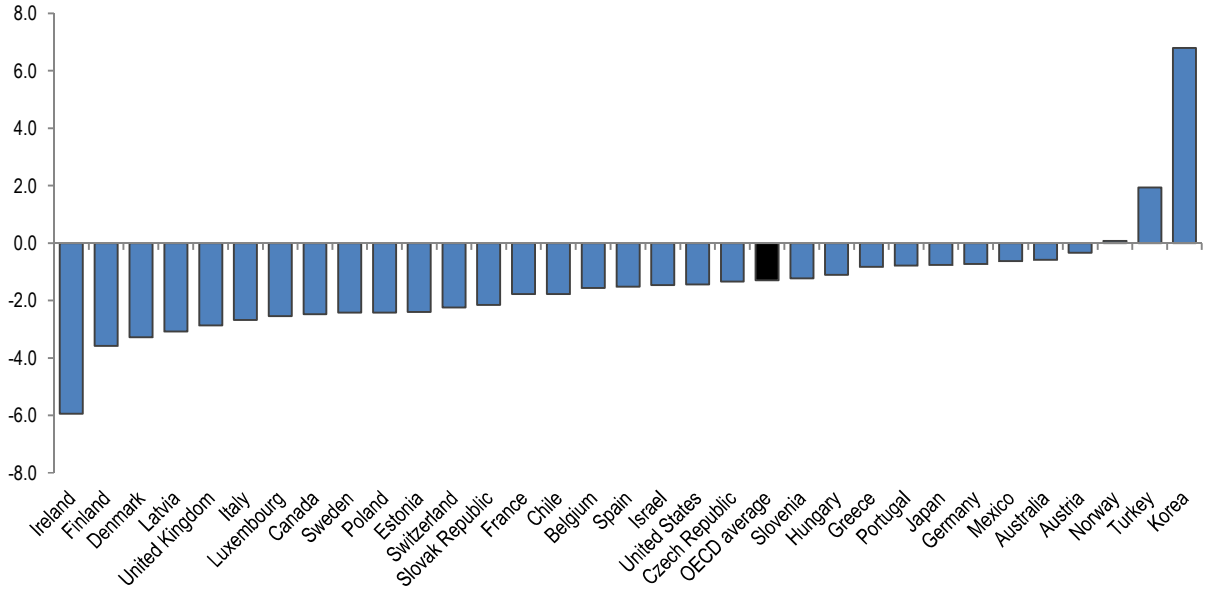
Although there is an observable trend in OECD countries to reduce the number of hospital beds available and length of hospital stays (Figure 1.2), investment in primary care may not be happening fast enough at a time when the burden of disease is shifting towards chronic diseases. The average annual growth rate in hospital beds from 2000 to 2014 ranged from -6.0% in Ireland to 6.8% in Korea and 2.8% in Turkey. Length of stay in hospitals fell, from 9.4 days in 2000 to 7.8 days in 2014. However, patients admitted to

hospital in Japan or Korea can expect to stay for more than 15 days, while those in Denmark, Turkey and Mexico stay on average fewer than 5 days (OECD, 2015a).

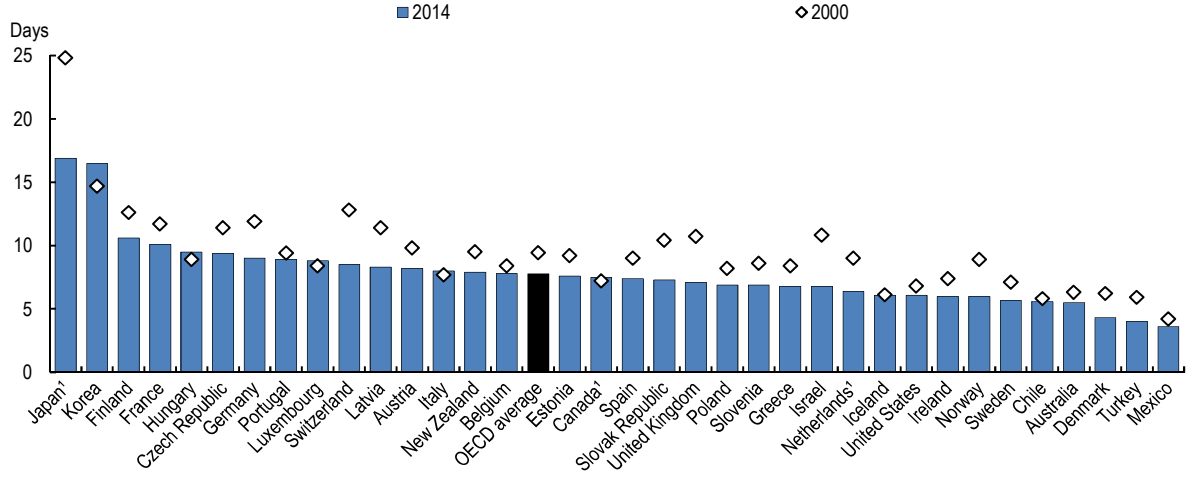
Concerted action should be taken to continue shifting care from inpatient to non-acute care settings and keeping patient out of hospitals, especially when hospitalisation could be prevented or care could be delivered more cost-effectively in a primary care setting.

Figure 1.2. Health care is progressively shifting out of hospitals but progress in some countries is still low

Panel A. Average annual growth rate of hospital beds, 2000-14 (or nearest year)



Panel B. Average length of stay in hospital, 2000 and 2014 (or nearest year)



Note: The OECD average includes 35 countries.

1. Data refer to average length of stay for curative (acute) care (resulting in an underestimation).

*Source: OECD Health Statistics (*2016), http://dx.doi.org/10.1787/health-data-en.

Building a richer data infrastructure on activities, quality and outcomes in primary care

Although primary care is being asked to do more, most health care systems lack sufficient data infrastructure to know whether or not primary care is delivering high-quality care. Compared to the hospital sector, a significant deficit of information exists on the patterns of care and outcomes in primary care. Quality standards, indicators and monitoring frameworks are much less developed in primary care. This may be because hospital-based care is more procedural, and so is more amenable to standardisation and measurement. The strengths of primary care (comprehensiveness, co-ordination and continuity) are harder to define and measure.

The development of comprehensive and actionable indicators would allow PCPs, patients and authorities to benchmark quality and performance against peers or against national guidelines. Doing so would also facilitate analysis of quality trends and provide the information needed to improve quality. This is especially needed as increased pressure is placed on the primary care sector to engage in more preventive work and deliver a wide range of care for patients with complex needs. Some OECD health care systems have made good progress in developing a richer information infrastructure to underpin quality monitoring and improvement in primary care. England, for example, has unique, comprehensive and routinely available data for every practice on quality of care. Its Quality and Outcomes Framework (QOF) is one of the most advanced monitoring systems across OECD countries. QOF is an incentive scheme that provides additional reward to general practitioners (GPs) for how well they care for patients based on performance against more than 80 clinical and other indicators. The programme is designed to incentivise and standardise the provision of evidence-based, high-quality care in general practice covering several major LTCs including mental health problems such as depression. It also includes indicators relating to public health and other services provided in primary care (contraception, screening and immunisation). Beyond the QOF, the country collects several patient experience measures with general practice. About 2.4 million patients registered with a GP practice are surveyed twice a year around access, making appointments, quality of care, satisfaction with opening hours and experience with out-of-hours National Health Service (NHS) services. England has other rich data sources on the quality of mental health care, prevention measures, or around the use of hospital care by GPs, all of which are published at the GP practice level (OECD, 2016a). Denmark and Israel also took steps to better measure quality and outcomes in primary care, although recent events in Denmark illustrate that unexpected obstacles can derail progress in this area (see Case Study 1).

Richer monitoring of primary care quality should be scaled up to measure whether or not the primary care system is delivering effective, safe and patient-centred care. Candidate indicators to measure the quality of primary care should concentrate around prevention, management of chronic diseases, elder care, mental health care and co-ordination between levels of care.

Case Study 1. Building rich information infrastructure to underpin quality monitoring and improvement in primary care in Israel and Denmark

Israel

- Israel's *Quality Indicators in Community Healthcare* (QICH) programme captures more than 35 measures of quality of care on preventive measures, use of recommended care, and the effectiveness of care, including for asthma, cancer and diabetes management as well as cardiovascular health.
- Data are available for almost the entire population. The four insurer/provider bodies in Israel draw on QICH data to benchmark their own performance and identify potential shortfalls.
- Insurer/providers developed i) innovative programmes including patient education and empowerment initiatives, and ii) targeted programmes to deliver greater access to high-quality care to specific patient groups (OECD, 2012a).

Denmark

- Denmark's *Danish General Practice Database* (DAMD) system was suspended in 2014 because of concerns (most notably among GPs themselves) around the legal basis and intended use of the data. Before that, however:
  - The DAMD system automatically captured primary care diagnoses, procedures, prescribed drugs and laboratory results. From April 2011 every practice was obliged to participate.
  - GPs were able to access quality reports for the management of chronic diseases, as well as other clinical areas of primary care practice, including diabetes management and cardiovascular health.
  - The system enabled easy identification of individual patients who were treated suboptimally and allowed GPs to benchmark their practice against others.
- Studies examining DAMD's impact found significant improvements in the proportion of diabetics on antidiabetic, antihypertensive and lipid-lowering medications (OECD, 2013a).

Source: OECD (2012a, 2013a).

Lesson 2. Patient-centred care requires more effective primary and secondary prevention in primary care

The burden of chronic diseases is increasing in OECD countries, a major cause of concern not only for population health but also for the economy as a whole. Combined with the trend to shift care outside the hospital setting, this calls for greater prevention efforts to be embedded in primary care practice. Efforts would include evidence-based primary care interventions such as targeted education programmes, counselling in primary care, cost-effective screening programmes and effective management of chronic diseases.

Tackling unhealthy lifestyles and improving early diagnosis to prevent premature mortality

Although key risk factors have declined in many OECD countries, unhealthy diets, obesity and alcohol consumption have spread in others (OECD, 2015a). Over the past decade, alcohol consumption rose in Australia, Norway, Sweden and the United Kingdom; and obesity among adults increased in all 15 OECD health care systems covered in the series of *OECD Reviews of Health Care Quality* (Figure 1.3). On average across these countries, obesity rates increased by 24% between 2000 and 2014. The burden of adult obesity is substantial in Australia, the United Kingdom and the Czech Republic, with more than one in five people obese. Increasing overweight or obesity rates among children between 2001 and 2014 also gives cause for concern in the Czech Republic (+93%), Portugal (+58%) and Italy (+32%).

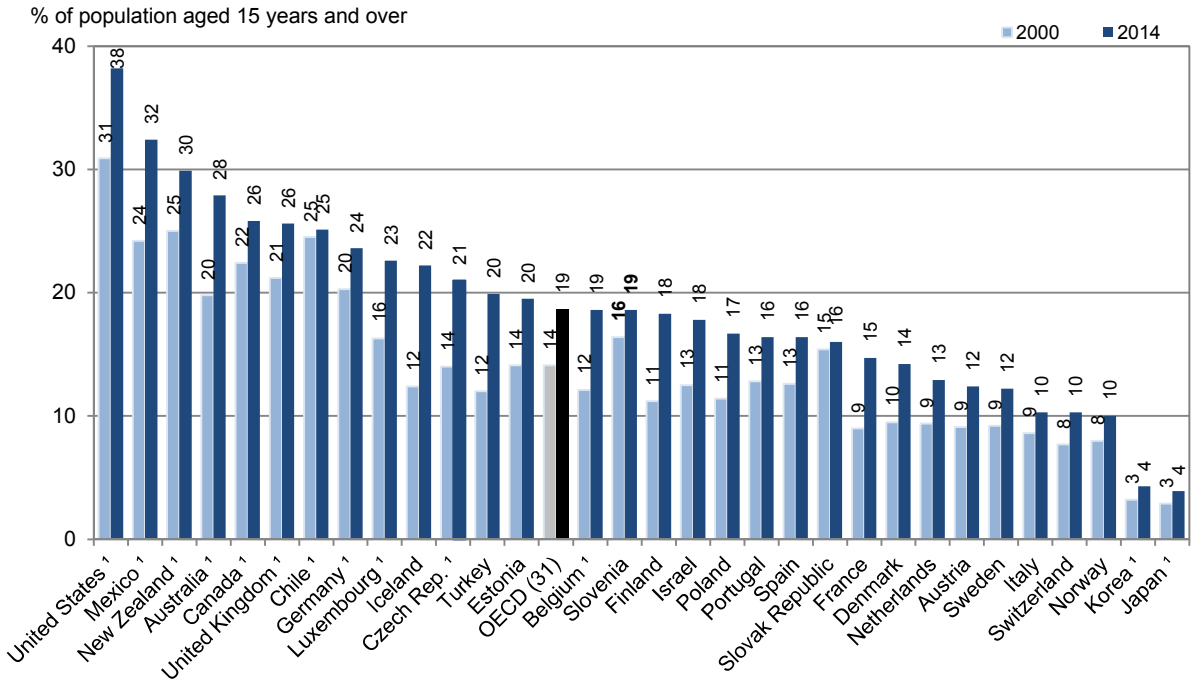
Together, alcohol consumption and obesity are risk factors for numerous health problems, including hypertension, high cholesterol, diabetes, cardiovascular diseases, respiratory problems and some forms of cancer. Unhealthy lifestyles and lack of physical exercise, which contribute to premature mortality, to some extent signal a failure of preventive efforts.

With these considerations in mind, it is important for health care systems to help people modify risky behaviours. OECD health care systems should tackle unhealthy diets by combining several interventions including mass media campaigns, food taxes with targeted subsidies on healthy food, nutrition labelling and marketing restrictions (Sassi, 2010). In a similar vein, health care systems should consider raising alcohol prices and regulating the promotion of alcoholic drinks to address harmful alcohol consumption. Targeted educational programmes and counselling in primary care are also cost-effective measure to tackle heavy drinking. Together, a package of fiscal and regulatory measures and primary care interventions would reduce the entire burden of disease associated with harmful alcohol use by an estimated 10% (OECD, 2015b).

Delivering evidence-based screening programmes may also reduce premature mortality. Health professionals and the public need to actively engage in interventions proven to reduce mortality (including cancer screening, for example). This was an important recommendation in Turkey, Japan, the Czech Republic and Australia, where less than 58% of women participated in a mammography screening programme in 2013 (OECD, 2015a).

In concert, primary care providers need to raise public awareness to detect and prevent risk factors through cost-effective screening programmes, health education and counselling actions. Such targeted programmes or counselling in primary care, combined with regulatory and fiscal measures, should be trialled in all OECD health care systems to address health risk factors and reduce premature mortality.

Figure 1.3. Increasing obesity rates in selected OECD countries



1. Data are based on measurements rather than self-reported height and weight.

Source: OECD Health Statistics (2016), http://dx.doi.org/10.1787/health-data-en.

Minimising the impact of chronic disease through effective secondary prevention

For conditions such as diabetes or cardiovascular disease, the cornerstone of effective management includes tailored patient education, lifestyle management, regular monitoring and control of diseases, support for self-management, and identification of complications (OECD, 2015c). Primary care has the potential to play a more pro-active role in secondary prevention and in the management of chronic disease, mental illness and multimorbidities. Given the trend to shift care outside the hospital setting, clear responsibilities for providing well-co-ordinated care and ensuring effective secondary prevention need to be assigned to primary care providers. OECD health care systems should learn from Israel, where primary care has successfully taken on prevention and management of chronic conditions. In the Clalit Health Fund, 80% of diabetic patients are cared for by PCPs (OECD, 2012a). This is remarkably high compared to the Czech Republic, where only a third of diabetes care was performed by PCPs (OECD, 2014b). Portugal, Italy and Sweden should also foster leadership of PCPs in prevention programmes (OECD, 2013b, 2014c, 2015d). These countries lack measures to support PCPs to take on responsibilities for managing chronic conditions.

Several countries have incentivised PCPs, or the broader primary care team, to take on responsibilities for managing chronic conditions. England's QOF is one of the largest programmes worldwide to embed evidence-based measures for secondary prevention in chronic disease management in primary care. The programme gives GPs a financial incentive to provide evidence-based care for a wide range of LTCs, including diabetes.

The QOF employs process measures (monitoring, prescribing and counselling), intermediate clinical outcomes (glycated hemoglobin, cholesterol and blood pressure), and patient-reported indicators (patient experience with care) to evaluate performance. Evidence shows that such financial incentives have been effective in improving the quality of diabetes care in the country (Latham and Marshall, 2015). The approach taken in Australia is also instructive. The *Practice Incentives Programme* (PIP) for diabetes aims to encourage PCPs to provide earlier diagnosis and effective management of people with established diabetes mellitus (see Case Study 2).

The enhanced role of primary care in secondary prevention is vital to minimise the deterioration of chronic disease. To maximise its benefit, such a strategy should be accompanied by steps to achieve greater care co-ordination and integration across providers (see Lesson 4), to ensure that PCPs have access to appropriate continuing professional development (see Lesson 8), and to support patients in managing their health conditions (see Lesson 7). Together, these measures will support PCPs to provide high-quality care for patients with chronic diseases, leading to reductions in inappropriate referral to specialist care and avoidable hospitalisation.

Case Study 2. Paying for high-quality care for diabetes in primary care

Australia's *Practice Incentives Programme* (PIP) links general practice financial incentives to 11 indicators, including quality indicators for diabetes care. The *PIP Diabetes Incentive* has three components – a sign-on payment, an outcomes payment and a service incentive payment:

- The sign-on payment is a one-off payment to practices that use a patient register and a recall and reminder system for their patients with diabetes mellitus.
- The outcomes payment is a payment to practices where at least 2% of the practice's patients are diagnosed with diabetes mellitus and GPs have completed a diabetes cycle of care for at least 50% of them. The diabetes cycle of care is to: assess diabetes control by measuring HbA1c; carry out a comprehensive eye examination; measure weight and height; measure blood pressure; examine feet; measure total cholesterol, triglycerides and HDL cholesterol; provide self-care education; and check smoking status, among other activities.
- The service incentive payment is paid to PCPs for each cycle of care completed for patients with established diabetes mellitus.

Although evidence around the impact of the *PIP Diabetes Incentive* remains limited, some studies suggest positive effects on the quality of care delivered, through improved diabetes management (Scott et al., 2009) or greater compliance with nationally established minimum requirements for diabetes care (Saunders et al., 2008).

Source: OECD (2015e).

Lesson 3. High-quality mental health care systems require strong health information systems and mental health training in primary care

Although OECD health care systems are among the most comprehensive and innovative in the world, with sophisticated quality assurance and improvement initiatives, mental health care systems have been left behind. Even in the OECD's most dynamic systems, where innovative policies around quality of care abound, the mental health sector is usually left out. To change this, health care systems need: i) more data on almost all aspects of mental health care; ii) stronger primary care to deliver high-quality care for mild-to-moderate mental disorders; and iii) greater care co-ordination of mental and physical health care services.

Collecting and reporting more data on mental health care quality

Despite the high burden of mental ill-health (affecting around 5% of the OECD population), high-quality services for mental illness are still thin on the ground. Care for common conditions and survival after a heart attack, stroke or with cancer has improved dramatically across OECD countries, yet people with severe mental disorders have a life expectancy some 20 years lower than the average population. Though outcomes for individuals with mental ill-health are known to be poor (people with a mild-to-moderate mental disorder are more likely to take sick leave, to be unemployed, and to suffer from a chronic disease like diabetes), big gaps in available information on mental health mean that it is difficult to fully understand the quality of mental health care and to push for improvements.

Transparency and accountability for the quality of mental health care is a challenge that many OECD countries are struggling with. In most, it remains hard to identify and follow people who need mental health care, and to understand the relationship between care received and outcomes. As a foundation for improvement, more and better data on mental health care are urgently needed to help policy makers and service providers tackle shortcomings in quality. All countries could develop and publish more mental health data, including at more granular local and municipal levels, and in traditionally hard-to-cover areas such as primary care. In a few countries these steps are being taken, for example in Norway, Scotland and Sweden (see Case Study 3). In Norway in particular, availability of indicators for mental health is generally good. The country made impressive progress in establishing and publishing relevant data on quality of care with the nationwide programme led by the Norwegian Directorate of Health (OECD, 2014d). Clear leadership from central authorities to provide a national, consistent approach towards measuring quality in mental health was a key enabling factor.

A national information system for mental health was recently introduced in Italy under the New Italian Health Information Infrastructure (*Nuovo Sistema Informativo Sanitario*, NSIS) (OECD, 2014c). In England, patient level mental health data are collected in primary, community and secondary care settings, including process and outcomes measures for the service user. These include, for example, data on hospital admissions for mental illness, patient experiences with community mental health services, access to psychological therapies and recovery rates, and waiting times. By contrast, a national strategic approach to measuring quality in mental health care is still lacking in Japan and Korea (OECD, 2012b, 2015f). Some localised efforts to improve collection of indicators of mental health care quality have been started, but are not rolled out nationally. Japan should look to establishing national collection of some key indicators that are still presently lacking. Candidate indicators would be around excess mortality for

patients with schizophrenia or bipolar disorder, prescribing practices, use of seclusion and restraint, or unplanned re-admissions (OECD, 2015f).

Health care systems should without delay invest in better data collection to track and report on quality and outcomes of mental health care. A better information infrastructure is essential for building stronger mental health care systems.

Case Study 3. Norway, Sweden and Scotland: Ways of using data

- In the difficult area of mental health care data, Norway has already made good progress in establishing and publishing relevant data on quality of mental health care. Indicators like inpatient suicide, excess mortality and waiting times for mental health services give a good impression of access to services, patient safety in services, and co-ordination of mental and physical health care. Most indicators that Norway collects, though useful, are primarily process indicators or measures of service capacity, for instance registration of diagnoses or staffing numbers.

- In Sweden, the National Board of Health and Welfare developed a multidimensional quality framework, *Good Care*, to monitor mental health care performance. The framework covers several dimensions of care, including effectiveness, safety, patient-centredness, timeliness, equity and efficiency, with more than 30 process and outcome indicators used to compare quality across regions or patient groups.

- In Scotland, performance measurement in the mental health care system focuses on comprehensive person-centred outcomes, and recovery. The main measurement instrument, the *Adult Mental Health Benchmarking Toolkit*, presents performance indicators in a scorecard format, combining structural, process and outcome indicators.

Source: OECD (2014e).

Developing primary and community sectors to deliver high-quality mental health care

Although concerted efforts have been taken to improve mental health care for severe mental illnesses, there is a current shortage of appropriate treatments for mild-to-moderate disorders across OECD countries. Mild-to-moderate disorders (such as depression and anxiety) are typically understood not to require highly specialised treatments delivered by psychiatrists or in inpatient settings in the vast majority of cases. Rather, they require strong primary and community care.

To ensure high-quality care for mild-to-moderate mental disorders, appropriate evidence-based treatments such as psychological therapies (including cognitive behavioural therapy) should be available in primary care. Even though primary care is overwhelmingly the first point of call for individuals experiencing mental distress, PCPs do not always have the right skills and treatment options to effectively respond to need. In 2012, three countries (Korea, Poland and Switzerland) reported that mental health was not a component of PCPs' training. By contrast, ten countries (Canada, Germany, Hungary, Ireland, Israel, the Slovak Republic, Spain, Sweden, Turkey and the United Kingdom) reported that PCPs had to take mental health training as part of their continuing professional development (OECD, 2014e). In England, *Improving Access to Psychological Therapy* initiative aims at increasing the provision of evidence-based treatments for mild-to-moderate mental disorders by PCPs. Australia and Denmark

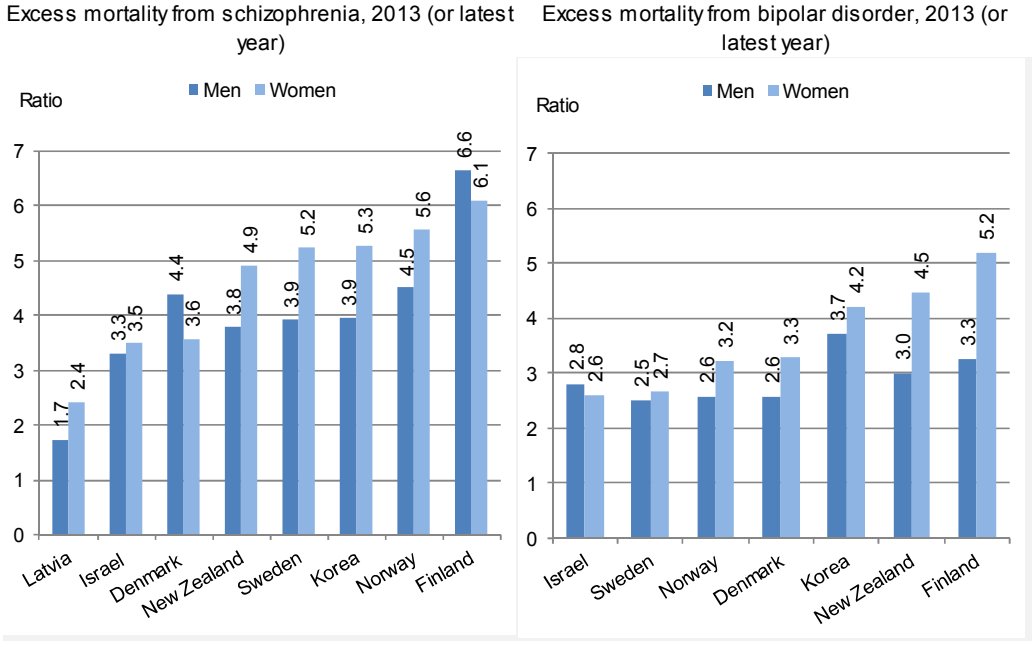
recently invested significantly in mental health training courses for PCPs. But in Norway, although GPs are expected to treat and manage mild-to-moderate disorders themselves, it is not clear to what extent GPs take up the mental health training opportunities on offer to them, or how good their mental health skills are (OECD, 2014d). This is also an identifiable gap in Japan. The current lack of PCPs in Japan may in particular drive up underdiagnosis of mild-to-moderate disorders, thus contributing to underprovision of care. Crucially, with the development a new specialism for GPs (see Lesson 1), Japan has the opportunity to place mental health at the heart of education and training of this new profession (OECD, 2015f).

To deliver effective care for moderate disorders, primary care should be backed up by good training, by support from specialist mental health care practitioners, and by good referral options should a patient need to access a more specialised level of care.

Improving co-ordination of mental and physical health care services

Effective co-ordination of care across health care settings, good follow-up in the community following hospitalisations, appropriate long-term support, and sensitivity to patient requests and treatment needs are important parts of securing high-quality care. Individuals with a psychiatric illness have a higher mortality rate than the general population (Figure 1.4), much of which can be explained by a higher rate of chronic disease (such as obesity or diabetes) and related risk factors (such as smoking, drug and alcohol use or lack of exercise). Research from Scotland, for example, found that depression, chronic pain and heart disease are the LTCs that most often co-exist with other conditions. In particular, mental health and physical health complaints were reported to co-exist in one out of six individuals aged 65–84 (Barnett et al., 2012).

Figure 1.4. Individuals with mental disorders have a higher mortality rate than the general population



Note: Excess mortality is compared to the mortality rate for the general population.

Source: OECD Health Statistics 2016, http://dx.doi.org/10.1787/health-data-en.

Good co-ordination of mental and physical health care services is key to tackling at least part of this excess mortality, as is more systematic attention to the physical health of psychiatric patients, for instance through regular health checks, and support to individuals trying to give up risky health behaviours. A multifaceted disease-related approach is needed to reduce this excess mortality, including primary care prevention of physical ill health among people with mental disorders, better integration of physical and mental health care, behavioural interventions, and efforts to change professional attitudes. The use of individual care plans (ICPs) could help support patients, and their care providers, to secure the care package that they need over time. Across several OECD countries (notably in Norway and Japan), ICPs are not fully exploited as a tool to promote good co-ordination and good quality of care between mental and physical health (OECD, 2014d, 2015f).

Concerted actions should be taken across OECD countries to promote the use of such plans to secure greater care co-ordination between mental and physical health. Scope exists to raise professional awareness around the need to attend to the physical health needs of individuals with mental ill-health. This is strongly recommended for mental health professionals and other professionals who may be unused to interacting with patients with mental ill-health.

Lesson 4. New models of shared care are required to promote co-ordination across health and social care systems

Integrated care addresses fragmentation in patient services and enables better co-ordinated and more continuous care. Based on published research, integrated care is found important for improving the quality and experience of care for patients with complex needs (Martínez-González et al., 2014a; Nolte and Pitchforth, 2014). While developing new models of shared care based on multidisciplinary practice is a key component to achieve greater integrated care, this might not be enough to build sustainable changes in the longer term.

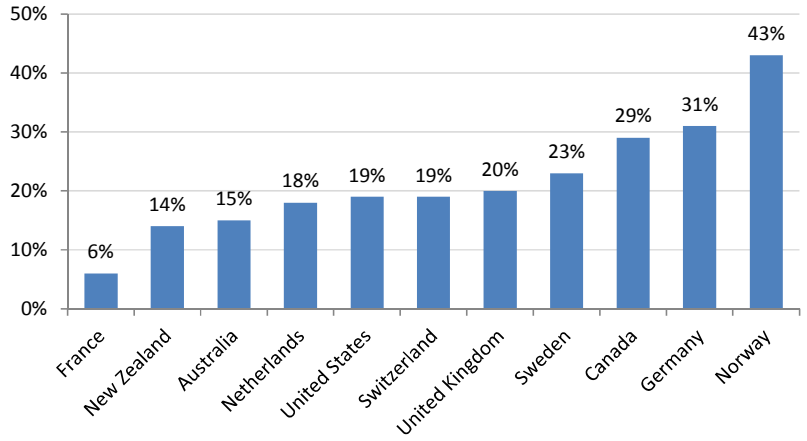
Addressing fragmentation in patient services through multidisciplinary care teams

Care continuity and care co-ordination are important for people with higher health care needs, such as those with chronic conditions and older people, who often need both medical and social care over time. Without consistently good co-ordination between primary care, hospitals and long-term care settings, there is a real risk that complex health needs will go unmet.

Poorly co-ordinated and fragmented care is often caused by services operating independently of each other, and can lead to poor patient outcomes, inefficient services and wasted resources. This is a source of great concern across OECD countries. Most health care systems experience co-ordination difficulties at the interfaces between various parts of the health care system and between health care, social care and long-term care. Most often, health care systems report poor care co-ordination between PCPs and specialists, with a weak transfer of patient records and related information across providers. Recent international data show, for example, that more that 20% of older adults in the United Kingdom, 23% in Sweden, and 43% in Norway reported that a specialist lacked their medical history or that their regular doctor was not informed about care received from a specialist (Figure 1.5). As a result, both quality and efficiency suffer.

Transformation towards more integrated and co-ordinated care requires the courage to challenge the ways in which patients have traditionally been treated. It effectively requires developing new models of care such as multidisciplinary health centres, which offer the potential to encourage health and social care to work more closely together. Such centres gather a number of GPs, usually working in group practice, jointly with other health care professionals (including hospital specialists), alongside professionals from other sectors, notably social workers. These centres offer a range of services, incorporating prevention and health promotion activities, and bridging for primary, acute and social care. Clinical pathways, disease management and case management are key instruments to promote communication and collaboration between providers. A large body of evidence shows that delivering health services seamlessly by multidisciplinary teams is more efficient: the likelihood of service duplication and of hospital use is reduced, while users' experience and quality of life are improved (WHO, 2008; Purdy, 2010).

Figure 1.5. Specialist lacked medical history or regular doctor was not informed about specialist care in several OECD countries



Note: Percentage of older adults reporting that their specialist lacked their medical history or that their regular doctor was not informed about specialist care.

Source: 2014 Commonwealth Fund International Health Policy Survey of Older Adults in 11 Countries.

Building sustainable integrated care using key instruments

All OECD countries have taken positive steps to move towards a more multidisciplinary approach to enable better co-ordinated and integrated care, and are experimenting with new models of shared care. OECD health care systems have taken different approaches to deliver integrated care, though, and some models appear to be failing to achieve sustainable change over the long term.

Norway and Portugal undertook considerable efforts to strengthen co-ordinated care, using multidisciplinary care teams to integrate primary and secondary care (see Case Study 4) (OECD, 2014d, 2015d, 2015g). Reconfigurations in the models of care in Norway made some steps towards system-wide transformation, although greater efforts are needed to continue developing new models of shared care. In Portugal, the gain was more modest, with a lower degree of integration in some *Unidade Local de Saude* (ULS) (groups of NHS health care providers that integrate hospitals and primary care centres in a defined geographical area).

A set of key instruments is effectively necessary to achieve sustainable, integrated and patient-centred care at system level (Table 1.2). The first key element to build vertical integration is to rely on a strong information system to ensure information sharing between providers and across levels of care. Interoperability of information systems is essential to connect health care professionals and services to co-ordinate patient care (see Lesson 10). Norway's information system was not established to support information sharing between primary care, municipalities and hospitals. In particular, information on the quality of primary care at local level was nearly total absent at the outset of the Co-ordination Reform.

Another key element is to establish financial incentives or adequate payment mechanisms to secure greater patient-centred integrated care. In light of this, payment systems should reward multidisciplinary care and chronic disease management, which as mentioned previously are core components of integrated care. In Norway, appropriate incentives were implemented until 2015 as a means of encouraging health services to embrace integration and to promote high-quality and patient-centred care. In Portugal,

pay-for-performance (P4P) (while accounting for a very small proportion of the ULS budget) is not directed towards integration of disease management.

The experience from Norway and Portugal suggests that comprehensive and sustainable change towards integrated care is more likely to be triggered at local level by the community, when there is strong commitment and involvement from all stakeholders. Strong commitment and involvement from all stakeholders are required to create the necessary environment for cultural change to achieve consensus on how to deliver patient-centred and co-ordinated care. Effective integration between primary and secondary care also requires genuine collaboration among providers, and efforts to break down cultural barriers and providers' wariness about working in new ways (OECD, 2015g). Lastly, as patients often enter the health care system via primary care, it is critical to make sure that PCPs support care co-ordination and bridge acute, primary care and social care.

Overall, developing new models of shared care based on multidisciplinary practice is fundamental to delivering co-ordinated and integrated care. Health care systems should have the opportunity to better use financial incentives, linked to strong information systems, to achieve greater patient-centred integrated care over the longer term. A culture of change and of mutual trust between health professionals will be essential to inspire such changes in health service delivery.

Case Study 4. Integrated care models in Norway and Portugal

***Distriktsmedisinsk senter* in Norway**

A distriktsmedisinsk senter (also called *Sykestue*) is an intermediate care facility, a place that is halfway between the hospital and the community, where people are admitted for a few days and cared for by community primary care practitioners (PCPs) working closely with hospital specialists. Some facilities only provide specialist care, while others provide a shared model of care between primary and secondary settings. Development of the shared model of care took place in the 1980s (in the Fosen peninsula), and then became the blueprint for the country's Co-ordination Reform in 2012. The reform encouraged experimentation with and diffusion of such facilities to provide high-quality health care more conveniently, particularly for elderly, frail or otherwise vulnerable populations that find it difficult to travel long distances.

***Unidade Local de Saude* in Portugal**

Unidade Local de Saude (ULS) in Portugal was set up nationally in 1999 to experiment with vertical integration. ULSs are groups of NHS health care providers that integrate hospitals and primary care centres in a defined geographical area. Such groups integrate the planning, delivery, and financing of both hospital and primary care services into a single organisation. They are responsible for providing a complete range of services to a defined geographical population. It is hoped that ULSs will demonstrate entrepreneurship and innovation in how care is delivered, especially for patients with LTCs, making use of greater financial and operational freedom. They improve multidisciplinary co-operation and are seen as central to delivering effective and co-ordinated care for patients with multiple needs.

Table 1.2. Key features to build vertical integration

	Strong information system	Adequate payment mechanisms	Bottom-up approach	PCPs supported to co-ordinate patient care	Collaboration and trust among providers
Norway	No	Yes	Yes	Yes	Yes
Portugal	No	No	No	Yes	No

Source: OECD (2014d, 2015d, 2015g).

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HEALTH CARE SYSTEMS NEED TO ENGAGE PATIENTS AS ACTIVE PLAYERS IN IMPROVING HEALTH CARE, WHILE MODERNISING THE ROLE OF HEALTH PROFESSIONALS

Transparency requires transforming the role of patients, placing them at the centre, so that they become partners in decisions about their own care. This should encompass affording respect to patients, involving them in prioritising and planning for health care systems and promoting their voice and choice through greater health literacy. Collecting patient experience measures is pivotal to delivering health services that are truly responsive to patients' needs. In a complementary manner, health professionals' role must be modernised to deliver greater patient-centred care. Securing a high-quality and high-performing medical workforce should entail more robust forms of quality assurance and monitoring around health professionals' practice as well as using the health workforce more efficiently, for example by extending nurses' scope of practice.

Lesson 5. A strong patient voice is a priority to keep health care systems focussed on quality when financial pressures are acute

In the aftermath of the 2008 global financial crisis, improving efficiency and productivity took on a renewed urgency in all OECD health care systems. In times of acute financial pressure, quality care risks being overlooked. Health care systems, therefore, should ensure that cost control and quality improvements are closely entwined. A strong patient voice is vital in these circumstances to ensure that the quality imperative is not lost and to pursue health service reforms that optimise both cost and quality.

Balancing the twin objectives of quality and efficiency

Clinicians and health care system managers, at central and local level, need to balance multiple system objectives simultaneously. Often, these will be in synergy. In particular, quality and cost control should not be thought of as being in opposition. Nevertheless, in times of acute financial stress, health care system managers may feel pressure to focus more on ensuring access and achieving financial balance than on quality indicators.

In Italy, for example, concerns were raised that quality was being overlooked in the context of its growing ageing population and rising burden of chronic conditions. Quality improvement effectively took a backseat as the 2008 economic crisis hit, while financial consolidation became an overriding priority. The country first reacted to the crisis with short-term responses (such as limited investment in community and long-term care and preventive services) to fulfil the primary goal of balancing costs and resources (OECD, 2014a). A new national strategy was then recently set up to combine expenditure control with high-value care for patients. This strategy is expected to optimise quality and efficiency in the longer term.

England saw a very small NHS budget increase following the 2008 financial crisis, while facing significant pressures on the demand side. As a result, the objective of achieving financial balance became a focal point of managers' attention, despite the high profile accorded to quality-improvement initiatives over recent years (OECD, 2016a).

By contrast, Portugal took efforts to ensure that fiscal constraints did not undermine care quality (OECD, 2015a). Cost control and quality improvements are seen as closely entwined, and the efforts made ensure either that efficiency gains do not undermine care quality, or that "quality" is a core part of assessing whether care delivers good value for money (see Case Study 5).

Case Study 5. The focus on quality lies closely alongside the priority of cost control in Portugal

The Portuguese health care system responded well to financial pressures over recent years, successfully balancing the twin priorities of financial consolidation and continuous quality improvement. The tough fiscal reforms did not diminish the country's commitment to continuously improve quality and maintain a universal public system.

Portugal used a diverse set of tools and approaches to realise these gains. The country implemented a comprehensive set of structural reforms to work towards fiscal sustainability, improved efficiency and better quality in the health care system. The pharmaceutical sector in particular saw significant changes following shifts towards the generic drug market and strengthening of procurement processes. In primary care, ambitious reforms to develop internationally innovative new service and payment models began in 2007. Significant efforts were committed to rationalising the hospital sector through specialisation and concentration of hospitals' services. The introduction in 2007 of the *Rede Nacional de Cuidados Continuados Integrados* was another innovative approach to better integrate health and social services for the elderly in need of long-term care services.

Such structural reforms were almost always backed up with sophisticated monitoring capabilities and a careful balance between incentives and sanctions to improve quality of care.

At service level, an equally extensive set of quality initiatives were introduced over recent years, ranging from standardisation of clinical practice, to better use of technology such as electronic medical prescription and shared medical information, to establishment of a national accreditation model. Stronger tools for monitoring the quality and outcomes of care were developed, including a quality benchmarking project that publishes facility-level quality and efficiency indicators on a monthly basis.

Source: OECD (2015a).

Ensuring a strong patient voice so as not to lose the quality imperative

Protecting and promoting patients' rights is an important step to strengthen the position of the patient in the health care system. It is of great importance in times of financial pressure, when high-quality care risks being overlooked.

Several OECD countries' legislation places patients' rights and patient safety at the centre of overall efforts to improve quality of care (Table 2.1). Australia, Denmark, Israel, Norway, Portugal, Scotland and Sweden, for example, have specific legislation to protect patients' rights, afford patients respect and dignity, while clarifying patient responsibilities. Such legislation generally gives patients a right to provide feedback or to raise concerns or complaints about the care they receive. Scotland provides an interesting example: patients' rights and principles for the delivery of health care are specifically defined in the Patients' Rights Act 2011. The legislation charges the NHS with the duty to encourage, monitor, take action and share learning from the feedback it receives. Scotland's *Our Voice* framework also supports the involvement of patients and the public at every level in improving health care services. This framework introduces innovative new mechanisms for hearing the voices of patients, families and carers at local and national level, including through a citizens' panel. Norway, too, has a Patients' Rights Act empowering patients to complain to the County Governor if they are not satisfied with their health care. Such legislation on patients' rights places patient-centredness as a core component of health care policies. By contrast, separate laws on patients' rights do not exist in Turkey, Korea, Italy and the Czech Republic but the related principles are nevertheless said to be embedded in practice.

Table 2.1. Key strategies empowering patients

	Formal definition of patient rights	Patient involvement at services level, or the decision making level	Measuring patient experience
Australia	Yes - Australian Charter of Healthcare Rights	Patients groups actively involved in the policy-making process, and in the hospital governance	Yes - Mandatory in the acute sector (as part of the accreditation) but not nationally standardised
Czech Republic	Yes - Czech Health Services Act	Limited involvement in policy making	Yes – Mandatory and standardised survey for hospitals, psychiatric clinics and rehabilitation facilities
Denmark	Yes - National Agency for Patients' Rights and Complaints	Limited involvement in policy making and patients not systematically represented on hospitals boards, home for the elderly and nursing homes	Yes - National surveys in several areas
Israel	Yes - Patients' Rights Law	There is no patient associations	Yes - National surveys in several areas
Italy	Yes - Patient rights are not specified by a single law but are present in several pieces of legislation (notably the Italian Constitution, and Law 502/1992, art. 14)	Limited involvement	Yes - Health Conditions and Use of Medical Service Survey but it is more about access than perceived experience with care
Japan	Not available	Limited involvement	Yes - National patient experience survey (only conducted every three years in hospitals: both in-patient and outpatient care)
Korea	Yes - Framework Act on Medical Services	Not available	Yes - Mandatory in the acute sector (as part of the accreditation) but not nationally standardised
Norway	Yes - Patient's Rights Act legislation	Patients groups actively involved in the policy-making process at national and service level	Yes - Several national surveys for in-patient and outpatient health care services
Portugal	Yes - Law 15/2014 (merge between patient charter and several piece of legislation)	Limited involvement	Yes - Several national surveys for primary care and hospital care
Sweden	Yes - Health and Medical Services Act, the patient safety act and the patient safety ordinance	The Patient's Advisory Committee support patient's involvement mistly as service level	Yes - National surveys in several areas
Turkey	Yes - Legislation recognise patient's right (1998 statute of patient rights)	Not available	Yes - Various departments and institutes report to be involved in the collection of information on patient experiences via surveys.
United Kingdom	Yes - In England: the NHS constitution ; in Scotland: The Patients' Rights	Yes – several mechanisms in place to foster patient's involvement. In England, since 2015/16 every GP practice is required to have a patient participation group to strengthen their voice. In Scotland, there is the Our Voice Framework; In Northern Ireland: The Health and Social Care (Reform) Act (2009, sections 19 and 20) sets the statutory duty of public and personal involvement.	Yes - Several national surveys in England, Scotland.

Source: OECD Secretariat based on the series of *OECD Reviews of Health Care Quality*.

Lesson 6. Measuring what matters to people delivers the outcomes that patients expect

Fundamental to patient-centred care is patient empowerment. Patients' empowerment puts the patient at the heart of health care services so they participate in decision making and take control of their health care needs. While the role of patients has been strengthened in many OECD health care systems, their involvement is still rather limited. Ensuring participation of patients or the public in decision-making processes and capturing patients' experiences with care are key policies to encourage patient empowerment.

Ensuring patient participation in decision making

Patient organisations can be central bodies in the oversight of health care and can push national authorities to improve quality of care. A positive trend across the OECD is the growing role of patient organisations at both service and national levels. At service level, patient organisations in Norway (for example, for mental health) provide support, networks, and in some cases services to local communities, which is highly beneficial for patients (OECD, 2014b). In England, since 2015/16 every GP practice is required to have a patient participation group. Such groups strengthen the patient voice and work with the practice to improve the services provided, as well as the quality of patient experience at the practice (OECD, 2016a). In Australia, the Consumers Health Forum and the Australian Consumers' Association are actively involved in the policy-making process and provide regular public commentary on government policy. Some jurisdictions in Australia have health consumer advisory committees to ensure patient involvement in hospital governance. This is a good initiative that should be extended to other health and social services, including primary care, long-term care and mental health services (OECD, 2015b). By contrast, patient involvement is relatively limited in the Czech Republic, Denmark, Israel, Italy, Japan and Portugal. In Denmark for example, patients are not systematically represented on the boards of hospitals or nursing homes (OECD, 2013a).

To build patient-centred health care systems, concerted actions should be taken to support patient groups or the public in taking part in health care decision making. This is essential to guarantee that the population has the best health conditions and has access to high-quality health care services.

Capturing patients' perspectives and perceptions

Capturing the perspective of patients provides a more complete understanding of their experience as they travel through the health care system. Information reported directly by patients offers insights that cannot be identified through other means. It empowers patients to play a greater role in decisions about their health care (Fujisawa and Klazinga, 2016). There is great promise in translating these metrics into actions that can improve patients' experience and their clinical outcomes. Patients are not the only beneficiaries. Gathering information about the things that matter to patients, such as quality of life, provides a useful basis for health professionals to improve clinical practice. Governments can use the information to deliver health services that are better shaped around patients' needs. Together, this equates to health services that are truly patient-centred.

Patient-Reported Experience Measures (PREMs) are increasingly collected by OECD health care systems. PREMs seek patients' perspectives about their experience of care. Such surveys can ask patients how long they waited for surgery, and whether they felt

their doctor spent enough time with them and gave them information that was easy to understand. Countries are at varying points in terms of collecting PREMs. In England PREMs are collected in systematic and standardised national surveys, covering the whole health care sector (hospital inpatients, emergency services, outpatients, maternity care, community mental health, general practice and integrated care). They also include some condition-specific areas identified as public health priorities, such as diabetes and stroke (Fujisawa and Klazinga, 2016). In addition, the *Friends and Family Test* is an innovation that asks patients if they would recommend the services they have used. The test is used in all primary and secondary health care services, and provides feedback in near real-time.

Surveys in Scotland cover hospital inpatients, primary care, social care, maternity care and cancer care. Notably, Scotland is a rare example of a country that has measures of patient experience in out-of-hours primary care. PREMs are also increasingly being used for quality improvement. The Czech Republic, which collects PREMs in inpatient care through standardised surveys from patients discharged from hospitals, psychiatric clinics and rehabilitation facilities, awards "Satisfied Patient" certificates to health care facilities demonstrating outstanding performance on patient experience. In Portugal, patient experience indicators are among those used to contract primary health care. While most OECD health care systems have at least few surveys to collect PREMs, it is often not done in a standardised way (as seen in Korea and Australia) and it is often collected infrequently (in Japan, for example, PREMs are collected once every three years).

The use of Patient-Reported Outcome Measures (PROMs) is less developed in OECD health care systems. PROMs are used to assess patients' perceptions of their outcomes, such as mobility, pain, anxiety and quality of life. PROMs can be used to inform decisions about the allocation of resources, by making assessments about the effectiveness of interventions. In a system where PROM data are publicly reported, they can be used to help patients make better-informed choices. Ideally, PROM data should be fed back to clinicians to help them improve the care and outcomes of patients. In some cases, OECD countries use PROMs to drive improvements in the quality of patient care (see Case Study 6).

Rarer still is collection of information about safety incidents reported directly by patients. These are known as Patient-Reported Incident Measures (PRIMs). The use of such instruments can help to identify adverse events that are not captured in hospital incident reporting systems, in medical records or by clinical staff. In England, the annual NHS staff survey asks hospital staff questions about near misses and the safety culture of the organisation. The 2011 inpatient survey included questions such as whether doctors and nurses washed or cleaned their hands between touching patients (Fujisawa and Klazinga, 2016). Such questions were also included in the Scottish 2014 inpatient survey.

Overall, OECD health care systems should continue investing in PREMs, PROMs and PRIMs. Collecting such information is pivotal to delivering health services that are truly responsive to patients. If countries are to be well-equipped to meet the challenges presented by ageing populations and the accompanying rise in chronic diseases, it is essential that the data collected correspond to what matters most to patients.

Case Study 6. PROMs can be used to make assessments about the effectiveness of interventions

The National Health Service in **England** introduced a system-wide PROM programme in 2009, and it is mandatory for all hospitals to participate. The programme, which is part of the NHS Outcomes Framework, encompasses four surgical procedures: hip and knee replacement, groin hernia surgery and varicose vein surgery. The programme combines condition-specific instruments with generic instruments. The former captures more precise information about particular conditions, while the latter enables patients' outcomes to be compared across a range of conditions. Patients complete surveys before and 3–6 months after a surgical procedure to assess whether the intervention improved their health. Hospital-level data are publicly reported, with applied case-mix adjustment to ensure meaningful comparisons can be made between hospitals.

In **Sweden**, PROMs are collected through national quality registers, and their routine use is encouraged. Among the clinical areas using PROMs are cardiac, breast cancer and rheumatism care, as well as care for hip fracture and spinal surgery.

In **Denmark**, the government has an agreement with the five regions to promote the use of PROMs in the areas of chemotherapy, epilepsy and prostate cancer. The purpose is to assess whether patients need check-ups, tests and other treatment to promote high-value care.

Israel recently commenced a pilot PROM programme, with a view to starting a national programme in which all hospitals will be expected to participate. The pilot involves two large hospitals, and the collection of PROM data for prostate cancer, cataract surgery and coronary artery disease. It is anticipated that the PROM programme will include hip and knee surgery as well. A national PROM programme for mental health already exists.

Source: OECD (2012a, 2013a, 2013b, 2016a); Fujisawa and Klazinga (2016).

Lesson 7. Health literacy helps drive high-value care

Health literacy refers to individuals' capacity and skills to access and understand information that helps them attain and maintain good health, and patients' ability to act upon health information. It is a key determinant of high-quality outcomes of care and of health care costs. An increasing body of research suggests that good health literacy is associated with more participation in health-promoting and disease-detection activities, healthier behaviour, and reduced hospitalisation, morbidity and mortality (WHO, 2013). For all these good reasons, health literacy should be considered as a public health objective per se. Yet this is seldom the case in OECD countries. While no one model exists for improving health literacy, encouraging informed-patient choice, promoting patient education, and investing in decision aids for patients are key elements.

Encouraging informed-patient choice

It is universally acknowledged that promoting patient choice increases opportunities for them to select providers that best meet their health care needs. It enhances patients' control over the health care services they use, which can also be a lever for quality improvement by increasing providers' accountability. But promoting informed-patient choice is only possible when quality-related information is made publicly available. Without information, users cannot participate in their health.

Although data accessibility is improving across OECD countries (see Lesson 9), the data are not always standardised to allow benchmarking across providers or to enable users to make informed decisions about their care. OECD health care systems should better ensure that patients can use quality-related information to assess the quality of providers. Among those at the forefront of attempts to help patients make informed choices are Australia, Denmark, Korea, Portugal and the United Kingdom. All these countries use tools to ensure that information regarding health care providers' performance is transparent. The strength of these tools is to report performance data in a systematic and standardised way to allow benchmarking across providers. For example, England supports patient choice in the area of primary care, hospital care, maternity, mental health services, etc. MyNHS is a public-facing website that draws upon these data to provide information on the performance of services (hospitals, GP practices, care homes, mental health providers and dentists) and consultant outcomes in 15 specialties, and public health, adult social care and health and well-being. Standardised information that allows benchmarking and is tailored to public use is also provided by NHS Choices, Care Quality Commission and Public Health England (OECD, 2016a). By contrast, the information around providers' performance in the Czech Republic, Italy, Israel, Japan and Turkey is either not publicly disclosed or is not standardised to allow for benchmarking.

All OECD health care systems should invest in tools to enable patients to make appropriate health decisions and increase their ability to navigate complex health care systems.

Promoting patient education and self-management

Patient education and self-management is an essential component of health literacy. It enables patients to be active participants in decision making affecting their health care, improving both quality and outcomes of care. Based on published research, it is well accepted that self-management and patient education prevents health complications and reduces adverse events. Evidence demonstrates that improving patients' self-management

reduces physician visits, emergency department visits and avoidable admissions for certain chronic diseases, as well as improving their health outcome (FitzGerald and Gibson, 2006; Holman and Lorig, 2004; Purdy, 2010).

A number of policies can encourage better self-management by patients. First, providers need to be able to explain complex health diagnoses and treatment approaches to patients in a user-friendly, easily understood manner. Training health professionals on effective communication of complex information is therefore important. Such training includes methods to assist patients to problem solve and interpret their symptoms, and to increase health professionals' awareness of the impact of patient self-management on health outcomes (Yank et al., 2013). Patient education programmes and counselling sessions are another fruitful way to support better patient self-management. Such interventions help patients develop a better understanding of how their conditions affect their lives and how to cope with their symptoms. This gives patients the tools, skills and support they need to improve their own well-being and quality of life (Purdy, 2010; Yank et al., 2013). A number of countries introduced education programmes specifically designed to support better patient self-management. One successful example is Israel, where patient education is provided through patient training courses and counselling sessions organised by health funds. Such programmes intend to improve lifestyle habits and self-management skills for those with complex needs (OECD, 2012a). Likewise, Australia adopted a national approach to health literacy in 2014 (*The National Statement on Health Literacy: Taking Action to Improve Safety and Quality*). Specifically, the National Statement focussed among other areas on education for patients and health care providers (OECD, 2015b). Scotland developed a *Health Literacy Action Plan* to make sure that health and social care services are catered to each citizen and promote self-management (OECD, 2016a). By contrast, a lack of strategy to promote patient self-management was noted in the Czech Republic and Korea (OECD, 2012b, 2014c).

Across OECD health care systems, greater efforts are called for to make sure that primary and secondary health services provide patient support as they take on a more active role in managing their own health conditions.

Investing in decision aids for patients

Transforming the role of patients so they become partners in making decisions about their care requires decision aids that help them consider the potential benefits and risks of treatment options. Access to quality-related information and instruction provided by doctors may not be enough to promote appropriateness of care. Patients sometimes ask for treatments, procedures and tests that are not necessarily in their best interest. A recent nationwide survey of physicians conducted in the United States showed that almost half of them receive requests from patients for an unnecessary test or procedure at least once a week. Three in ten said this happens at least several times a week (*Choosing Wisely*®, 2014). Patients might need tools that help them better understand evidence-based recommendations and that support them in demanding high-quality and good-value care. Yet presently too few decision aids are available for patients.

The *Choosing Wisely*® campaign is an interesting initiative attracting attention worldwide as a potentially useful tool for empowering patients by assisting them in making the right decisions about their care. The campaign was launched in the United States, but has since expanded to more than ten countries. Its overarching aim is to promote discussions between clinicians and patients to help patients choose care that is supported by evidence, that does not duplicate other tests or procedures patients have

already received, and that is free from harm and truly necessary (see Case Study 7). It is hoped to be effective by educating both patients and their doctors, and by facilitating a discussion between them that assists in decision making. So far, only Australia, Italy and the United Kingdom have invested in such tools, while Japan has started to publish a list of *Choosing Wisely*® recommendations.

OECD health care systems should demonstrate greater commitment to such decision aids geared towards patients. Not only do they help deliver better patient-centred care, they can also help ensure that the benefits of clinical guidelines or standards of care are not lost at the point of care.

Case Study 7. The *Choosing Wisely*® campaign helps patients make the right decisions given their health conditions

The *Choosing Wisely*® campaign is led by clinicians who identify services for which there is strong evidence of significant overuse with potential harm or cost. The campaign hinges on changing doctors' behaviours and practices and the public's knowledge and attitudes. It empowers both physicians and patients and emphasises the centrality of the doctor–patient relationship in helping patients make the right decisions given their health conditions.

The campaign is based on a bottom-up approach with broad physician engagement, with a list of "do not do's" across multiple medical specialties. There are lists written for doctors, with accompanying lists for patients in more consumer-friendly language. The lists identify inappropriate care across a range of medical specialties, with the aim of reducing its use. The premise of the campaign is to pull evidence-based medicine out of scientific journals and into the public domain. The overarching objective is to reduce unnecessary care and harm, while at the same time reducing costs to the health care system.

Source: http://www.choosingwisely.org/.

Lesson 8. Continuous professional development and evolving practice maximise the contribution of health professionals

While robust approaches to health professional education and licensing for physicians are the norm across OECD countries, more could be done to make sure that health professionals have the knowledge and skills they need in today's rapidly evolving health care systems. Encouraging continuous medical education (CME) and continuous professional development (CPD) and changing scope of practice (for nurses, for example) are two ways to maximise the contribution of health professionals in delivering high-quality care.

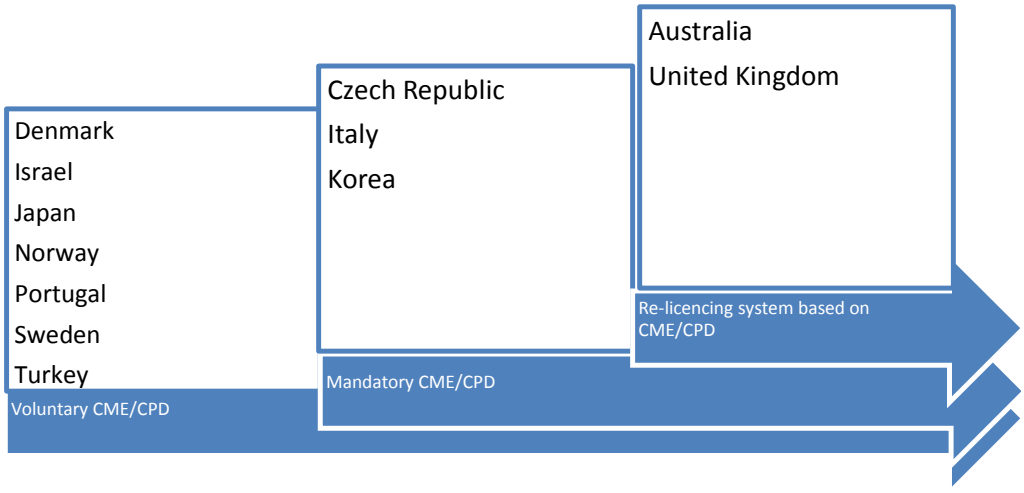
Ensuring a high-performing medical workforce throughout their medical careers

Health care systems are changing rapidly, with accepted best practice evolving and new technologies and techniques continuously introduced. In some health care systems, it is accepted that awarding a license to practice at the end of medical education is not sufficient to ensure high-quality care across a career of 50 years or more. In light of this, OECD health professionals, and health care system leaders, are seeking effective ways to support the health workforce to deliver high-quality care throughout their medical careers.

CME and CPD are effective ways to support the health workforce to deliver high-quality care throughout their medical careers. However in several health care systems, CME and CPD approaches are informal or unmonitored. This is a potential weakness in the Czech Republic, Denmark, Israel, Italy, Japan, Korea, Norway, Portugal, Sweden and Turkey (Figure 2.1). In Turkey, although CME and CPD are voluntary, the medical workforce (e.g. family physicians) is provided with orientation training and face-to-face training through a distance education system. By contrast, a more formalised approach is taken in Australia and the United Kingdom, with minimum requirements backed up by monitoring and appropriate sanctions for enforcement (OECD, 2015b, 2016a). Linking CME and CPD requirements to re-licensing medical professionals is a strength that makes Australia and the United Kingdom leaders across the OECD. Such approaches should be trialled in other OECD countries to support the health workforce to deliver high-quality care throughout their medical careers.

Nonetheless, a delicate balance must be struck between robust quality assurance and maintaining trust in medical professionals and ensuring adequate space for clinical judgement. In Denmark and Sweden for example, external involvement in regulating health professionals' knowledge and skills is deliberately light-touch (OECD, 2013a, 2013b). Sweden has no formal, national systems of CME and CPD, and consistent with Sweden's culture of local empowerment, trust and shared values, this agenda is not nationally mandated. The responsibility for CME and CPD for all employed medical staff in Sweden rests with employers (e.g. county councils, municipalities and private providers). In Denmark, professionals engage in regular CPD and learning, but expectations and requirements around this are not formalised in any way. In Norway, only GPs have the choice to re-license every five years, although the system is not mandatory. Higher fees are offered to GPs who undertake re-licensing.

Figure 2.1. Ensuring and improving the quality of health professionals



Source: OECD Secretariat based on the series of *OECD Reviews* of *Health Care Quality*.

Maintaining the quality and efficacy of CME and CPD activities is another important consideration. Current approaches to developing health professionals' skills and knowledge need to be strengthened in such a way as to be best matched to changing population needs. To some extent this can be included in CME and CPD activities, for instance by tailoring available training to areas of professional weakness. Italy did this in 2013 by requiring CME and CPD providers to offer certain high-priority training such as maternal health, sexual health and preventive health (OECD, 2014a).

While each OECD health care system will continue to develop its own approach to CPD and CME, it is vital that all centre educational objectives or professional development on preventive care, chronic disease management or rehabilitative care.

Allocating health professionals' roles more efficiently

Beyond robust CME and CPD systems, task shifting and the development of new roles for health professionals are gaining momentum in OECD countries. An increasing body of evidence supports the effectiveness of sharing or transferring roles traditionally performed by doctors to nurses. Nurses are found to provide as high-quality care as PCPs in the provision of first contact care and the routine management of chronic diseases for stable patients; and nurse-led care is associated with higher patient satisfaction, lowered overall mortality and lowered hospital admissions (Laurant et al., 2005; Martínez-González et al., 2014).

Developing a primary care nurse role to be involved in prevention, in patient education and in chronic disease management is identified as a priority for health policy in several OECD countries. With appropriate training, nurses can, for example, co-ordinate the early discharge of patients with LTCs, take responsibility for the co-ordination of patient care, or be a first point of contact for patients and their families. An increasing number of OECD health care systems are going in this direction to provide better-quality care and to reduce health care cost. In Japan for example, long-term care managers have a role in co-ordinating care (see Case Study 8) (OECD, 2015c). Sweden offers another illustrative example as practice nurses and other non-physicians play a significant role in frontline care delivery. Sweden was one of the first European countries

to create nurse-led clinics for patients with LTCs, such as diabetes and heart failure (OECD, 2013b). In a similar vein, nurses in Portugal can take on a case manager role for patients with diabetes to be responsible for annual checks, patient education and other aspects of case management (OECD, 2015a).

Health care systems should have the opportunity to use health professionals in a more efficient manner by changing their scope of practice. Developing a primary care nurse role or care co-ordinator role can not only help manage the increasing demands for health care, but it is also an essential step to help reduce dependency on the hospital sector and increase care co-ordination and integration. The introduction of new roles for nurses or other allied health professionals will require an enabling legislative and regulatory framework, and often needs to overcome opposition from medical professionals.

Case Study 8. Japan's unique cadre of long-term care managers

Japan created a new profession of long-term care managers to co-ordinate provision of health and social services care needs for elderly individuals. Care managers carry primary responsibility for ensuring the co-ordination of care for elderly individuals with complex needs, and are a first point of contact for such patients and their families.

The profession is now highly systematised, with clear qualification criteria. The role, competencies and responsibilities of care managers are clearly recognised as an important part of the solution to providing better-quality health and social care.

Care managers in Japan come from a mix of professional backgrounds (including nurses, dentists or social workers) and their professional association, which counts around 25 000 members, offers training, seminars and publications.

Source: OECD (2015c).

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HEALTH CARE SYSTEMS NEED TO BETTER EMPLOY TRANSPARENCY AND INCENTIVES AS KEY QUALITY-IMPROVEMENT TOOLS

Although growth in health spending has been slower since the 2008 global financial crisis, government health spending is expected to continue to rise in the medium to long term. The share of health spending now accounts for around 15% of government spending, and public spending on health and long-term care is on course to reach almost 14% of GDP by 2060. Health care systems need to find effective ways to improve their efficiency. Health authorities need reliable mechanisms to guarantee the accountability and transparency necessary for a more efficient, high-performing health care system. Measuring, monitoring and benchmarking quality over the whole pathway of care are essential ingredients in such a process. Improving accountability and transparency also involves mechanisms such as external quality evaluation, incentivising high-quality care, and sharing and learning from good practices. Not only are data and incentive structures crucial to build a strong accountability framework, they are also key instruments to realise efficiency gains without losing sight of the quality imperative. The importance of monitoring capabilities and incentives as levers for quality improvement should not be underestimated, especially in times of acute financial stress.

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.

Lesson 9. High-performing health care systems have strong information infrastructures that are linked to quality-improvement tools

Good information systems are fundamental to assure that health care is effective, safe and patient-centred, and to make optimal use of available resources. In most health care systems, however, the data generated remain concentrated on inputs and activities, with a dearth of information around outcomes and quality of care. More systematic data collection is needed, notably in the area of primary and community care. This is a fundamental step to then move to more systematic public reporting and to appropriately link payment to outcomes, quality and high-value care.

Investing in health data infrastructure

A well-established information infrastructure is a key enabler for monitoring quality of care with reliable and valid quality measures. It can consist of various data sources such as mortality statistics, specific clinical registries (such as a cancer or diabetes registry), administrative databases, electronic health records (EHRs) and surveys conducted on specific patient groups or households. Depending on the quality and comprehensiveness of the data infrastructure, such data sources can serve as a tool not only to assess volumes of care and inputs within the health care sector, but also to monitor quality in the provision of care (OECD, 2013a).

The increasing availability of a range of national databases with individual-level records across the spectrum of health care administration, from population health surveys to disease registers, is a positive trend across OECD countries. Most countries have national inpatient hospitalisation data, mortality data, population health surveys and disease-specific registries. Only Italy, Japan, Portugal and Turkey do not report national registers for specific patient groups, such as those with cancer or diabetes (Table 3.1). In these countries, disease registers are not regarded as a formal component of the national information infrastructure, hampering progress towards measuring quality of care. By contrast, Denmark and Sweden have made remarkable progress in measuring quality of care through clinical registries (OECD, 2013b, 2013c).

Although health information infrastructure is improving, the data generated by health care systems are too concentrated on inputs and activities. Substantive gaps remain in what is known about the outcomes and quality of care. A general dearth of national data for primary, community and long-term care is noted in particular. This is a major weakness in Australia, Italy, Japan, Korea, Norway, Sweden and Turkey, where clinicians and managers have relatively scant information on patient outcomes (Table 3.1). By contrast (and as already mentioned in Lesson 1), Denmark and Israel developed comprehensive and actionable indicators to support quality improvement in primary care, although Denmark's initiative derailed recently (see Case Study 2). The approach taken in the United Kingdom and Portugal is also instructive and can guide other OECD countries in such a process. Both systems have unusually rich data at individual provider level and they successfully collect outcomes and quality indicators around prevention, management of chronic diseases, and elder care (OECD, 2015a, 2016a).

Table 3.1. Key strategies towards monitoring and improving care quality

	National quality registers	Collecting information on the performance of PC practices and individual level	National reporting and learning system for patient safety
Australia	Yes	No	Yes
Czech Republic	Yes	No	No
Denmark	Yes	Yes	Yes
Israel	Yes	Yes	Yes
Italy	No	No	Yes
Japan	No	No	Yes
Korea	Yes	No	No
Norway	Yes	No	Yes
Portugal	No	Yes	Yes
Sweden	Yes	No	No
Turkey	No	No	No
United Kingdom	Yes	Yes	Yes for England, Wales, and Northern Ireland

Source: OECD Secretariat based on the series of *OECD Reviews of Health Care Quality.*

In a similar vein, information is lacking on practice variation and health disparities across OECD countries. While addressing practice variation and inequalities in health is often regarded as a key pillar of a strategy to improve quality of care, important gaps in information limit understanding the extent of the problem, informing policy development and resource allocation, and assessing impacts of strategies over time. Israel, for example, is not capable of stratifying health outcomes and quality of care by key dimensions of inequality. In the Quality Indicators in Community Healthcare (QICH) in particular, disaggregated data by district population group and geography are lacking (OECD, 2012a). Making indicators available by key dimensions of inequality is essential to map and monitor such disparities.

All OECD health care systems should invest in a strong information infrastructure, with robust data collection spanning all levels of care. Strengthening health information infrastructure requires steps to collect more information on outcomes and quality of care (notably in primary care), as well as on practice variations and health inequalities.

Moving to public reporting and rewarding quality and value

Beyond the development of health information infrastructure, considerable thought must be given to how data can be made accessible and useful to users, health professionals and regulators. Publishing data, providing performance feedback and rewarding high-quality care are key instruments to promote accountability, facilitate shared learning and push for quality improvement.

Performance feedback and public reporting provide the necessary accountability mechanisms in the health care governance model to drive quality improvement and health care system performance. The reputational effect of collecting and publishing data on the quality of care is an important driver of improved performance. Collecting and publishing data at individual level to rank providers relative to peers gives poorer performers an impetus to improve. This also provides a platform to share experiences and facilitate learning about good practice for quality improvement. In Israel, performance feedback and peer comparisons were found to provide persuasive incentives for doctors to improve quality of primary care (OECD, 2012a). Turkey's health information infrastructure

enables providers to compare their performance at the province and country level, which might steer quality improvement.

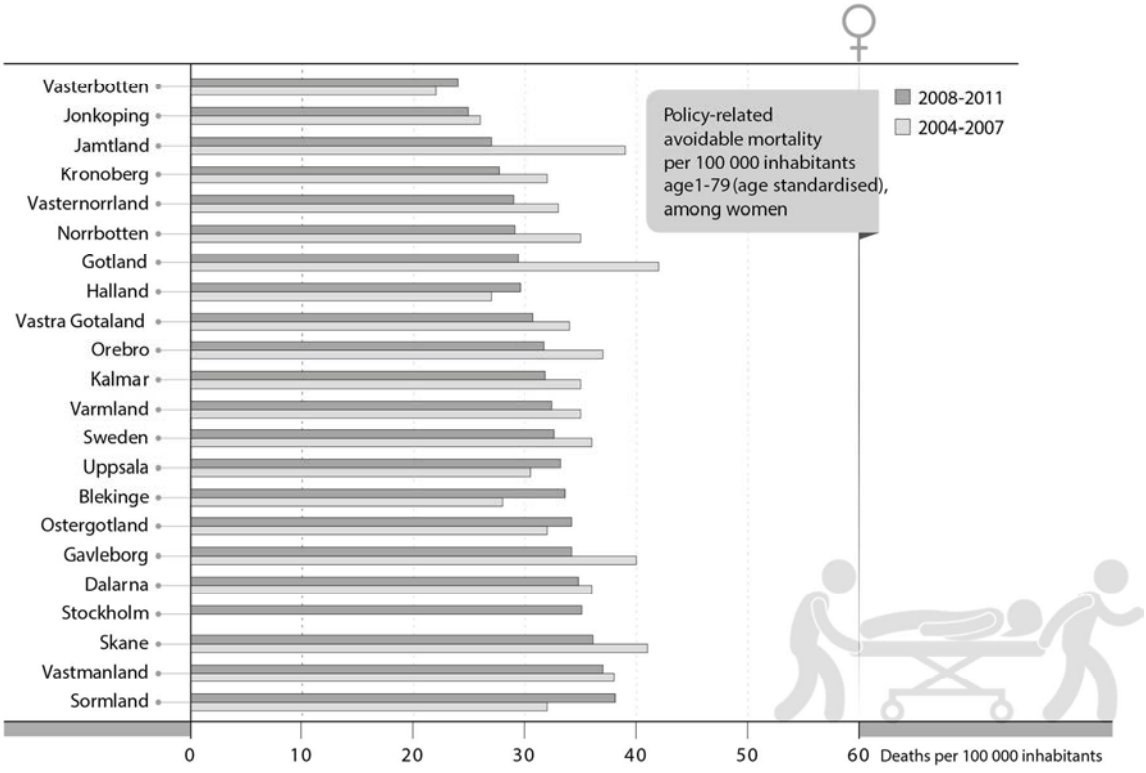
The Swedish benchmarking of health outcomes, conducted by Swedish Association of Local Authorities and Regions (SALAR), demonstrated the potential for various stakeholders to improve via rigorous open comparison. The country annually publishes counties' performance across more than 150 indicators of health care quality and efficiency. Sweden showcases a breadth and depth of transparent public reporting that few other OECD countries can currently emulate. Figure 3.1 shows rates of avoidable mortality per 100 000 inhabitants, for two time periods, disaggregated by gender and by region, age-standardised and nationally benchmarked (OECD, 2013c). In the United Kingdom as well, Public Health England publishes a vast number of public health, health and social care indicators for local clinical commissioning groups and local authorities. The NHS is notably profuse in terms of what it publishes at provider level (hospital, GP practice and consultant) (OECD, 2016a).

Using health information infrastructure to reward high quality in the provision of care is equally important. While evidence of the effectiveness of P4P is mixed (OECD, 2016b), experiences from OECD countries show that financial incentives are likely to work and drive improvement in quality of care when accompanied by other non-financial incentives. Korea's *Value Incentives Programme* (VIP; see Case Study 9), which applied to the hospital sector, had the virtue of balancing financial incentives with non-financial incentives (OECD, 2012b). This careful balance has been found effective to drive quality improvements in acute care. Another interesting practice comes from Sweden, which used financial incentives to stimulate compliance with clinical guidelines to encourage quality development in high-priority areas such as patient safety, long term care and mental health. Financial incentives were distributed from the central government to local governments that demonstrated improvement in reducing unnecessary hospitalisations and the use of inappropriate drugs among elderly people in institutional care (OECD, 2013c). Such an approach successfully aligns information and financial incentives to the quality and outcomes of care.

More broadly, payment systems should be redesigned to reward quality and value as far as possible, rather than to merely reimburse inputs or activity. Fee-for-service (FFS) schemes are appropriate for discrete interventions with a natural limit on demand, such as vaccinations – but remain prevalent across OECD health care systems (OECD, 2016b). Most primary care in Denmark, for example, is paid for by FFS. This is poorly suited to rewarding the core functions that primary care seeks to deliver, namely comprehensiveness, continuity and co-ordination. One solution is to develop the FFS model by redefining "service" more broadly. In Japan, for example, the FFS schedule contains packages of comprehensive care for people with chronic diseases (OECD, 2015b). This comes close to a capitation system where rates are adjusted for specific patient groups, dependent on need. This is an intelligent approach to paying for bundles of preventive and management care for people with complex needs, but more experimentation, evaluation and sharing of lessons learnt across OECD health care systems are needed in this area.

Pro-active efforts are needed to move to more public reporting and to increase incentives linked to the value and quality of care. A careful balance between financial and non-financial incentives has potential to drive continuous improvement in health care quality and efficiency.

Figure 3.1. Sweden's *Open Comparisons* system is at the forefront of attempts to improve public reporting



Source: Adapted from SALAR (2012), Quality and Efficiency in Swedish Health Care, Regional Comparisons 2012, Swedish Association of Local Authorities and Regions, available at http://webbutik.skl.se.

Case Study 9. Korea combines financial and non-financial incentives to drive improvements in acute care

The *Value Incentive Programme* (VIP), a pay-for-performance (P4P) scheme, is an innovative policy to use financing to drive improvements in quality of care. Launched in 2007, the programme initially sought to cover Korea's tertiary hospitals in seeking to lift Korea's performance in two areas of comparatively poorer performance among OECD countries: acute myocardial infarction (AMI) and the proportion of caesarean deliveries.

The VIP seeks to rank hospitals according to their performance in delivering good-quality clinical care and patient outcomes. Participation in the VIP is mandatory among Korea's 44 tertiary hospitals. The VIP works by computing "quality scores" for each hospital on its performance in addressing AMI and delivering an appropriate amount of caesarean deliveries.

The results of each of the measures for AMI and caesarean deliveries are published on the Health Insurance Review and Assessment (HIRA) Service website and hospitals are provided with result reports. Each year, hospitals are distributed into one of five grades according to their score. These grades are used to determine whether a hospital receives a financial bonus as a reward for good performance.

Results from the VIP are positive, with improvement in quality of care for AMI and caesarean deliveries. The key levers for driving performance under the VIP have been i) the relatively small size of bonus (to help mitigate against the risk of providers diverting resources to focus on certain things in order to maximise incentive payments), ii) the collection and publication of data on quality and their reputational effect. The Korean balance of modest financial incentives and a focus on data collection is found to be the virtue of the *VIP*.

Source: OECD (2012b).

Lesson 10. Linking patient data is a pre-requisite for improving quality across pathways of care

Understanding the performance and quality of health care systems requires the ability to monitor the same individuals over time, through the whole pathway of care. However in most health care systems, data are in silos, separated and disconnected. Too few countries are able to observe patient pathways and outcomes as patients experience health care events, receive treatments and face improvements or deteriorations in their health status.

Linking patient records across databases

To improve the quality and efficiency of health care, health care systems need to follow individual patients across the care continuum. Following patients through different health and health care events often requires the linkage of patient records across databases. Record linkage involves linking two or more databases using a unique patient identifier. In 2012, 14 countries had national data containing identifying information that could be used for record linkage for hospital inpatient data for example (OECD, 2013c). Only Australia, Germany, Poland and the United States did not report a unique identifying number within their national hospitalisation databases. At the same time, the use of a personal identifier for data linkage is reportedly complicated due to privacy legislation in Australia, the Czech Republic, Israel, Italy, Japan, Korea and Norway. By contrast, the United Kingdom, Sweden, Portugal and Denmark strengthened their legislative framework to permit privacy-protective data use. In the United Kingdom notably, several legislative frameworks were introduced so that information can be collected, held securely and made available with safeguards in place to protect individuals' data. Sweden provides an interesting example of how linking personal health data led to improvement in quality and effectiveness of care (see Case Study 10) (OECD, 2013a). In Turkey, patient records are maintained over a single identification number, and patients can access their own data in a dedicated and safe electronic system where they can choose with which physicians and institutions to share their data.

Case Study 10. Sweden follows patients' cycle of care to improve quality and effectiveness of care

Sweden uses a range of data sources to undertake both quality and efficiency assessments of clinical care guidelines. Use of national registers for the health care needs, activities and outcomes of particular patient groups is widespread, with a focus on using such information to audit and improve the quality of care. Research on the national hip fracture register, for example, led to the finding that some orthopaedic prostheses have a much longer life expectancy than others, which led to new practices in orthopaedic procedures.

Data linkage enables evaluating the extent to which guidelines are followed and whether or not the health outcomes of the patient meet expectations. Sweden is able to link elderly patients' health care needs, activities and outcomes across its dementia register, senior alert register (containing information on falls, pressure sores and malnutrition) and its palliative care register. This evidence is then used to revise the guidelines, completing an ongoing cycle of improvement in care quality and efficiency.

Source: OECD (2013a, 2013c).

Using electronic health records to better support data linkage

An EHR is a computerised patient-centred medical record that contains a wide range of information including a patient's characteristics, medical history, treatments and laboratory results. Ideally, EHRs are built to be shared between providers and across health care settings to support the provision of the most appropriate care. The overarching objective of such systems is to improve the quality and safety of care, avoiding medical errors as well as facilitating optimal care pathways and promoting efficiency in the use of health care system resources (OECD, 2013a).

In most health care systems, the use of EHRs is at least reported in PCP offices or hospitals. In 2012, EHRs were widely used among both PCP offices and hospitals in Israel, Portugal, Sweden and the United Kingdom (Table 3.2). However, a general lack of interoperability of EHRs persists across health and social care settings in the Czech Republic, Israel, Italy, Korea, Norway, Sweden and Turkey. There, EHRs are rather provider- or organisation-centric, and are not portable across health care settings or between providers. The lack of interoperability is a major weakness hampering the possibility of conducting research to improve quality across pathways of care.

Investing in a national EHR system enabling information sharing between health care facilities and providers is essential to support provision of the most appropriate care and to push for quality improvements. Health care systems should strive to develop standard data requirements that are applied consistently to all providers nationwide. This is fundamental to adequately support co-ordinated and integrated care (see Lesson 4).

Table 3.2. Use of electronic health records in OECD countries

	Proportion of primary care physician offices with electronic data capture	Proportion of hospital with electronic data capture
Austria	>80%	100%
Belgium	70%	75%
Canada	41.3%*	na
Denmark	51%	100%
Estonia	98%	100%
Finland	100%	100%
France	na	na
Germany	>80%	>90%
Iceland	100%	100%
Indonesia	≈20%	na
Israel	100%	100%
Japan	15.2%**	14.20%
Korea	63.50%	52-66%***
Mexico	≈15%	≈30%
Netherlands	100%	100%
Poland	≈15%	≈5%
Portugal	90%	70%
Singapore	14%	80%
Slovak Republic	na	na
Slovenia	90%	90%
Spain	≈90%	≈70%
Sweden	100%	100%
Switzerland	20%	90%
United Kingdom	≈100%	100%
United States	57%	19%

* Percentage of physicians (not physician offices).

** Percentage of physician offices (both GPs and specialists).

*** 66% of tertiary/general hospitals and 53% of hospitals use electronic medical records (EMRs).

Source: OECD (2013a).

Lesson 11. External evaluation of health care organisation needs to be fed into continuous quality-improvement cycles

Mechanisms for external evaluation of health care facilities are institutionalised across OECD countries to promote accountability and trust between various stakeholders (the public, health care managers, purchasers and regulators). It is hoped that such mechanisms will not only assure the quality of health care organisation but will also improve quality and safety of care. Maximising the impact of external evaluation requires a balanced approach between quality assurance and quality-improvement mechanisms, where external evaluation is fed into a continuous quality-improvement process at service level. A more comprehensive approach is also called for in a majority of OECD health care systems to ensure that the focus of external evaluation (such as accreditation) goes beyond the acute care sector to include primary and community care.

Encouraging continuous and formative processes of external evaluation

External evaluations are control mechanisms to assure and improve the quality of health care facilities (Klazinga, 2000). Such mechanisms range from statutory inspection, ISO certification and peer review to accreditation. They all use explicit standards, derived from the best available evidence, to assess performance of health care organisations through surveys, assessments or audits. External evaluations are particularly needed when the information infrastructure is underdeveloped and when performance data are lacking.

Overall, external evaluation mechanisms have been progressively embedded in the quality governance architecture to meet the changing demands of public accountability, clinical effectiveness and improvement of quality and safety (Shaw, 2004). This is a positive trend observed across most OECD health care systems, reflecting a greater emphasis on both patient safety and clinical performance.

Three types of approach emerge across OECD health care systems (Table 3.3). The first consists of a formative process of external evaluation, involving continuous quality improvement through monitoring, feedback and incentives. Such approaches, which are reported in Australia, Denmark and England, often rely on a mandatory accreditation system combined with strong internal quality improvement at service level. It is the most sophisticated and extensive form of external quality assurance mechanism for health care facilities. It contains incentives to seek continuous quality improvement through standard setting, measurement, feedback and evaluation of change. The list of accredited providers is most often widely known among the public through a transparent information system. The accreditation scheme in Denmark, for example, effectively nurtured a quality-improvement culture. The key to making the accreditation approach effective in Denmark is its comprehensive set of standards and indicators, its mandatory nature and uniform scoring system, and the fact that each health care organisation must request re-accreditation after three years. The approach taken enabled the professionalisation of quality-improvement work, and focussed leadership attention on achieving continuous quality gains.

The second approach relies on a two-fold system based on a compulsory inspection system and a voluntary accreditation system. Such mixed systems are reported in Israel, Japan, Korea, Portugal and Turkey. In such systems, there is still an important reliance on quality-assurance mechanisms, while too few organisations nurture a quality-improvement culture at service level.

The last approach consists of a summative process for external evaluation based on a one-time assessment. This one-off evaluation was reported in the Czech Republic, Italy, Norway, Northern Ireland, Scotland, Sweden and Wales. With this approach, the risk is to be too focused on minimal requirements and to contain too few incentives for providers to seek continuous quality improvement.

While the last type of approach is the first step in quality assurance, it might be too narrowly oriented to encourage continuous quality gains in the longer term. To drive improvement in safety and quality, health care systems should ensure that external evaluation is not just a one-off assessment but rather is linked to a continuous quality-monitoring and -improvement process.

Table 3.3. Three approaches towards external evaluation of health care organisations

	Formative approach	Mixed system	Summative approach
Countries	Australia, Denmark, England	Israel, Japan, Portugal, Korea and Turkey	Czech Republic, Norway, Italy, Sweden, Northern Ireland, Scotland, Wales

Source: OECD Secretariat based on the series of *OECD Reviews of Health Care Quality.*

Extending accreditation to other sectors beyond acute care

Beyond ensuring a balanced approach between quality assurance and quality-improvement mechanisms, room exists to expand the current scope of accreditation. The majority of OECD health care systems limit the accreditation process to inpatient hospital care. The lack of comprehensive accreditation programmes for primary care is a major weakness in the Czech Republic, Italy, Japan, Korea, Norway and Sweden. Norway, for example, only carries out planned, risk-based audits in primary care. By contrast, Australia, England and Portugal pursue another path by extending accreditation to the primary and community care sector. In particular, England's approach to health service accreditation is at the forefront of OECD efforts, and is a model for other health care systems to emulate (see Case Study 11). It is unusually comprehensive as it accredits all providers of primary and social care (OECD, 2016a). Australia is taking steps in this direction. The accreditation of the National Safety and Quality Health Service (NSQHS) standards has been extended to community health services, but is not mandatory for all services. It is recognised that many primary and community care services require additional support to fully implement the NSQHS standards. The Australian Commission on Safety and Quality in Health Care is working on two projects in relation to this to: i) develop a patient safety and quality-improvement framework for primary care based on the NSQHS standards; and ii) facilitate development of a governance and reporting framework for general practice accreditation in Australia.

Overall, OECD health care systems need to extend the focus of accreditation to other sectors beyond the acute care sector, including primary, community, long-term and social care. Strengthening and broadening accreditation programmes to all primary and community services is essential if more care is to be delivered outside of the acute care setting (see Lesson 1).

Case Study 11. England has a comprehensive accreditation programme for primary care

In England, the Care Quality Commission (CQC), an independent statutory body established in 2009, is responsible for the inspection for hospitals, adult social care, general practice, mental health care services, ambulances and community-based services. All providers of regulated activities, including NHS and independent providers, have to register with CQC and follow a set of fundamental standards of safety and quality below which care should never fall. The CQC assesses if providers are meeting these fundamental standards through monitoring and inspection.

The findings of such assessments are shared with the public, and citizens are encouraged to share their experience or report concerns to the CQC. The role is similar to the tasks of the Joint Commission in the United States, and the standards are in line with those of the Joint Commission.

England's health care system is one of the few in the OECD to have a comprehensive accreditation programme for primary care. By April 2017, almost all GP surgeries in England will have been inspected and rated. Notably, among the inspection measures is how well people with LTCs are cared for by the practice, and whether the care helps to avoid unnecessary hospital admissions. Out-of-hours services are also subject to inspection. Detailed individual practice inspection reports are publicly available on a website.

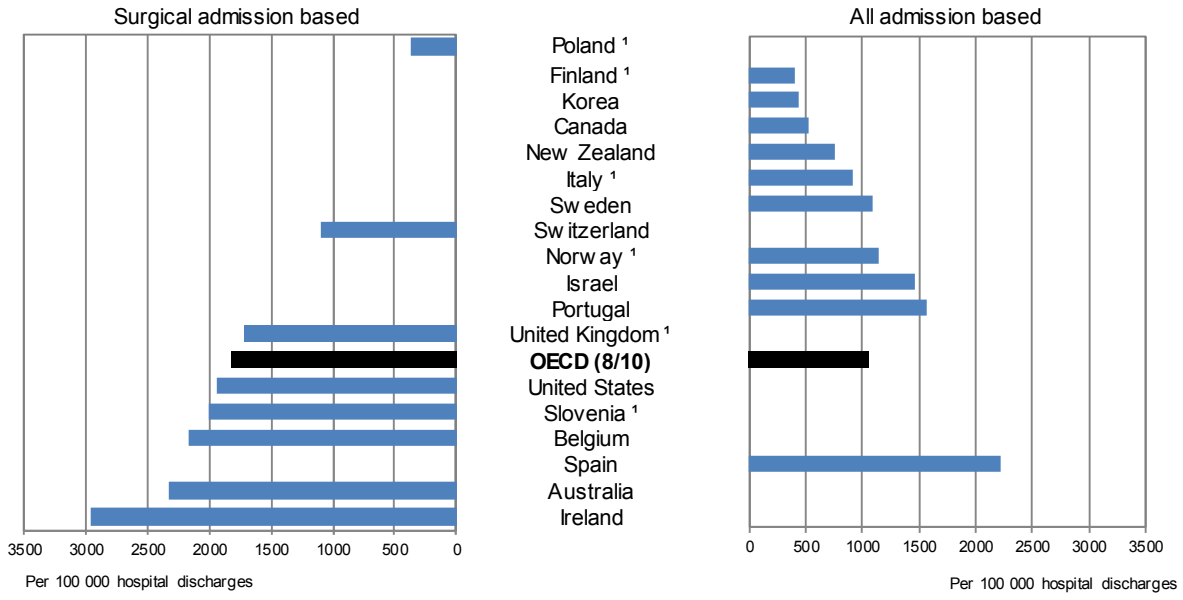
Source: OECD (2016a).

Lesson 12. Improving patient safety requires greater effort to collect, analyse and learn from adverse events

As evidenced by undesired health outcomes (such as adverse drug reactions, medical device-related adverse events, health care-associated infection or post-operative complications), ensuring safe care for patients is an ongoing challenge for OECD health care systems. In 2013, rates of sepsis after abdominal surgery ranged, for example, from 364 per 100 000 admissions in Poland to more than 2 227 per 100 000 admissions in Australia and 2 960 in Ireland (Figure 3.2).

Despite good quality assurance for new technologies (in particular, pharmaceuticals), health care systems most often focus on procedures for market access and very little is done to follow up on the safety and effectiveness of approved technology. At the same time, health care systems need to collect and report indicators to identify failures in standards of care and to learn from them. To improve patient safety and minimise harm, OECD health care systems need to conduct more systematic health technology re-assessment and to set up robust national adverse event reporting and learning systems.

Figure 3.2. Postoperative sepsis in abdominal surgeries are preventable and indicative of poor-value care



Note: Rates were not adjusted by the average number of secondary diagnoses.

1. The average number of secondary diagnoses is < 1.5.

Source: OECD Health Statistics 2016, http://dx.doi.org/10.1787/health-data-en.

Systematically assessing new and existing technologies

Quality assurance of pharmaceuticals appears good across several countries, with effective systems developed for authorising the use of such technologies (although quality assurance for medical devices is often considered less stringent than that for pharmaceuticals). Strong institutions at system level are in place to regulate market entry and use. These institutions are most often in charge of marketing authorisation, pharmaco-vigilance and clinical trials.

However, the use of medical devices and pharmaceuticals in real life sometimes leads to discovery of unpredicted side effects such as safety incidents and adverse events that were not detectable in clinical trials. In this case, a gap exists between the efficacy of the product assessed during clinical trials and its observed effectiveness in real life use. While this gap is widely recognised, the safety and effectiveness of new technologies is only rarely assessed through formal re-evaluation. Recent evidence shows that health technology re-assessment is seldom used in OECD countries. A third of OECD health care systems rely on periodic re-assessment after technologies are included in the range of benefits covered by public funding (Auraaen et al., 2016). This is the case for instance in Australia, Belgium, Chile, the Czech Republic, Denmark, Finland, France, Japan, Korea, the Netherlands, Poland and Switzerland. However, only few OECD countries (Australia, Chile, Spain and the Slovak Republic) initiate a re-assessment of a technology following specific events related, for example, to new evidence on clinical safety and cost-effectiveness of existing technologies.

To reduce the incidence of adverse events, and improve patient safety on the ground, concerted action should be taken to assess the safety and effectiveness of approved technologies. Health care systems thereby need to engage a dynamic approach, involving more systematic re-assessment processes for existing technologies.

Developing reporting and learning systems from adverse events

Improving patient safety requires strong mechanisms to monitor adverse events and promote sharing and learning. Appropriate quality indicators need to be collected and reported to identify failures in standards of care and to learn from them. The approaches taken in the Czech Republic, Korea, Scotland, Sweden and Turkey are too patchy, with no national adverse event reporting and learning systems (Table 3.1, third column). By contrast, Italy is an instructive example that could guide other countries in the process of capturing more adverse events and promoting opportunities for learning (see Case Study 12). Its *National Observatory on Good Practices for Patient Safety* encourages continuous improvement of quality and safety of care by sharing learning from adverse events in hospitals and clinics and promoting transfer of good practices. The *Observatory* has very effectively raised awareness among health care professionals and nurtured a culture of change across the whole country (OECD, 2014a).

To minimise harm, each adverse event should be collected and analysed, with information fed back to providers. This should result in recommendations to prevent adverse events and should be shared with other providers to promote learning. Implementing such a reporting and learning system should be a policy priority across OECD health care systems to detect, measure and learn from adverse events.

Case Study 12. Italy's *National Observatory on Good Practices for Patient Safety* promotes sharing and learning from adverse events

While the patient safety policy agenda in Italy is relatively recent, it is internationally regarded as a model to emulate. Set up in 2008, the *National Observatory on Good Practices for Patient Safety* is designed to:

- develop strategies for continuous improvement of quality and safety of care by promoting transfer of safe practices
- develop patient safety improvement interventions
- develop a network of health professionals who share knowledge and experiences to facilitate transfer of experience.

Case Study 12. Italy's *National Observatory on Good Practices for Patient Safety* promotes sharing and learning from adverse events *(cont.)*

A bottom-up approach is implemented through regional and inter-regional workshops in which all Italian Regions and Autonomous Provinces (R&AP) participate. Learning from these workshops is consolidated, and emerges as national recommendations applicable across the country, made publicly available on the *Observatory's* portal. The next step, regional implementation of these recommendations, is supported by AGENAS, the national authority tasked with supporting R&AP to improve health care quality. Using a questionnaire, AGENAS monitors compliance with the recommendations and seeks to understand the barriers that R&AP encounter in implementation.

Source: OECD (2014a).

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Conclusions

Delivering high-quality care is an essential feature of a high-performing and resilient health care system. High-quality care is care that is safe, effective and patient-centred, and should never be taken for granted. Health care systems face tremendous challenges – complex care needs and care processes, increased health care demands (especially for chronic conditions), and, crucially, an economic landscape in which health care systems will have to achieve more for less. Assuring, monitoring and improving the quality of health care is more than ever a central concern across all OECD health care systems.

To meet these demand- and supply-side challenges while ensuring health care systems' financial sustainability, governments should insist upon transparency to support their health care systems to continuously secure better quality and outcome of care. Steering on outcomes will allow governance and health service delivery to be adaptable, responsive and centred on providing high-value care. Remodelling health care systems and changing cultures is not an easy task, but experiences from OECD countries reveal three priority areas for action:

- *Places*: Health care systems need to invest in key primary care functions to offer comprehensiveness, continuity and co-ordination to patients with complex needs. Building a strong primary care foundation requires investment to create co-ordinated and high-quality community care services and to develop a rich information infrastructure to underpin transparent quality monitoring and improvement.

- *People*: Transparency means placing patients at the centre, to deliver high-value care that maximises both quality and efficiency. This should encompass affording respect to patients, involving them in decisions affecting health care, as well as promoting their voice and choice through greater health literacy. Collecting patient experience measures is also pivotal to delivering health services that are truly responsive to patients' needs. Listening and engaging with patients while modernising the role of health professionals will be central to the foregoing priority of strengthening primary care.

- *Data and incentives*: Health care systems need to invest in the right data and incentives to promote accountability and transparency. Collecting and publishing information around outcomes and quality (rather that inputs and activities), moving to performance feedback and linking payment to the provision of high-quality care are key instruments that should not be underestimated, especially in times of acute financial stress.

Accountability frameworks and incentives are, in particular, important levers to support quality improvement. In primary care, health care systems should collect more quality indicators around prevention, management of chronic diseases, elder care and mental health care (as seen in the United Kingdom, Portugal, Israel and Denmark).

Performance feedback and rigorous open comparison are also key tools to create a platform to share experiences and facilitate learning to improve. Combined with public reporting, non-financial incentives are successful drivers for quality improvement (as seen in Israel, Korea and Sweden). Financial incentives, such as those linking payment to quality and outcomes of care, are effective when they are directed towards high-priority areas such as greater management of chronic conditions (as seen in Australia and the United Kingdom), quality of hospital care (as seen in Korea) or mental health and long-term care (as seen in Sweden).

Last but not least, more research is needed to achieve a better understanding of health care system achievement and performance. Proper and repeated application of the plan-do-study-act cycle should underpin this, focussed on patient outcomes to steer local and national policy making. While OECD health care systems are getting better at embedding evaluation of local initiatives, system-wide assessment of health care system performance is still lacking. Such evaluation should be more systematically conducted to assess the impact of policies and to fill existing gaps in knowledge. To plan national health strategies and prepare health reforms, concerted action is needed to undertake national health care system performance assessments and to benchmark results internationally.

Annex A

Policies that influence health care quality across 15 health systems

Table A.1. Health system governance in member states that have participated in the *OECD Reviews of Health Care Quality* series

Country	Health system governance structure
Australia	Health care governance is shared between the federal and state/territory governments. • Federal government distributes funds for health services to the states, and holds responsibility for general regulation and strategic oversight; • The states are primarily responsible for the organisation and delivery of care.
Czech Republic	Health care governance is shared between central government, regional government and the health insurance funds. • Central government holds responsibility for general regulation and broad public health objectives; • Regional governments hold responsibility for accessibility of individual care in their geographic area; • Health insurance funds are obliged to guarantee the care of their clients within certain distance and time limits.
Denmark	Governance sits at state, regional and municipal level. • Central government holds responsibility for overall regulatory, supervisory and fiscal functions; • The five regions are responsible for hospitals as well as for self-employed health care professionals; • The municipalities are responsible for disease prevention and health promotion. Regulation takes place through national and regional guidelines, licensing systems for health professionals and national quality monitoring systems.
Israel	Health care governance is shared between the Ministry of Health and the four health insurance funds. • The Ministry of Health supervises the quality of services provided by the health funds; • The funds also own hospitals, clinics and pharmacies. Citizens have the right to enrol in any fund. Sub-national governments plays very little role.
Italy	Primary responsibility for the organisation and delivery of health care lies with Italy's regions. Central government retains a secondary role, with responsibility for ensuring "essential levels of services needed to ensure civil and social rights throughout the territory". It may override regional authority in instances where an essential level of service cannot be delivered.
Japan	Health care governance sits almost exclusively with • The Ministry of Health, Labour and Welfare, which is the main actor in health system governance, planning and supervision. The Prefectures are responsible for developing health plans, but have limited regulatory or funding powers to steer local providers' activities.
Korea	Health care governance sits almost exclusively with • Central authorities (including the Ministry of Health and Welfare and the Health Insurance Review and Assessment Service, HIRA); • Professional bodies (such as the Korean Medical Association and the Korean Hospital Association); • Individual providers. Sub-national governments play very little role.
Norway	Governance sits at state, regional and municipal level. • Central government determines national health policy, prepares legislation and allocates funds. The Ministry of Health and Care Services owns four Regional Health Authorities, responsible for highly specialised somatic and mental health care; • Counties are responsible for the provision of statutory dental health services; • Municipalities have responsibility for primary somatic and mental health care as well as nursing care.

Portugal	Health care governance is shared between the Ministry of Health and the five health regions: • The Ministry of Health is responsible for regulation, planning and management of the NHS; • The regions each have a health administration board and take responsibility for management of population health, supervision of hospitals, and direct management of primary care and public primary care providers.
Sweden	Governance sits at state, regional and municipal level. • Central government is responsible for overall health policy; • County councils and regions are largely responsible for funding and provision of services. The majority of primary care centres and almost all hospitals are owned by the county councils; • Municipalities are responsible for the care of older and disabled people.
Turkey	Health care governance sits almost exclusively with • The Ministry of Health, which is the main actor in health system governance, planning and supervision. It has also had a close role in operating primary, secondary and tertiary facilities. Recently, however, the Provinces have assumed a greater role with the creation of hospital unions and public health institutes at provincial level. Municipal authorities have little role.
England	Health care governance sits almost exclusively with • The Secretary of State for Health which has overall responsibility for policy settings in the NHS and for the work undertaken by the Department of Health (DOH). The DOH is a strategic body which gives mandate to the NHS England (also referred as the National Health Service Commissioning Board); • NHS England's principal function is to develop an effective and comprehensive system of health commissioning to drive continuous improvements in quality and outcomes. NHS England comprises a national support centre, 4 Regional and 27 Area Teams; • Clinical commissioning groups at local level are responsible for planning, purchasing and providing health care for their catchment population (emergency care, elective hospital care, community health services, maternity and infant care, and mental health services).
Northern Ireland	Health care governance sits almost exclusively with • The Ministry of Health, Social Services and Public Safety which is responsible for the administration and management of health. It has strategic oversight of both health and social care; • Health and Social Care Local Commissioning Groups and Trusts are responsible for the delivery and commissioning of care.
Scotland	Health care governance sits almost exclusively with: • The Scottish Government's Health and Social Care Directorate which is responsible for the development and implementation of health and social care policy. It allocates resources and sets the strategic direction for NHS Scotland, the primary provider of health care services; • NHS Scotland is organised into 14 Regional Boards.
Wales	Health care governance sits almost exclusively with • The Welsh Government which has overall responsibility for planning of the system; • Local Health Boards, trusts and local authorities also have established management and planning mechanisms.

Source: OECD Secretariat based of the series of *OECD Reviews of Health Care Quality*.

Table A.2. Assuring the quality of health system inputs in member states that have participated in the *Health Care Quality Reviews* series

Country	Accreditation/inspections of health services	Professional training and certification	Authorisation of medical devices and pharmaceuticals
Australia	Accreditation is an important element of the overall quality improvement architecture of the health system. All public and private hospitals and day procedure centres have to be accredited to the National Safety and Quality Health Service Standards. The standards are developed and maintained by the ACSQHC, which also approves agencies that can carry out the accreditation. Accreditation for general practice remains however voluntary (75% of general practices in Australia participate in accreditation).	The regulation of health practitioners is governed by the Health Practitioner Regulation National Law Act 2009. Australia has also adopted a national system for regulating health practitioners in 14 professions: the National Registration and Accreditation Scheme (NRAS). There is an online register of practising and cancelled health practitioners. Employers and consumers can use it to check a health professional's registration status. Health professionals must renew their registration annually through participation in a prescribed amount of annual CPD. AHPRA has a system of random audits to check practitioners' compliance.	Almost any product for which therapeutic claims are made must be entered on the Australian Register of Therapeutic Goods (ARTG) before it can be supplied in Australia. The ARTG is maintained by the Therapeutic Goods Administration, which is responsible for safeguarding and enhancing the health of the community through the effective and timely administration of the Therapeutic Goods Act 1989.
Czech Republic	There is a mandatory assurance of minimal safety and quality standards through one-time accreditation. These requirements are further specified in a ministerial bulletin and are mandatory for all providers of care. The governments also introduced a voluntary accreditation programme for in-patient providers. However, the ministry does not have much information about the quality of the internal quality control systems in most facilities.	The certification process is regulated by ministerial decrees and Act No. 95/2004 in accordance with EU Directive No. 36/2005/ES. Post-graduate training of physicians (in some specialties) is subsidised by the Ministry of Health through the "residential places" programme, which started in 2009. CME is mostly the responsibility of professional chambers. This may be beneficial because chambers have the most valid information about the needs of various groups of physicians and consequently develop appropriate forms of CME, but the lack of independent oversight may risk variable quality in terms of the material offered as well as the risk of the CME process becoming a formal procedure.	Pharmaceutical registration is obtained through the State Office for Drug Control (SUKL) or according to the EU law. A detailed system of registration and monitoring adverse reactions is in place at the SUKL. Each holder of a registration must establish his own pharmaco-vigilance system to be able to co-operate with the SUKL and to react to possible risk. Czech regulation on medical devices is guided primarily through the Medical Devices Act and the main responsibilities lie with the ministry and SUKL, which can prohibit or restrict the use of a medical device. SUKL monitors adverse events in connection with medical devices and co-ordinates clinical trials.
Denmark	A sophisticated accreditation system has been put in place in Denmark: the *Den Danske Kvalitetsmodel* (DDKM, the Danish Health Quality Programme) which is a national and interdisciplinary quality system for the health care system. DDKM was implemented in 2010 and in 2012 all public hospitals were accredited for the first time, valid for a three-year period. The programme has a uniform scoring system. The accreditation programmes are mandatory for public hospitals, pharmacies, and pre-hospital units (but do not cover primary and community care).	Diplomas of professionals and professional training are assured via a system of certification executed by the Danish Health and Medicine Agency covering a total of 16 publicly authorised health care professions, among them doctors and nurses. Authorisation is given by the Danish Health and Medicines Authority. Danish law and departmental regulations do not require re-certification. Danish health professional voluntary engage in regular CPD and learning, but there is no formal expectations and requirements.	The Danish Health and Medicines Authority (DHMA) is also supreme authority for health care and regulatory control of medicines. DHMA also monitors medical devices on the Danish market, which includes assessment of accidents with medical devices and inspection of Danish device manufacturers. DHMA is responsible for developing, support, standard setting and control/supervision.

Israel	Israel currently has two tier accreditation programme, through compulsory inspections linked to the licensing of medical facilities and a voluntary accreditation programme (the Joint Commission International model of accreditation). Inspections are undertaken on a routine basis with a frequency of between three months to three years depending on whether the facility is a hospital, surgical clinic, dialysis facility or other type of facility providing medical services.	The Israeli Medical Association has the predominant influence in recognising doctors as medical specialists, once they have an approved medical degree and meet the requirements of their chosen specialty. There is currently no professional re-certification process in Israel. A number of non-obligatory courses (for CME and CPD) are provided by various organisations such as scientific associations and vendors of health and medical products, but these are not obligatory to maintain medical practice. At the same time, procedure for re-certification of foreign doctors does not exist yet in Israel.	Not available
Italy	Italy has progressively strengthened its accreditation process for health care facilities through several legislative decrees. At present, accreditation is mandatory for hospitals to be eligible for funding from the SSN, but a number of accreditation models have been developed across regions with varying levels of sophistication. Since 2010, there is a national attempt towards standardisation of the accreditation process (Technical Group for Accreditation, TRAC). This is a positive move to achieve a co-ordinated approach at system level, ensuring transparency and accountability around the performance of health care facilities throughout the country.	Medical education in Italy is regulated by the Italian Ministry of Education, University and Research, meaning that teaching uniformity is secured all over national territory. After medical school, graduates must pass a national examination so as to be placed on a national physician register and be allowed to practise. Continuing medical education (CME) is recognised as an important element to ensure physician fitness to practice. Italy has launched in 2000 the National Programme on Continuing Education in Medicine (NPCEM), which requires health care professionals to obtain 50 CME credits per year. The system is not link to re-certification.	The Italian Medicines Agency (AIFA) is the competent authority in charge of the pharmaco-vigilance, production, research, pricing, reimbursement and drug approval in Italy. The safety of pharmaceuticals is further ensured through a postmarketing surveillance system which monitors safety information and adverse reaction for all authorised drugs through the National Network of Pharmacovigilance (*Rete Nazionale di Farmacovigilanza*). The AIFA monitors medical devices through inspection at manufacturing sites of finished medicinal products and medicinal gases. An information system has been developed to monitor medical devices bought or used by all public health providers.
Japan	In Japan, all health care providers must meet minimum quality standards as a condition for reimbursement. The requirements to be met however are relatively basic and largely focus on staffing levels. There is not a national accreditation programme but Japan Council for Quality Health Care (JCQHC), an independent agency, has been carrying out hospital accreditation assessment since 1995, based on the Joint Commission International model of accreditation. As of 2014, 27.5% of hospitals were accredited by this programme.	Professionals have the national-level licenses, allowing them to practice anywhere in the country. The MHLW grants a license to an individual. For physicians a minimum of two years of additional clinical training is required before starting to practice. Certification and continuous professional development is available on a voluntary basis In the Medical Doctors Act.	The Pharmaceutical and Medical Device Agency (PMDA) is responsible for evaluating the effectiveness of new medical devices and pharmaceuticals under the Pharmaceutical Affairs Act. The Act stipulates the quality, effectiveness and safety assurance for medical equipment and pharmaceutical products. New drugs are evaluated on their effectiveness and safety via randomised clinical trials. All new drugs with proven effectiveness and safety are approved and automatically reimbursed without assessment on cost-effectiveness.
Korea	Korea has a good system for hospital accreditation. Korea's hospital accreditation process covers a large number of areas. However, at the end of 2011, accreditations undertaken to date have covered the 44 tertiary hospitals	After passing the national examination to become a medical doctor, physicians can do a one-year internship which leads to another national examination, which is then followed by four-year residency training (the programme is	The Korea Food and Drug Administration (KFDA) is a governmental agency to assure the safety, hygiene and efficacy of food and drugs. The KFDA executes regulation of both pharmaceuticals and

	but only 12% of general hospitals and 0.6% of small hospitals. While this may in part reflect the infancy of the new arrangements, the change from mandatory to voluntary accreditation has weakened its role as a strategy for quality assurance, particularly in the small and medium hospitals where accreditation is most needed.	shorter for family medicine). Once a medical professional has completed their education and professional licensing requirements, assessing their ongoing professional performance is the responsibility of the KMA. Continuous medical education is currently available in Korea for both doctors and nurses, but the extent to which professionals are undertaking this education is unclear. The Ministry of Health and Welfare is currently planning to introduce a "license report programme" that would make it mandatory for health care professionals to report their licence status on a regular basis and undertake continuous medical education.	medical devices. In order to ensure that pharmaceuticals in the Korean health care system continue to remain clinically appropriate, the KFDA has also undertaken a re-examination process for newly approved drugs which is conducted 4-6 years after the receipt of approval. Policies to assure the quality of medical devices include application of "good manufacturing practices" (GMP) for medical devices by manufacturers and device; legal structures that regulate clinical studies on medical devices; legal requirements for tracking, recall and repair of devices; a one-stop medical devices licensing review process and the development of a database on safety and adverse effects of medical devices.
Norway	Health care organisations can, on a voluntary basis, be certified according to ISO 9001. The Norwegian regulation for internal quality assurance of health services assures the quality of health care providers and facilities, but there is no accreditation system for medical facilities in Norway.	Health care professionals are licensed and authorised according to the Health Personnel Act. There are 29 registered health professions. Under the Act, the Norwegian Registration Authority for Health Personnel (SAK) is responsible for granting health professional authorisation. The Norwegian Directorate of Health is responsible for specialty recognition, and is the competent authority for issuing certificates of specialist training for certain groups. CME is voluntary for health professional. However, the Norwegian Medical Association has organised a system of five-yearly recertification for specialist GPs, approved by the Directorate of Health.	The Norwegian Medicines Agency (NOMA – *Statens legemiddelverk*) oversees pharmaceuticals. The Agency, which is in charge of marketing authorisation, pharmaco-vigilance and clinical trials, further maintains the Norwegian Electronic Prescription Support System (FEST). Fest is a database with core information on clinical decision and drugs used in Norway. The Norwegian Directorate of Health is the competent authority for medical devices in Norway. Medical devices have to fulfil the requirements given by the European Directives. The Directorate is responsible for market surveillance of devices and manufacturers on the Norwegian market as well as surveillance of the Norwegian Notified Bodies designated to certify medical devices.
Portugal	The national and official Accreditation programme in Portugal (managed by the Directorate-General of Health), the National Model of Health Accreditation, is based on the Andaluzia Accreditation Model (ACSA International). Portugal's accreditation programme covers all types of health unit (primary care, hospital, hospital services, etc.) and it is still voluntary. In addition to this voluntary programme, there are two private companies with voluntary accreditation programmes: CHKS (United Kingdom) and Joint Commission International (United States). The Inspectorate of Health-related	Professional training and certification of doctors and nurses Physicians in Portugal follow a six-year degree programme, the last year of which encompasses institutional medical practice. This is then followed by an internship which comprises one year of general training and a variable period of four to six years of specialised training, leading to specialisation. Continuous professional development (CPD) is not integrated in national standards or guidelines for quality of care, and CPD is entirely voluntary. The development of a policy on re-certification (which would include	The safety and appropriate use of pharmaceuticals in Portugal is ensured by INFARMED, the national authority for medicines and health products. INFARMED is tasked with monitoring, assessing and regulating all activities relating to human medicines and health products for the protection of public health. INFARMED is also the competent authority for medical devices, in the context of market surveillance, clinical investigation and in the designation and monitoring of notified bodies. Medical devices are regulated according to European Directives to

	Activities (IGAS) also performs the disciplinary and audit function for the NHS, and audits NHS institutions and services.	CPD/CME activities) has however started.	ensure a high level of health protection and safety of consumers and users.
Sweden	The Health and Social Care Inspectorate plays an overarching inspection and supervisory role to assure the quality of health care organisation. Sweden does not have an accreditation system for health care organisations.	Health care professionals trained in Sweden are licensed according to the 2010 patient safety act and patient safety ordinance. For some professions the diploma has to be supplemented with a certificate of completion of a specific internship/practice experience. There are no formal, national systems of CME and CPD or for recertification. This agenda is not nationally formalised and the responsibility rests with the employers (county councils, municipalities and private providers).	The MPA (Medical Products Agency) is the Swedish national authority responsible for the regulation and surveillance of the development, manufacture and sale of drugs and other medical products. The legislation in Sweden is based on two EU Directives, Council Directive 93/42/EEC concerning medical devices and 2001/83/EC Medical Products for human use. Various surveillance activities are in place.
Turkey	The Department of Health Care Quality and Accreditation within the Department of Health Services in the Ministry of Health has developed and executed an impressive programme of quality standards and the assessment of their compliance. A series of 321 standards (covering 621 audit items) are used to assess the quality of health-care services (hospitals but also emergency services and dental practices). All hospitals are evaluated once a year and there is a scoring system. The programme is impressive, with a pay for performance scheme linked to the hospital score.	Standards for medical specialty training do not seem harmonised over the various specialties and CME structures are voluntary and differ between specialties. Professional efforts to pursue modern form of continuous medical education are still in their infancy. This might mitigate efforts to further drive quality gains in health-care services.	The Turkish Medicines and Medical Devices Agency is responsible for the regulation of four key areas: pharmaceuticals (licensing, risk assessment, pharmaco-vigilance, pricing, ensuring rational drug use and access to drugs), medical devices, cosmetics and laboratory services. A track and trace system is being implemented for medical devices which track the location of every medical device (i.e. of each patient) and its outcomes.
England	England's Care Quality Commission (CQC) inspects all health and social care providers in England. Its fundamental role is to monitor, inspect and regulate services to make sure they meet standards of quality and safety, and to publish what it finds, including performance ratings, to help inform patient choice.	Jurisdiction for bodies involved in health professional regulation is largely United Kingdom-wide. Professional standards for all doctors and nurses working in the whole of the United Kingdom are set by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), respectively. These bodies set the standards that health practitioners must attain and maintain, and are responsible for taking action when the standards are not met (such as the loss of the right to practise in the UK). Participation in CPD activities has long been required for doctors working in the United Kingdom, a condition of employment in the NHS and later a condition of participation in the royal collages (speciality schools) for physicians. In 2012 a system of five-yearly revalidation was introduced for physicians, and a system of revalidation is soon to be introduced for nurses. Revalidation involves the appraisal of a doctor's performance in the workplace, against national standards across a	The current legislative basis for the quality and assurance of medical devices derives from EU Directives, which have been into four sets of UK regulations which apply across the UK. The Medicines and Healthcare Products Regulatory Agency (MHRA) as an executive agency of the Department of Health (DH) to enforce the regulations relating to the safety of medicines and medical devices in the UK. The Governments of the devolved nations then work closely with the MHRA. For example, The Northern Ireland Adverse Incident Centre acts as a regional centre for reporting and investigating adverse incidents involving medical devices and non-medical equipment, while MHRA's alerts to NHS Wales are made through the Welsh Government's Public Health Alert System. Other national bodies, for example the Scottish Antimicrobial Prescribing Group (SAPG), aims to improve quality and safety around pharmaceutical
Northern Ireland	The Regulation and Quality Improvement Authority (RQIA) plays a central regulatory role in the health and social services sector in assuring and improving quality of care. Its powers include conducting reviews and carrying out inspections and investigations, and reporting on arrangements by statutory bodies for the purpose of monitoring and improving the quality of the health and personal social services.		
Scotland	In Scotland, Healthcare Improvement Scotland (HIS) inspects and reviews health care services, through announced and unannounced inspections. HIS also inspects independent sector facilities such as private hospitals, voluntary hospices		

	and private psychiatric hospitals. It publishes performance reviews and inspection reports on a website to provide public assurance of the quality and safety of health services.	range of domains (for example, knowledge, skills and performance; safety and quality; communication). Evidence required in doctors' portfolios differs across domains, and may include proof of training or assessment of skills, continuing medical education, audit (a quality improvement process), or validated tools for feedback about doctors' practices and anonymous records.	consumption. The SAPG aims to enhance the quality prescribing of antibiotics in hospitals and primary care, through a national framework for antimicrobial stewardship. SAPG's work underpins the Scottish Reduction in Antimicrobial Prescribing (ScRAP) initiative, an educational toolkit that aims to reduce unnecessary antibiotic prescribing.
Wales	In Wales, health services are reviewed against a range of published standards, policies, guidance and regulations by Healthcare Inspectorate Wales (HIW). Its role is to provide independent assurance of the quality and safety of health services. It produces inspection reports as a result of investigations. Traditionally, HIW has not looked at the primary care sector, although a review of GP services is to be undertaken in 2015.		

Source: OECD Secretariat based of the series of *OECD Reviews of Health Care Quality*.

Table A.3. Health system monitoring and standardisation of practice in member states that have participated in the *OECD Reviews of Health Care Quality* series

Country	Quality Indicators and performance Reporting	National standards and guidelines	Clinical audits
Australia	The National Health Performance Authority (NHPA) collects data on the performance of public and private hospitals and primary health care organisations, based on various measures and metrics. It publicly reports these findings through the MyHospitals and MyHealthyCommunities websites. On hospitals, Australia compiles and reports on a range of data, detailing the characteristics of public hospitals, non-admitted patient care, admitted patients and the care they receive in hospitals, elective surgery and ED visits. These statistics are publicly reported. Compared with the volume of hospital information that exists, there is a surprising lack of data relating to quality of care in primary health care in Australia. This limits the ability to track the patient pathway through the health system. However, Australia does not consistently collect information about patient harm, over-use of pathology testing and antimicrobial stewardship in primary care. Several reports on performance are published in Australia: the annual Report on Government Services (ROGS) includes health services and reports on key indicators of safety and quality.	Australia's delivery of a set of national standards for all acute health care facilities is a leading example of quality of care improvement efforts in a federated country. The NSQHS standards and accreditation scheme represent important elements of the overall safety and quality improvement architecture of the health system. The standards address well established and universal quality issues for health services, and are acute-care focused. The National Health and Medical Research Council (NHMRC) is the federal government body responsible for clinical guidelines. The NHMMRC noted that there are between 500 and 600 guidelines in circulation in Australia, covering a wide range of clinical topics and settings, and of varying quality and currency. The way guidelines are funded and developed is problematic in Australia. Another problem relate to the confusion caused by the existence of hundreds of clinical guidelines produced by numerous organisations. It is unknown the extent to which clinical guidelines are contributing to quality improvements in the health system, or better population health outcomes.	While there are requirements to conduct clinical audits included throughout the national standards, there are also different approaches adopted by the states. Western Australia, for example, has implemented a mandatory review of all deaths that occur in public hospitals and private health facilities that provide services for public patients. Queensland conducts an annual "Bedside Audit", where clinicians collect information on certain elements of care to gauge whether expected standards have been met. At a national level, the Royal Australasian College of Surgeons makes it a requirement to participate in the Australian and New Zealand Audit of Surgical Mortality as part of the college's Continuing Professional Development programme. The ACSQHC also conducts audits to assess compliance with standards.
Czech Republic	A substantial amount of data is gathered across the Czech health care system. Most data is focused on volumes of care and resources within the system. Clinical data is also gathered almost exclusively by specific registries (organised by disease, targeting specific group of population, or hospital based). The focus of most registries is on clinical features, primary diagnosis and description of the treatment and less on the clinical pathway and outcomes experienced by the patient. The information infrastructure is fragmented, with several entities that gather and process data. However health data are rarely converted into reports or information that can be used by professionals or policy makers to improve quality. The openness of the data infrastructure is effectively relatively low – collaboration between academic partners and state institutions on data analysis is infrequent and patients have very limited access to information on the performance of local services. One key avenue to explore in the Czech Republic would be transparent national comparison, or benchmarking, of	So far the Czech Republic has not adopted a system-wide approach focussing on health targets. The main initiatives around standards and guidelines in the Czech health care system have traditionally been clinical guidelines spearheaded by the medical profession, mainly Purkyně's Association (the country's main medical research umbrella association). Clinical guidelines have until now predominantly been developed at a non-governmental level by the different professional societies and subsequently adopted by the national authorities. The ministry is now planning to become more involved through the EU funded "Implementation of Clinical Practice Guidelines in the care covered by public health insurance" project which has started in late 2013. Most Czech guidelines are still disease and	A system of internal auditing of quality and the system of monitoring of patient safety is made mandatory by law but it remains relatively unenforced. It is not clear to what extend such audit results in real improvement processes at patient care level. Such unenforced approach presents risks for the future of quality of care in the Czech Republic.

	provider performance.	specialty-based (rather than addressing multi-morbidity).	
Denmark	Denmark has very good databases on quality of care. The data-infrastructure for primary care, the clinical and hospital sector is well developed compared to the data infrastructure for home care and nursing home care. The hospital sector is better served than primary care, although progress has been made with the establishment of Danish General Practice Quality Unit (DAK-E). The Unit uses a system of automatic data capture from primary care records to monitor quality over thirty areas, including management of chronic diseases such as depression, COPD, diabetes or heart failure for example (DAMD system). Several methods are applied systematically to ensure that the data collected are used actively for quality improvement. Denmark has an advanced system for public reporting on quality: Sundhed.dk. The Danish e-health portal, is the official portal for the public Danish health care services and enables patients and health care professionals to find information and communicate. The country also publishes annual reports based on national clinical databases, and reports on regional variation in health outcomes.	The central government reaches agreements with the Danish regions on high-level service goals such as mortality or adverse event rates, without specifying more detailed targets for population-based health care outcomes. The *Folkesundhedsprogram 1999-2008* (Public Health Programme 1999-2008) included a series of targets for the reduction of inequality in health. Clinical guidelines have until now predominantly been developed at a non-governmental level by the different professional societies and the regions. With the 2012 government annual budget, the development of clinical guidelines was undertaken at national level by the Danish Health and Medicines Authority (DHMA). Clinical guidelines have traditionally been developed along the lines of specialties, specific diseases and procedures, but attention is now shifting to the standardisation of the organisation of service delivery and to guidelines addressing multi-morbidity.	Several audits are conducted in Denmark: the annual clinical audit at national level (based on all national clinical databases), annual qualitative audits at regional and local level, and ad hoc in-depth national clinical audits on specific items (for example reports on regional variation in survival on lung cancer).
Israel	In Israel, there is an extensive range of data that is collected by community health facilities on nearly the entire population. The basis for this has been electronic patient records, which has led to the specification of a minimum data set called the Quality Indicators in Community Health Care (QICH) programme. The QICH is one of the most comprehensive programmes for monitoring the quality of primary care among OECD countries today. In contrast to primary care, too little is known about the quality of care delivered in hospitals. Poor information on hospital quality makes it difficult to assess whether frequent reports of quality shortfalls are highlighting systematic problems. The extent to which data is collected varies dramatically by hospital. Israel may not yet have exploited the full potential of transparency to drive improvements in the quality of care. Until recently, patients in Israel have little basis on which to make informed choices should they wish to do so.	The Ministry of Health sets a list of targets to influence the quality of care and addressing health inequalities. The two major health funds (Clalit and Maccabi) also periodically set internal targets for clinics. Maccabi developed targets by region for performance on different quality of care indicators. For each quality indicator, Clalit's management seeks to set a target, informed by international benchmarks, trials and expert opinion. Hospitals are then scored on their performance relative to the target. The various professional organisations associated with the Israeli Medical Association are the principal developers of clinical guidelines in Israel. These guidelines are usually developed in compliance with evidence-based medicine principles. In a small number of cases, the Ministry of Health will develop and publish guidelines.	The Ministry of Health conducts quality audits to verify standards of professional practice.
Italy	Italy has a large number of rich national (*Griglia LEA* and the *Programma Nazionale Esiti* for example) and regional databases (the Tuscan Performance Evaluation System for example) that contain information on the quality and outcomes of health. These indicators mostly	Initiatives around standard setting and guideline distribution in the Italian health care system are undertaken at both national and regional levels. Although a national attempt has been undertaken to co-ordinate and	The Italian National Institute of Health conducts inspection and quality control of medical and diagnostics devices, pharmaceuticals and food product and packaging.

	relate to hospital care. The country also has numerous patient registers (most of which are operated by professional and scientific societies). In general, these patient registers are highly fragmented, with uneven coverage and linkage across the country. In an effort to make best use of this data, the *Nuovo Sistema Informativo Sanitario (*NSIS – New Health Information System) was established in 2001. There is however a current deficit of information on the patterns of care and outcomes in primary and community care. Several ways are used to publicly report health system performance in Italy. All information on health databases and indicators are published on the official website of the Ministry of Health for example. However, the potential for patients to make use of quality data appears to be still rather scarce, notably in the areas of primary and community care. Data on individual long-term care centres, specialists or general practitioners is not made publicly available in Italy.	harmonise regional activities around clinical standards and guidelines, there are still significant regional variations in clinical guidelines activities. The National Programme on Clinical Guidelines (*Piano Nazionale Linee Guida*, PNLG) has been established to steer the behaviour of health care professionals towards appropriate and effective provision of health care services. The National Guidelines System (*Sistema Nazionale per le Linee Guida*, SNLG) has also been set-up to create diagnostic and therapeutic paths, as well as developing evidence-based documents including clinical practice guidelines.	AGENAS has also an inspection role to ensure that agreed minimum standards are applied in all regions. It is noted that this inspection role should be strengthened.
Japan	The information infrastructure at system level is focused on quantifying activities. Japan has a national database of health insurance claim data, covering almost all services provided since 2009. The database includes an estimated 130 million claims including in-patients, outpatients and dental care and prescriptions, every month, but does not include medical records such as test results and cancer stage. A quality- and outcomes-oriented systematic data infrastructure, comprising patient registers and quality indicators is under developed. At the same time, too few information on the activities and outcomes achieved within hospital care is available in Japan. There are however some sophisticated initiatives conducted by some hospitals to measure and improve quality (such as the Quality Indicator project undertaken by St Luke's International Hospital), but such initiatives are not uniform across the country. The Japanese reporting of health system mainly focuses on health status and lifestyle, structure and service delivery. Report on quality of care is still not available in the country at system level. There are innovative public reporting activities from for example the Japan Hospital Association (JHA), All Japan Hospital Association (AJHA) and National Hospital Organization (NHO).	Since 1985, based on the Medical Service Act, each of Japan's 47 prefectures has set out a five-year Regional Medical Care Plans which evaluates the current status of the regional health system and addresses specific local needs and challenges, supplemented by many statistics. The current Plan requirements, introduced in 2013, include specific regional targets, and several targets are also defined through the fee schedule. "Health Japan 21" sets a target to prevent disease associated with adult life habits. JCQHC has been developing guidelines since 2007 through rigorous and scientific approach, and nearly 160 guidelines are at present available on the JCQHC's website; Medical Information Network Distribution Service. Compliance to guidelines is voluntary and the impact of guideline developments on quality is not clear.	Prefectures are required to make regular audits and improvements to their plans, but there is not a systematic approach to this. This is because there is a lack of comprehensive and actionable indicators to support quality improvement.
Korea	Korea has world-class information technology infrastructure and health care data. HIRA has developed an extensive data infrastructure, and has the ability to monitor the use of health care services in ambulatory care and hospital care. HIRA makes an explicit effort to measure a range of quality of care indicators on in-patient care, long-term care, and outpatient care (with outcome, structure and process indicators).	The focus on developing guidelines is relatively new in the Korean health system. The two main actors responsible for the development of clinical guidelines are the government and academics (i.e. the Korean Academy of Medical Sciences). Since 2004, clinical research centres in Korea have specialised in specific	Health Insurance Review and Assessment Service (HIRA) is responsible for quality assurance and auditing of claims for publicly reimbursed medical services. Three assessment programmes were for example carried out– on in-patient care (AMI, stroke,

	Korea has undertaken a number of initiatives to improve public reporting on quality of care. Both HIRA and KOIHA undertake public reporting on health care providers. HIRA for example publishes a broad list of service providers with both positive and negative results on a website. Reporting through accreditation is undertaken through KOIHA, which discloses the names of accredited medical care institutions (so far mainly hospitals). In addition, the Emergency Medical Service Act obliges the Ministry of Health and Welfare to publicly disclose the results of a quality assessment of the Korean Emergency Services every year.	disease areas. These research centres were established as part of the Clinical Research Support Project. The research centres are responsible for developing practice guidelines, which are made available on the website of the Korean Guideline Clearinghouse.	prophylactic antibiotics for surgery, caesarean section), long-term care and outpatient care. Assessment is based on a broad range of indicators covering outcome, structure and process. The Korea Institute for Healthcare Accreditation (KOIHA) also conducts audits to ensure that agreed minimum standards are applied in hospital as part of the accreditation programme.
Norway	A national quality indicator system for the health sector has been implemented by the Norwegian Directorate of Health, which gathers hospital care and primary care indicators that measure the quality in structure, process and result within the health sector. There are the IPLOS registry, HELFO database, KOSTRA system and registries covering different diseases, health outcomes and professional areas. In primary care, some broad indicators are collected such as prescribing patterns, hospital admissions for chronic conditions, but little is known about the quality of care. At the same time, Norway has no information infrastructure at local or at national level to systematically collect a dataset that would allow GPs, patients and authorities to benchmark quality and performance against peers or against national guidelines. Public reporting in Norway is weak. There is only the Norwegian official web-based portal (helsenorge.no) that has started a reporting cycle for health professionals and patients and the Samdata Report (but it only includes structural and process indicators).	At national level, the Norwegian Directorate of Health is the only responsible body devoted to develop and disseminate national clinical guidelines. Professionals are invited to take part in the developments of such guidelines. Local authorities and Regional Health Authorities facilitate the implementation of national clinical guidelines, and ensure their effective use. At present, there are approximately 400 national clinical guidelines for health care providers that are distributed in paper version or available on the Internet.	The Norwegian Board of Health Supervision carries audits in the primary and specialised health care sector. County Governors (under the supervision of the Norwegian Board of Health Supervision) perform between 300 and 400 health services quality audits each year, of which approximately two thirds are in primary care services. These planned supervisory quality activities are risk-based, some part of a yearly national strategy under the leadership of the Board of Health Supervision and some based on local risk assessment.
Portugal	Portugal has an extensive information infrastructure which spans almost all levels of care, and this data is also actively used to drive quality improvements. The primary care information architecture, SClinico, covers more than 350 facilities. Information available includes demographic data (name, gender, date of birth, etc.) and clinical data (health problems, allergies, personal and family history, medical history, medication and prescriptions, appointments, referrals, etc.). The architecture of the hospital information infrastructure is also nationally standardised, enabling the monitoring of hospitals outcomes on an ongoing basis for all NHS hospitals, by hospital and by region. Performance indicators, which go far beyond the typical process and activity-based hospital indicators, are collected across four dimensions – access, quality, productivity and financing. The reported data	In Portugal quality indicators and targets are included in contracting with ACES, PHCUs, and FHUs, and in the incentive structures for FHUs. Clinical guidelines are mandatory in Portugal. In September 2011 a protocol was signed between the Directorate-General of Health and the Portuguese Medical Association to drive improvements in the health system. This Protocol included guideline development and implementation, evaluation of the impact of guidelines and their applicability, to train clinical auditors and to perform clinical audits, and to develop integrated care pathways. Issuing scientific advice on clinical guidelines falls to the Scientific Advisory Board, appointed under dispatches from the Secretary of State	The Directorate-General of Health which sits the Department of Quality in Health is responsible for conducting clinical audits of health care providers. The Health Regulation Authority (*Entidade Reguladora da Saúde*– ERS) is also responsible for conducting audits.

	then is available to hospital providers and service users on an online platform on a monthly basis.	Assistant to the Minister of Health.	
Sweden	Sweden has an impressive track record around measuring and publishing indicators on the quality of care, both at provider level and at population level. The indicators used today measure the quality in structures, processes, results, and the efficiency of Swedish health care. Most of the available data sources measure in-patient care and specialised out-patient care. In primary care however, the data infrastructure is currently not equipped to deliver the information needed to assure and improve the quality of primary care and elderly care. Quality indicators in the primary care and community health services are not collected and publish. A primary care register is currently being set-up by the National Board of Health. There are a number of different types of national reporting activities conducted by different authorities and organisations. There is first the Quality and Efficiency in Swedish Health Care publication. This is a yearly report that serves as a well-used source of information for the care providers at different levels. There is also in-depth national assessments of a defined area of care that are conducted by the National Board. Data is reported at different levels (national, regional, county council and unit level) and is disaggregated by age, gender and socio-economic status.	The National Board of Health and Welfare's selection of guideline topics is preceded by consultation with the county councils and the regions. The Board produces the guidelines with external scientific and clinical experts. This gives the guidelines both high quality and high credibility. For some activities recommended in guidelines, the government provides grants to stimulate implementation of the guideline and encourage broader quality development in the particular clinical area addressed (on dementia and schizophrenia for example). The National Board of Health and Welfare conducts regular evaluations of compliance with the national guidelines, repeated after around three to four years and focused on those aspects of care deemed to have major need for improvement. There are several targets and standards in Sweden. Given the historical problem of long waits, Sweden has set-up specific waiting time targets. For primary care also the targets are that a patient should be able to contact primary care immediately.	The National Audit Office is part of the formal regulatory framework applied around the Swedish Government. The agency has recently shown increasing interest in auditing health care and is planning to study the compliance of the health care system with the criteria set out in the Swedish Health and Medical Services Act. The focus of this work will be, amongst others, dental care, pre-hospital care including the ambulance service, and quality registries.
Turkey	In Turkey a broad variety of data sources has been developed and improved over the past ten years. Nevertheless, the focus of most of these has been on monitoring trends in health needs and in health-care activities. In primary care, a limited number of activities and outputs are measured; those that are produced focus on basic measures of population health (such as all-cause mortality and activity around maternal and child health). These data do not relate to chronic and non-communicable diseases but work is already underway to achieve this. In hospitals, improvements have been made for public hospital services with the establishment of a quality indicator programme. Private hospitals claim that they collect already some quality indicators, few of these are made available either to the Ministry of Health or to patients. There are few types of national reporting activities. Information is in practice made available on websites, but it is limited to information on structure (whether certain facilities are available) and less on process quality and outcomes. There is no national and regional quality report.	There are national standards for hospital and primary care. For hospital, the Department of Health Care Quality and Accreditation within the Department of Health Services in the Ministry of Health has developed and executed an impressive programme of quality standards and the assessment of their compliance. A series of 321 standards are presently used to assess the quality of health-care services. In primary care, these focus mainly on the physical fabric of the building and availability of clinical equipment and emergency drugs, and there is a limited number of activity-related standards. Turkey has embarked on an ambitious programme to translate an extensive set of clinical guidelines written by the Finnish Medical Society. There are however difficulties of embedding a large number of guidelines at once, and in particular of changing practice through guidelines with little sense of local ownership or participation during development.	The Department of Health Care Quality and Accreditation (within the Department of Health Services in the Ministry of Health) conduct regular audits to assess compliance with defined standards.

England	England has a long-established history in the design, collection, analysis and dissemination of quality indicators, and this is enabled by the relatively sophisticated information infrastructure that underpins the NHS. *Quality Dashboards* provide additional real-time data at hospital level, as well as an overview of trends and outliers. Benchmarking with peers allows identification of Trusts that are statistically worse than their peers in England for a particular indicator. Indicators include waiting times for cancer diagnosis and treatment, hospital mortality ratios, hospital-acquired infections and other adverse events, cancelled operations rates, PROMs and Friends and Family Test outcomes. However, most of England's quality indicators relate to acute, hospital-based services. Few, if any OECD health systems can match the volume and detail of openly published health system performance data that exists in England. The NHS Choices website publishes data on the outcomes of surgeons' care for ten surgical specialities, with plans to extend this to other surgical and medical specialities, including cancer care. The primary care performance data for individual General Practices collected through the QOF have always been publically available.	The National Institute for Health and Care Excellence (NICE) sets standards of care and produces clinical effectiveness assessments, assesses cost effectiveness, and produces guidelines for a wide range of clinical and public health activities. NICE also produces Quality Standards, which are usually based on NICE clinical guidelines. The Quality Standards are a concise set of prioritised, specific, precise and measurable statements, designed to drive and measure priority quality improvements within a particular area of care.	The national clinical audit programme began across England and Wales in 1996, were reviewed in 2006, and have been overseen by Healthcare Quality Improvement Partnership (HQIP) since 2008 on behalf of England and Wales. The outputs of audits should feedback to clinical staff, as well as informing policy, strategy and service planning, with audits based on widely agreed standards. In England, the Healthcare Quality Improvement Partnership promotes quality improvement through audit and confidential enquiries. It manages the National Clinical Audit Programme, comprising more than 30 condition-specific clinical audits. There is a set of over 60 national audits in England, in part carried out by HQIP, and in part led by the Royal Colleges or professional bodies.
Northern Ireland	In Northern Ireland available quality and performance indicators are limited. Key databases available do include adverse event monitoring, complaints, hospital administrative databases clinical registries (e.g. hip surgery), and patient experiences. In Northern Ireland, public access to data and information on the quality and safety of their health and social care services is principally achieved through the DHSSPS and the Health and Social Care Trust websites. There are also Health and Social Care Trust Annual Quality Reports. Additionally, a wide range of data and information is available from the Information and Analysis portal on the DHSSPS website.	In Northern Ireland, the Department of Health, Social Services and Public Safety (DHSSPS) has a wide, if not overwhelming, range of interwoven standards and guidelines that are generated from a variety of sources. These include Minimum Care Standards, focusing on safety and quality of care of regulated organisations, designed to address unacceptable variations in the standard of care and improve quality. They also include Quality Standards, which focus on overarching standards of good governance and best practice across health and social care services. These standards are used by RQIA in carrying out clinical and social care governance reviews.	In Northern Ireland, the Guidelines and Audit Implementation Network (GAIN) is responsible for clinical audit. It has published a number of clinical audits since its inception and provides clinical audit training to health and social care staff. However, the status of the role of the GAIN is not clear. It is noted that although the GAIN is funded by the DHSSPS, the outputs of the organisation are not formally endorsed by the Department. It is also not clear how the role of the RQIA and audit activities of the GAIN articulate.
Scotland	Scotland has a well-developed performance framework, and uses quality indicators to measure progress towards the stated outcomes it wants to achieve. Scotland has developed new integration indicators (such as how well people are supported to live as independently as possible and the extent to which health and care services seem to be well co-ordinated). NHSScotland established the *Information Services Division* to provide information on activities, costs and outcomes within the health system. Its *Quality Measurement Framework,* includes quality outcome indicators.	The Scottish Intercollegiate Guidelines Network (SIGN) is an internationally-recognised authority in the production of evidence-based clinical guidelines, which support Scotland's key challenges around chronic disease and other conditions. SIGN guidelines are derived from a systematic review of the scientific literature and cover health issues including those relating to NHS Scotland priority areas, such as cancer, cardiovascular disease and mental health. They are designed to	In Scotland, national quality registers and clinical audits have emerged as bottom-up, clinical-led processes in Scotland, often led by pioneering clinicians. In addition, Scotland participates in the UK-wide programme of national clinical audits run by the Healthcare Quality Improvement Programme (HQIP). The Clinical Outcomes Measures for Quality

	In Scotland, an abundance of information on health and social care is available to the public. *Scotland Performs* measures and reports on progress in achieving the outcomes in the National Performance Framework. The ISD produces more than 100 statistical publications and clinical audits each year, all of which are available on its website.	draw on current evidence to assist in meeting the aims of reducing variations in practice, and improving patient outcomes.	Improvement (COMQI) group has started to take on the strategic management of the national audits. Work is also underway to develop a system for auditing the effectiveness of the audits.
Wales	The Welsh Government Quality Dashboard reports qualitative and quantitative data around priorities and pressure points. Quality Statements are another way that quality indicators are drawn together. For emergency care, a dashboard of indicators has been created by the Unscheduled Care Board, in conjunction with the Welsh Government. The Secure Anonymised Information Linkage Databank (SAIL) also brings together a wide array of routinely collected data on health, well-being and services. The Integrated Unscheduled Care Dashboard is a positive step towards more proactive use of data – making information available in real time, and promoting a usable format for NHS Wales professionals – and a good base to build on.	Wales principally draws on the clinical guidelines developed by the National Institute for Health and Care Excellence (NICE), with some established collaboration around pharmaceuticals and medical devices.	A number of peer review processes focusing on clinical practice have been started in Wales, notably for cancer, and appear to be effectively identifying weaknesses and in some cases changing practice. The networks leading the Peer Review plan each Peer Review, co-ordinate self-assessment, training and documentation within each Health Board, and then report on the Peer Review visit and process within each Health Board. Wales has set up a National Clinical Audit & Outcome Review Advisory Committee to improve participation and performance in agreed national audits. Wales also has "Mortality Case Note Reviews", which are undertaken for all deaths in hospital in Wales.

Source: OECD Secretariat based of the series of *OECD Reviews of Health Care Quality*.

Table A.4. Improvement programmes in member states that have participated in the *OECD Reviews of Health Care Quality* series

Country	Use of financial incentives to improve quality	Patient safety initiatives
Australia	The Practice Incentives Programme (PIP) consists of incentives for general practice that are tied to quality and patient outcomes. There is no national programme for hospital but some states incorporate safety and quality into pricing of hospital. Queensland authorities for example withhold payments for six "never events". Western Australia also uses a Performance-based Premium Payment Program to promote quality in hospitals. Incentive payments for example were paid directly to clinicians for best practice in the areas of fragility hip fracture treatment, stroke unit care, and acute myocardial infarction treatment.	Australia has been strongly pursuing a patient safety agenda over the past decade or so. Since 2006, there is the Australian Commission on Safety and Quality in Health Care (ACSQHC). The Australian Government then endorsed a National Safety and Quality Framework in 2010 that placed safety as the central organising theme and approved the Australian Health Service Safety and Quality Accreditation Scheme.
Czech Republic	No, there is no financial incentive to drive quality improvement.	No formal national patient safety strategy but departmental safety goals based on the WHO World Alliance for Patient Safety exists in the Czech Republic. Medical malpractice can be addressed by civil and criminal court proceedings and by the Chamber of Physicians. It is mandatory for all practicing physicians to be a member of the Chamber. Patient safety is also implemented through accreditation mechanisms, but patient safety culture and implementation of safety policies vary.
Denmark	No, there is no financial incentive to drive quality improvement.	Denmark has an impressive series of patient safety initiatives, which focus on specific services in hospitals. These are often initiated by the Danish Patient Safety Association. Four important programmes have been set up to secure patient safety: The Danish Adverse Event Study in 2001, The Danish Society for Patient Safety (DSFP), The Danish Safer Hospital Programme, and The National reporting system for adverse events. All necessary functions around patient safety, such as development, standard setting, monitoring and control and support for safety improvements in practice, are in place in Denmark.
Israel	No, Israel's health funds rarely employ significant financial incentives to drive quality improvement.	Patient Safety is not sufficiently prioritised; there is an absence of a National Patient Safety Programme. Formally however, all Israeli hospitals are expected to collect information on infections, and report this to the Ministry of Health. The Ministry is responsible for analysing data to then develop prevention or improvement plans. This information is provided to the public in yearly summary reports without disclosing hospital identity. There is a lack of standard policies against infections and data to monitor whether hospitals are taking proactive efforts to prevent hospital acquired infections.
Italy	No, there is no financial incentive to drive quality improvement at national level. The fee-for-service component in primary care includes financial incentives to encourage PCPs working in group practice. These supply-side incentives pertain to structure indicators such as the use of computer system or the recruitment of support or other medical staff. The FFS element of PCPs payment does not contain quality-related measure. There are however some interesting initiatives at regional levels, such as the Performance Evaluation System in Tuscany.	The National Observatory on Good Practices, co-ordinated by AGENAS, in 2008 was set up with an aim to encourage continuous improvement of quality and safety of care by sharing learning from adverse events in hospitals and clinics, and to promote transfer of good practices. The observatory lead to improvement actions applicable across the country and made publicly available on the Observatory portal. The implementation of these actions, together with the Recommendations for preventing sentinel events issues by the Ministry of Health is monitored by AGENAS. The Ministry of Health also collects data about sentinel events.
Japan	Yes, Japan uses financial incentives but exclusively through the Fee Schedule. However incentives to promote better quality of care in the fee schedule, mostly reward structure and resources rather outcomes. A number of additional payments are for example set to reward accredited hospitals and providers with better	Medical safety is assured by several pieces of legislation – the Medical service act, and the Pharmaceuticals Affairs Act –, and safety monitoring and reporting is required. Based on the Medical Service Act, prefectures, cities with public health centres and special districts of Tokyo are expected to make an effort to establish a Medical Care Safety Support Centre, which handles

	structures and resources (higher number of health professionals and a bigger size of in-patient room). However, additional payments have recently been enhanced in the fee schedule for care complying with clinical guidelines in palliative care and pressure ulcer management, and also to introduce better outcomes of rehabilitation care.	complaints, responds to their queries and gives advice The Medical Care Safety Support Centre needs to provide necessary support to assure medical safety (such as for example providing training on medical safety to health professionals, providing information of medical safety). All hospitals and clinics with beds also have medical safety management committee and incident reports need to be collected and analysed in order to develop measures to assure safety. Several other efforts also exist to prevent adverse events: prefectures provide training to health care providers and JMA has been organising different workshops on patient safety, there is a voluntary reporting and learning system for patient safety.
Korea	Yes, the Value Incentive Programme targets improvements in acute care (acute myocardial infarction and the proportion of caesarean deliveries). The government seeks to further expand the Value Incentive Programme to include (beyond the largest tertiary hospitals), some general hospitals.	Weak attention to patient safety is given in Korea: legislation for malpractice, measurement for adverse events and dedicated policies to improve performance do not exist. Korea does not currently report patient safety indicator data. Many tertiary hospitals in Korea appeared to have internal systems for monitoring patient safety and critical errors, however these were likely to have been the initiative of the hospital and used for internal quality control and improvement. There is no specific monitoring system or legislation to monitor and address medical malpractice in Korea. Medical providers are not required to have liability insurance and the primary recourse for patients is to pursue legal proceedings for damages in instances of malpractice.
Norway	The fee for service elements of GP payment have a few quality-related incentives built in, but they are few and do not systematically reflect national priorities or clinical guidelines. Financial incentives have also been introduced under the Coordination reform. The municipality was required to co-fund hospital care, and there were financial penalties for municipalities if discharge is delayed. These financial incentives aimed at increasing co-operation between primary care and specialised health care services.	Many legislations and initiatives have been implemented to ensure patient safety in Norway. The patient safety agenda started through the adoption of the Patient's Right Act in 1999 and was further developed and governed through the National Unit for Patient Safety. All Norwegian specialised health care providers are obliged to report serious unexpected adverse events with death or serious bodily harm to the Norwegian Board of Health Supervision. A National Reporting and Learning System (NRLS) has been set up at the Norwegian Knowledge Centre for the Health Services to provide advice to hospitals in their process of reporting adverse events. The NRLS also carries out national analyses of adverse events to make warning and recommendations. This system results in the dissemination of regular reports and learning briefs.
Portugal	Yes there are several financial incentives that span all levels of care. In primary care, Family Health Units can receive additional remuneration derived from the individual health professionals' performance, and the unit's results, across a selection of indicators. Quality and performance targets are defined in the hospital contract. Nearly 5% of the total hospital budget is allocated to hospital according to their performance levels. These indicators relate to access, clinical performance and economic performance.	Patient safety is the joint responsibility of the Directorate-General of Health and the regional and local bodies. Patient Safety is one of the seven strategic priorities of the National Strategy for Quality in Health in Portugal, which defines the development of following specific actions: elaboration of guidelines in the field of patient safety, namely in surgical and medication safety; the creation of the national system of notification of incidents and adverse events and the co-ordination of the prevention and control of health care associated infections. The National System of Notification of Incidents (NOTIFIQ@) is a further instrument of continuous improvement for Quality and Patient Safety.
Sweden	Yes there are several financial incentives to drive quality improvement. Sweden has made significant use of financial incentives to steer change (via grants to local governments and dedicated funded to encourage innovative initiative). Starting in 2010, the annual transfers from the central government to municipalities have included performance targets based on outcomes results for elderly care, and quality targets in specific areas such as reductions in unnecessary hospitalisations of old people or use of inappropriate drugs. Financial incentives are also used to secure	There are several initiatives to promote patient safety. SALAR has developed eight care bundles in order to prevent adverse events covering health care associated urinary tract infections; central line infections; surgical site infections; falls and fall injuries; pressure ulcers; malnutrition; medication errors in health care transitions; and drug-related problems. The National Board of Health and Welfare issues various formal statements and standard in order to promote patient safety. National procedures for reporting adverse events and errors are also in place. The Swedish Patient Safety Act stipulates that health care providers must investigate incidents that have caused or could have

	patient safety (for example for measurement of pressure ulcer prevalence, compliance to basic hygiene routines and clothing rules, hospital overcrowding; use of retrospective medical record review to assess the rate of adverse events and a reduction in the prescription of antibiotics to out-patients)	caused a health care injury. Reports about medical malpractice are investigated by the National Board of Health and Welfare. In December 2010, the national government and SALAR reached a "pay for performance" agreement in order to promote patient safety. Each year, a set of criteria and goals are defined that, if meet by a county council/region, triggers release of additional funds from the national government.
Turkey	Turkey has used payment reforms as a key instrument to achieve several of its reform targets. Both in the primary care and in the hospital sector, clear incentives for delivering more services have been built into the remuneration of providers. In hospital care, a strict pay for performance scheme is linked to the accreditation score for public hospitals and for private institutions SSI. The focus was mainly on structure and process criteria, rather than clinical outcomes. In primary care, performance related payment is embedded within the capitation payment.	Although there is no systematic system for adverse event reporting in place in Turkey, several steps have been taken with respect to medical safety. All electronic medicine prescriptions have been logged into a central registry (Prescription Information System) since 2012, which is now compulsory. A pilot study in 32 cities looks at the extent to which PIS data can be used to audit physician prescribing and giving them feedback on their prescribing patterns vis-a-vis peers; it covers five acute and five chronic disease, and the pilot is being evaluated in conjunction with WHO, for example on the volumes of antibiotics prescribed.
England	Widespread use of financial incentives (and sanctions) is a distinctive feature of the English policy landscape. Several financial incentive schemes exist: the *Quality Premium* (worth GBP 270m) is directed to Clinical Commissioning Groups and the *Better Care Fund* (worth GBP 3.8bn) is directed to Clinical Commissioning Groups and Local Authorities; in hospital care, the *Commissioning for Quality and Innovation* (CQUIN) Fund is worth GBP 1.75bn. Contract sanctions may also be applied to secondary care providers, if national standards are breached. In primary care, there is the Quality and Outcomes scheme.	England has comprehensive databases of patient safety incident reports; staff are encouraged to report events which have, or may have caused harm to patients, and patients and carers can also report events. Reports are then sent electronically to the National Reporting and Learning System (NRLS), for further analysis and learning at national level. There are several programmes and initiatives which aim to strengthen patient safety work across the NHS: a network of 15 *Patient Safety Collaboratives*; a *Sign up to Safety Campaign; a Healthcare Safety Investigation Branch*. Several specific programmes of safety work are also underway in the English NHS, including initiatives on pressure ulcers; anti-microbial resistance; mental health; etc.
Northern Ireland	Yes, the DHSSPS provides strategic direction and identifies priorities for service delivery each year through a Commissioning Plan Direction. This is accompanied by an Indicators of Performance Direction, which sets out a range of performance indicators intended to improve Health and Social Care Trust performance. The HSCB then translates these directions into an annual Commissioning Plan, which sets out the system-wide programmes and initiatives and financial allocations and performance requirements of the five regional Health and Social Care Trusts.	The Public Health Authority has primary operational responsibility for patient safety. The PHA created the Health and Social Care Safety Forum in 2007 to support health and social care organisations in providing safe, high quality care. Health and social care bodies (HSCB) have also well-established adverse incident monitoring systems and in conjunction with the Public Health Bureau. The HSCB works to ensure the learnings from trends in incidence data and investigations with a regional application are effectively disseminated and there are Mortality and Morbidity Meetings in each Trusts to consider incidents and complaints. *Changing the Culture* 2010 is Northern Ireland's strategy and action plan for the prevention and control of healthcare-associated infections. The *Leadership Attributes Framework* was announced in November 2014 aims to assist knowledge building and leadership around quality improvement and safety.
Scotland	Primary care, and the UK-wide Quality and Outcomes Framework (QOF), provides the only Scottish example of explicitly linking quality to financial incentives. Savings and reinvestment from quality and efficiency gains do act as an indirect financial incentive to improve quality. Scotland's NHS Boards are required to deliver an annual efficiency saving of 3% of baseline funding, to be reinvested in frontline services. Much of these savings are expected to be found by through improvements in the quality of care.	Scotland launched the world's first national Patient Safety Programme in 2008, with an emphasis on preventing avoidable mortality and harm in acute adult hospitals. The scale and ambition has grown and the scope of the patient safety work in Scotland now extends to primary care, mental health and maternal and child health. The Patient Safety Programme initiatives were designed in recognition of common adverse events, such as sepsis and mental health-related harm. The programme includes performance measurement at both a local and national level. Most results from the safety work are reported locally, and national data are not published in a systematic manner. In addition, all NHS Boards providing services directly to patients have had their processes for managing adverse events reviewed, to help them learn and improve their services.

Wales	Financial incentives to promote quality are also in place for General Practitioners, throughout the Quality and Outcomes Framework. Wales has made some changes to the use of the QOF, notably reducing the scale of points in the clinical domain, and finally removing clinical points in the QOF for 2015/16. The recently introduced (2014-15) Integrated Medium Term Planning approach for Health Boards and NHS Trusts is also underpinned by a new financial duty on Health Boards.	Each Health Board and NHS Trust in Wales has a system of collecting adverse events using an electronic DATIX system. Patient safety incident reports are submitted to the National Reporting and Learning System (NRLS) and the data is used to develop guidance and tools to help improve patient safety at a local level. The Welsh Government has an agreement with NHS England to ensure continued reporting to the NRLS by Welsh Organisations. Guidelines are on a Patient Safety Wales website. An updated list of 25 core Never Events was produced in 2013/14. Wales has a number of strategies in place to monitor and tackle hospital acquired infections (including the *1000 Lives Improvement Programme)* and antimicrobial resistance.

Source: OECD Secretariat based of the series of *OECD Reviews of Health Care Quality*.

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OECD PUBLISHING, 2, rue André-Pascal, 75775 PARIS CEDEX 16
(81 2016 29 1 P) ISBN 978-92-64-26777-0 – 2017

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ISBN 978-92-64-26777-0
81 2016 29 1 P