

Article

Towards actionable international comparisons of health system performance: expert revision of the OECD framework and quality indicators

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Abstract

Objective: To review and update the conceptual framework, indicator content and research priorities of the Organisation for Economic Cooperation and Development's (OECD) Health Care Quality Indicators (HCQI) project, after a decade of collaborative work.

Design: A structured assessment was carried out using a modified Delphi approach, followed by a consensus meeting, to assess the suite of HCQI for international comparisons, agree on revisions to the original framework and set priorities for research and development.

Setting: International group of countries participating to OECD projects.

Participants: Members of the OECD HCQI expert group.

Results: A reference matrix, based on a revised performance framework, was used to map and assess all seventy HCQI routinely calculated by the OECD expert group. A total of 21 indicators were agreed to be excluded, due to the following concerns: (i) relevance, (ii) international comparability, particularly where heterogeneous coding practices might induce bias, (iii) feasibility, when the number of countries able to report was limited and the added value did not justify sustained effort and (iv) actionability, for indicators that were unlikely to improve on the basis of targeted policy interventions.

Conclusions: The revised OECD framework for HCQI represents a new milestone of a long-standing international collaboration among a group of countries committed to building common ground for performance measurement. The expert group believes that the continuation of this work is paramount to provide decision makers with a validated toolbox to directly act on quality improvement strategies.

Key words: conceptual framework, health policy, health systems research, OECD Health Care Quality Indicators project, performance measurement, quality indicators

Introduction

Health care quality is a core dimension of health system performance within which reliable standardized indicators have become increasingly available [1, 2]. Originally developed with the aim of improving patient outcomes in specific health care settings, health care quality indicators now yield comparative information to be used for monitoring, management and policy making within and across health care systems [3–6].

Under the umbrella of the Organisation for Economic Cooperation and Development (OECD), the ‘Health Care Quality Indicators’ (HCQI) Project was initiated in 2001, with the aim of developing and reporting common indicators for international comparisons of health care quality [7]. The general objective was to help Member States (MS) identify priority areas for quality improvement and to provide an indication of achievable standards by examining results among best performing countries.

In 2006, the OECD released a common conceptual framework for health system performance, within which the core quality dimension was envisaged as a nested matrix, including an initial list of candidate indicators under the vertical dimensions of ‘effectiveness’, ‘patient safety’ and ‘responsiveness/patient-centeredness’ [8].

Consistent with the conceptual framework released by the US Institute of Medicine [9], such dimensions were horizontally subdivided according to levels of health care needs over the life cycle: ‘staying healthy’ for healthy subjects, ‘getting better’ for people affected by a disease, ‘living with illness or disability’ for those living with a chronic condition and ‘coping with end of life’ for terminal patients. Since then, the quality matrix had been used to define the scope of the HCQI project without further revision.

Over the past decade, an ongoing activity of data collection and statistical analysis has been carried out, progressively expanding the coverage of the matrix and the number of countries involved. Coordination and management of the process has been ensured by a continuous dialogue between a central OECD secretariat and a representative group of HCQI experts from OECD and non-OECD countries, international organizations including the World Health Organization and the European Commission and other relevant collaborating institutions, including universities, subject matter experts and research organizations.

Since 2007, results of the HCQI project have routinely contributed to international comparisons through the publication of the OECD series ‘Health at a Glance’ [10] and the release of OECD Health Statistics alongside other international health data on expenditure, resources, utilization and outcomes.

In 2013, the OECD HCQI data collection process included a total of 70 indicators covering the following ‘themes’: Primary Care (PC); Acute Care (AC); Mental Health (MH); Cancer Care (CC); Patient Safety (PS) and Patient Experiences (PEs). The collection reports data from 34 countries, including non-OECD member countries such as Singapore and Latvia [11].

Alongside the regular data collection, there has been a concerted research and development (R&D) effort to continuously improve the definitions and availability of quality indicators for the international comparability of results achieved by health care systems. New indicators have been pilot tested and data specifications included in a reference guide used to instruct the global data collection [12]. A common goal for the HCQI program of work was also strengthening the national information infrastructure to produce more complex and reliable indicators in an increasing number of countries [13, 14].

During recent years, the production of performance reports using standardized HCQI definitions has continued to increase at the

international, national and subnational level [15–19]. Despite these successes, following the completion of the 2013 OECD data collection, it was evident that the data collection methodology was becoming more complex and demanding on countries and that the growing numbers of indicators and participating countries was placing additional burden on the coordination and management of the project. Moreover, HCQI experts generally agreed that more attention to the choice of indicators and R&D studies was needed, including prioritizing indicators that have proven to be reasonably ‘actionable’ by decision makers to improve quality of care and health outcomes.

The present paper summarizes the results obtained to respond to the following questions:

- Is the OECD conceptual framework for the HCQI still relevant?
- How to allocate each indicator to a unique position in its structure?
- What are the essential criteria to adopt future HCQI?
- Using defined assessment criteria, which indicators should be retained or dropped from the set of indicators, and how often should they be measured?
- Which research and development activities are needed to improve the international comparability of HCQI?

This paper reports the results of the framework review and the critical appraisal of the indicators undertaken to respond to the questions above, as well as the structure and content of the revised OECD framework agreed by the Expert Group, and the set of research and development (R&D) activities endorsed by the Health Committee of the OECD.

Methods

The study design was based on a modified Delphi procedure, which included a review of the evidence on quality indicators conducted by a panel of five experts, two rounds of ratings according to predefined criteria and a final consensus meeting. The study was conducted between May and November 2013.

Initially, all HCQI were allocated to the original OECD conceptual framework, according to the themes that historically guided indicator development within the project (e.g. MH, CC and PC).

A Delphi data collection sheet was developed, comprising a set of standardized worksheets, one for each theme, through which a small panel of five experts independently scored each indicator according to six criteria (Table 1). Scores were expressed on a Likert scale of agreement, ranging from 1 to 9 (strongly disagree to strongly agree). Additional columns requested expert opinion on: (i) whether to keep and report regularly, keep and report less frequently, or drop the indicator from future OECD HCQI data collections; (ii) degree of priority for R&D to improve international comparability of the indicators (five-point scale, very low to very high) and (iii) optional comments. Indicators routinely reported as part of the HCQI project but not included in the data collection (e.g. childhood and influenza vaccination rates) were excluded from the questionnaire.

Although relevance was used as a gating criterion for the inclusion/exclusion of indicators, ratings were requested for all criteria to underpin the calculation of averages and the discussion/modification of initial scores.

Ratings were revised in person at a one-day meeting, organized to (i) undertake a critical review of the full set of indicators currently available at the HCQI, (ii) identify an agenda for future R&D work and (iii) develop a set of recommendations for the broader expert group.

Table 1 Criteria used to score HCQI

Criterion	Definition
Validity	Sufficient scientific evidence exists to support a link between the value of an indicator and one or more aspects of health care quality
Reliability	Repeated measurements of a stable phenomenon get similar results
Relevance	An indicator measures an aspect of quality with high clinical importance, a high burden of disease or high health care use
Actionability	An indicator measures an aspect of quality that is subject to control by providers and/or the health care system and is actually used at a national level for policy making, monitoring or strategy development
International feasibility	An indicator can be derived for international comparisons without substantial additional resources
International comparability	Reporting countries comply with the relevant data definition and where differences in the indicator values between countries reflect issues in quality of care rather than differences in data collection methodologies, coding or other non-quality of care reasons

These recommendations were discussed at a final consensus meeting, where the broader HCQI expert group agreed on: (i) indicators that should be kept or omitted from future HCQI data collections and (ii) priorities for a future R&D agenda on indicators of quality of care.

Results

The HCQI Expert Group agreed that the 4 × 3 quality matrix represented the appropriate scope for the project.

The revised structure of the broad OECD conceptual framework within which the HCQI is included is presented in Fig. 1.

Minor changes to the original structure were agreed upon:

- change the wording of ‘staying healthy’ to ‘primary/secondary prevention’ to provide a clearer distinction with ‘living with illness and disability—chronic care’
- include the categories of ‘individual patient experiences’ and ‘integrated care’ under the theme of ‘responsiveness’, to pave the ground for future indicator development

Scores agreed by the panel are shown in Table 2. On average, the Delphi panel scored relevance, actionability and validity higher than reliability, international feasibility and comparability, recommending omission for 25 indicators. The panel suggested dropping six indicators from each of the groups of PS and PEs, while recommending to retain all three CC indicators.

For indicators recommended for retention, the average scores ranged between 5.4 (PEs) and 7.4 (CC). For ‘omit’ indicators, average scores ranged between 5.3 (PEs) and 6.7 (PS).

In terms of relevance, scores were generally very high, with the notable exception of indicators in the area of PEs, e.g. ‘difficulty to travel’ (considered too generic as a question to patients), and five more indicators related to waiting times and cost (perceived to be more relevant for ‘access’).

Lower relevance and validity scores were allocated to indicators that were more likely to capture differences among local clinical practices and way of organizing health care services, rather than aspects of quality of care. On this basis, MH readmissions indicators were dropped considering the varying roles of hospitals in disease management across countries.

Both relevance and reliability led to omitting paediatric PS indicators, considered to be more likely reflecting quality issues for overall PS rather than the specific target population.

Similarly, low reliability and feasibility scores were attributed to indicators where regularly collected data were limited (e.g. retinal examination in diabetes for which only five countries provided data in 2013) or where not all required data elements were consistently available (e.g. hip fracture surgery within 48 h, where there is cross-country variation in recording the exact time of surgery). Exclusion was also recommended when the uniform application of standardized definitions was considered difficult, e.g. accidental puncture and postoperative haemorrhage or haematoma, or could easily lead to a very small numbers of adverse events, e.g. paediatric safety indicators.

Further R&D was recommended for indicators considered borderline under the same criteria: (i) exploring the reasons of large variation in surgery within 48 h after hip fracture, (ii) use of different definitions or proxies of in-patient suicide in MH, (iii) impact of data capturing systems on excess mortality in MH and (iv) heterogeneous approaches to CC measurement.

In terms of actionability, lower average scores were assigned to hypertension hospital admission in PC, in-hospital mortality in AC, all indicators excluded from PS (except for retained surgical item) and waiting time on day of consultation, consultation skipped due to difficulties in travelling in PEs. In these cases, the panel agreed that it was difficult for policy makers to identify immediate solutions that would counteract underperforming results.

International feasibility oriented choices towards a sustainable data collection. Three case-fatality indicators for events occurring ‘in any hospital’ were dropped, as they were regarded as adding little value to the other six mortality indicators already present in the framework. All in-hospital indicators for the ‘same hospital’ were recommended for retention, due to their large degree of availability.

In terms of international comparability, a major concern was expressed for different coding practices, particularly for diagnoses and medical procedures. Hospital admissions for hypertension were dropped for the likely under-reporting of conditions recorded as principal diagnosis. Similar concerns were expressed for cross-country variation in the recording of secondary diagnoses, which can impact on the accuracy of indicators in given performance domains, e.g. PS. Moreover, the panel suggested to pool indicators on diabetes admissions with and without complications and to carefully revise the definition of lower amputations, recognizing cross-country differences in coding and data capture for these indicators.

Improved comparability was at the basis of many recommendations for R&D.

In relation to coding, the panel recommended investigating the following: role of primary and secondary diagnosis, different definitions of admissions/discharges, use of transfers and criteria to map indicators across ICD9–10. Other activities suggested include defining composite measures for PC indicators, assessing indicators of pharmaceutical prescriptions, reporting of secondary diagnoses in PS indicators, statistical methods and national representativeness of CC indicators and sampling methods and validated definitions of ‘doctor’ and ‘regular doctor’ in PE surveys.

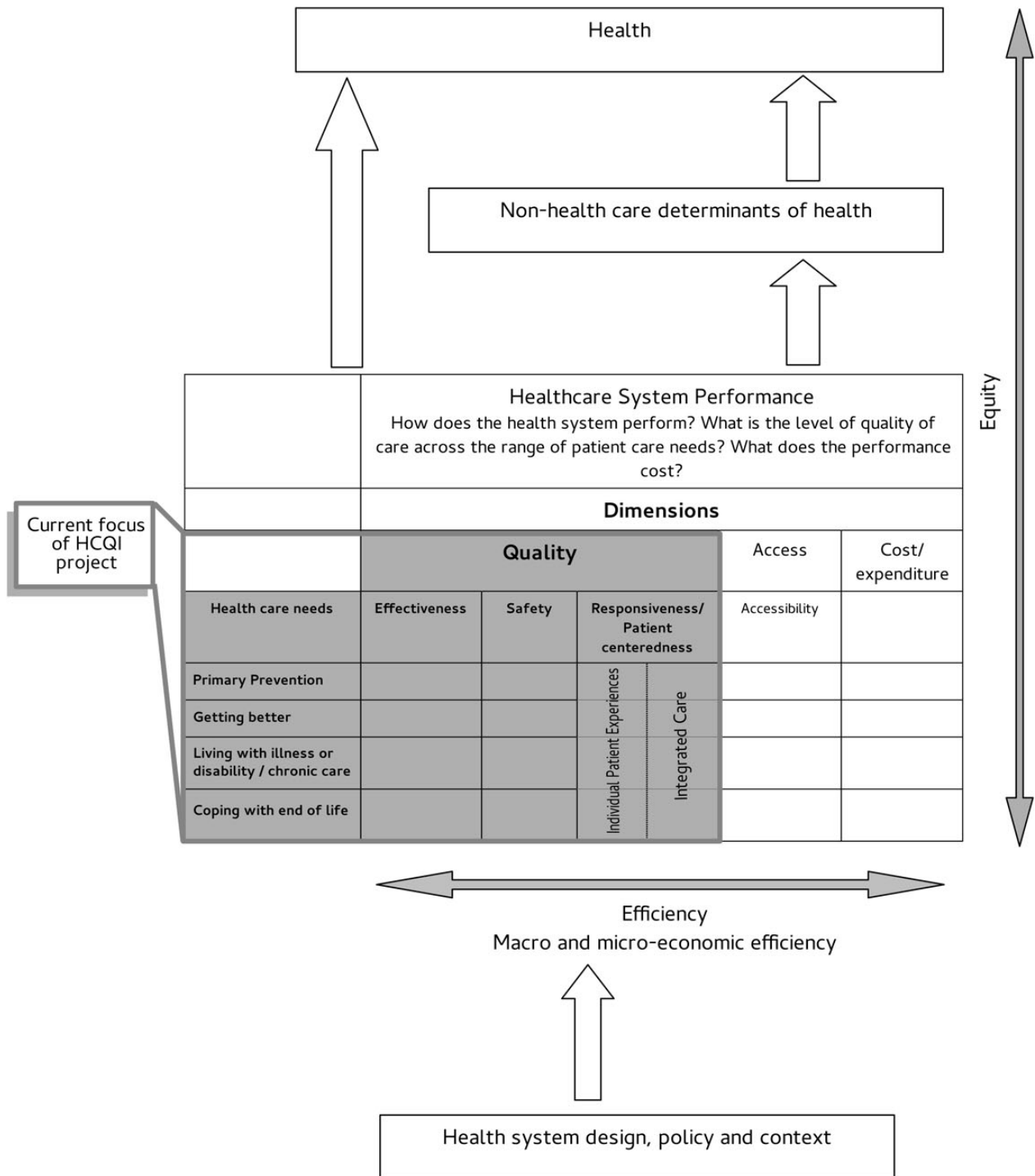


Figure 1 Revised OECD framework for performance measurement.

Final average scores for all indicators and all criteria included in the questionnaire are reported along with the number of experts supporting retention and prioritization of R&D in Table A1 in Appendix.

The final consensus meeting adopted all recommendations made by the Delphi panel, with the only exception of four indicators of PEs previously moved to ‘access’, which were reintegrated into the quality dimension (waiting time on the day of appointment, consultation skipped due to costs, medical tests, treatment or follow-up

skipped due to costs and prescribed medicines skipped due to costs). Six additional prescription safety indicators obtained from a previous study were also added [20].

The final allocation of each indicator to a unique position in the 4 × 3 quality matrix is shown in Table 3, including (i) indicators retained for the 2015 data collection (in plain bold), (ii) indicators included in the framework, but not part of the routine biennial data collection (in italic) and (iii) dropped indicators (in plain text). The

Table 2 Average scores assigned by the Delphi panel for each criterion used to review indicators included in the HCQI 2013 data collection, by theme and recommendation for future data collection

Criterion	PC		AC		MH		CC		PS		PEs		Overall
	Keep (N = 13)	Drop (N = 2)	Keep (N = 7)	Drop (N = 3)	Keep (N = 6)	Drop (N = 8)	Keep (N = 3)	Drop (N = 0)	Keep (N = 8)	Drop (N = 6)	Keep (N = 8)	Drop (N = 6)	
Relevant	6.9	6.7	7.5	7.0	7.3	6.7	8.2		7.6	7.7	6.6	4.4	7.1
Valid	6.8	6.4	6.8	6.3	6.5	5.9	8.0		7.3	6.8	5.4	5.7	6.5
Reliable	6.7	5.3	7.2	7.1	5.2	6.6	7.4		6.3	5.2	5.0	5.1	6.1
Actionable	6.7	6.4	7.2	7.2	5.9	6.0	7.4		7.9	7.5	5.8	5.9	6.6
Internationally feasible	6.2	5.5	6.5	6.2	4.8	6.3	7.0		7.0	6.7	4.8	5.2	6.0
Internationally comparable	6.0	4.8	6.2	5.6	5.5	5.6	6.4		6.2	6.1	5.0	5.1	5.7
Overall	6.6	5.8	6.9	6.6	5.9	6.2	7.4		7.0	6.7	5.4	5.3	6.3

Keep = keep and publish regularly, keep and publish less regularly; drop = omit from future OECD HCQI data collection; N = number of indicators falling in each subcategory.

content of the matrix presents a triangular pattern with an empty row at the bottom. Among vertical dimensions, the one most covered is 'effectiveness', followed by 'safety' and 'responsiveness'. The horizontal dimension of 'coping with end of life' is still empty for international comparisons.

The classification allowed for different themes to fit into the same cell in the matrix (e.g. 'living with illness'). However, experts noted that for several indicators more than one domain could be considered along one or both axes depending on the context. For example: prescribing indicators for antibiotics may fall under 'effectiveness' (i.e. high rates reflect prescription beyond indication or inappropriate/ineffective use) or 'safety' (i.e. high rates may affect future resistance); hypertension may fall under 'primary or secondary prevention' or 'living with illness' depending on whether it is viewed as a modifiable risk factor for future disease development or as a disease; obstetric trauma as a safety indicator may equally fit under the health care needs category of preventive intervention or under 'getting better'; PEs may provide responses on visits done by healthy subjects or people with chronic diseases.

In the final mapping, allocations were based on expert agreements on the most prevalent contextual interpretation for each indicator. However, experts advised that the multi-dimensional nature of many HCQI shall be given adequate consideration in the interpretation of the results.

Discussion

This critical appraisal produced international consensus on the revised structure and content of the OECD framework for HCQI.

Overall, agreement was reached on omitting 21 and retaining 49 indicators of those included in the 2013 data collection. The amalgamation of diabetes indicators and the further addition of prescription safety indicators lead to a total of 53 indicators, plus additional 9 indicators collected by other means, for a total of 62 indicators foreseen for data collection and publication in 2015.

The appraisal offered a unique opportunity to bridge past achievements with the resolution of current challenges in the international comparison of health systems.

The results achieved can be seen as a concerted response to resolving the challenges in the international comparisons of health systems, building upon principles described elsewhere as sets of 'must do's' and 'trade-offs' [4].

For 'must do's', the appraisal provided a way forward to reinforce the 'legitimacy', 'validity', 'feasibility' and 'technical support' in the production of international comparisons of quality of care for OECD countries.

The process adopted for the choice of indicators reinforced 'legitimacy' through shared coordination, producing recommendations as a result of an open dialogue among peers, including a total of 57 international experts representing the countries participating in the project. The agreed R&D plan was jointly developed and tasks assigned on the basis of voluntary contribution of MS.

Notably, the Delphi panel relied on higher scores for established criteria, e.g. relevance and validity for the initial choice of items retained in the revised framework. This is not surprising, because indicators that are part of the OECD data collection have stood up to scientific testing at the national level. The choice of including indicators that are still difficult to collect, e.g. 30-day in and out of hospital mortality in AC or death after discharge and excess mortality in MH, while excluding MH readmissions that scored even better overall and were reported by many countries, reflects the level of priority assigned by HCQI experts to such fundamental criteria.

However, the fact that actionability stood as the second highest criterion met by all quality indicators shows that other practical criteria are equally important to identify a core suite that fits the needs of policy makers. This criterion clearly oriented the choices for retention in the areas of AC and PS.

The criteria of reliability, international comparability and feasibility oriented further discussions on the omission of indicators and R&D based on the practical experience of the HCQI data collection.

In PC, issues of reliability were at the basis of the omission of hospital admission for hypertension and retinal exam for people with diabetes. A total of six PS indicators were recommended for omission, due to either an extremely low volume of cases (paediatric) or difficult applicability of the definitions and/or inconsistent coding across countries (accidental puncture, postoperative haemorrhage or haematoma).

Improving the reliability, feasibility and comparability of indicators is at the core of the cross-cutting R&D agenda agreed by the Expert Group.

One aspect that was recognized to be overtly important was systematic variation in coding practices. For example, payment systems that provide a higher payment for more complicated cases may create an incentive for hospital administrators to ensure that secondary

Table 3 Results of the mapping of OECD HCQI to the revised conceptual framework^a

	EFFECTIVENESS	SAFETY	RESPONSIVENESS / PATIENT CENTEREDNESS	
PRIMARY/SECONDARY PREVENTION	CD Vaccination against diphtheria, tetanus and pertussis, children aged 1 Vaccination against measles, children aged 1 Vaccination against hepatitis B, children aged 1 Influenza vaccination coverage, population aged 65 and over	PS Obstetric trauma vaginal delivery with instrument Obstetric trauma vaginal delivery without instrument	PE Regular doctor spending enough time with patients during the consultation Other doctor spending enough time with patients during the consultation Other doctor providing easy-to-understand explanations Regular doctor providing easy-to-understand explanations Regular doctor giving opportunity to ask questions or raise concerns Other doctor giving opportunity to ask questions or raise concerns Regular doctor involving patients in decisions about care or treatment Other doctor involving patients in decisions about care or treatment Waiting time of more than 4 weeks for getting appointment with a specialist Medical tests, treatment or follow-up skipped due to costs Consultation skipped due to costs Prescribed medicines skipped due to costs Consultation skipped due to difficulties in travelling Waiting time of more than 1 hour on the day of consultation with a doctor	
	PC Hypertension hospital admission Annual retinal exam for diabetics			
	CC Mammography screening in women aged 50-69 Cervical cancer screening in women aged 20-69			
GETTING BETTER	AC Admission-based AMI 30 day in-hospital (same hospital) mortality Patient-based AMI 30 day (in-hospital and out of hospital) mortality Patient-based ischemic stroke 30 day (in-hospital and out of hospital) mortality Admission-based ischemic stroke 30 day in-hospital (same hospital) mortality Admission-based hemorrhagic stroke 30 day in-hospital (same hospital) mortality Patient-based hemorrhagic stroke 30 day (in-hospital and out of hospital) mortality Hip-fracture surgery initiated within 48 hours after admission to the hospital Patient-based AMI 30 day in-hospital (any hospital) mortality Patient-based ischemic stroke 30 day in-hospital (any hospital) mortality Patient-based hemorrhagic stroke 30 day in-hospital (any hospital) mortality	PS Retained surgical item or unretrieved device fragment (15+ yrs) Postoperative PE or DVT (all surgical discharges) Postoperative PE or DVT (hip and knee discharges) Postoperative sepsis (all surgical discharges) Postoperative sepsis (all abdominal discharges) Postoperative wound dehiscence (15+ yrs) Retained surgical item or unretrieved device fragment (0-14 yrs) Accidental puncture or laceration (0-14 yrs) Accidental puncture or laceration (15+ yrs) Postoperative haemorrhage or haematoma (0-14 yrs) Postoperative wound dehiscence (0-14 yrs) Postoperative haemorrhage or haematoma (15+ yrs)		
	CC Breast cancer five year relative survival Cervical cancer five year relative survival Colorectal cancer five year relative survival Breast cancer mortality in women Cervical cancer mortality Colorectal cancer mortality			
	PC Overall volume of antibiotics for systemic use prescribed Volume of cephalosporins/quinolones as proportion of all systemic antibiotics prescribed			PC Long-term use of benzodiazepines/benzodiazepine-related drugs in elderly patients Use of long-acting benzodiazepines in elderly patients Pilot of prescription safety indicators (6 indicators)
LIVING WITH ILLNESS OR DISABILITY / CHRONIC CARE	PC Asthma hospital admission Chronic Obstructive Pulmonary Disease (COPD) hospital admission Diabetes hospital admission (uncomplicated, short and long-term complications) Diabetes lower extremity amputation Congestive Heart Failure (CHF) hospital admission Adequate use of cholesterol lowering treatment in diabetic patients First choice antihypertensives for diabetes patients			
	MH Excess mortality for patients with schizophrenia Excess mortality for patients with bipolar disorder Deaths after discharge from suicide among people diagnosed with a mental disorder Deaths after discharge from suicide among people diagnosed with schizophrenia/bipolar disorder In-patient suicides among people diagnosed with a mental disorder In-patient suicides among people diagnosed with schizophrenia or bipolar disorder Hospital (same) re-admissions within 30 days for patients discharged with schizophrenia Hospital (same) re-admissions within 30 days among patients discharged with schizophrenia Hospital (any) re-admissions within 30 days for patients discharged with schizophrenia Hospital (any) re-admissions within 30 days among patients discharged with schizophrenia Hospital (same) re-admissions within 30 days for patients discharged with bipolar disorder Hospital (same) re-admissions within 30 days among patients discharged with bipolar disorder Hospital (any) re-admissions within 30 days for patients discharged with bipolar disorder Hospital (any) re-admissions within 30 days among patients discharged with bipolar disorder			
COPING WITH END OF LIFE				

^a Text in **Plain Bold**: Indicators finally retained for data collection 2015; Text in **Italic Bold**: Indicators finally retained outside data collection 2015; Plain Text: Indicators omitted from future data collection
Abbreviations: CD=Communicable Diseases, AC=Acute Care, PC=Primary Care, MH=Mental Health, PS=Patient Safety, PE= Patient Experiences

diagnoses are widely captured, or countries consistently reporting a higher number of secondary diagnoses are likely to capture more admissions for specific indicators, particularly in PS [21]. A related case is coding at different phases of episodes of care, particularly in hospitalizations. In the HCQI guidelines, the terms ‘discharge’, ‘admission’ and ‘separation’ have been considered interchangeable to allow wider adherence to the data collection, based on local practices. However, it is possible that results for countries using diagnostic codes at one stage may vary considerably from those recording at other stages.

To explore the effect of these issues on several indicators, the broad group agreed to launch a series of targeted studies, using common protocols across volunteering countries.

The provision of adequate ‘technical support’ for data correspondents is a direct consequence of increased attention to methodological aspects. With increasing complexity, and the prospective challenge of covering all dimensions of the performance framework, it is important that the data collection process proceeds as efficiently as possible. Targeted IT tools can be used to harmonize the application of standard guidelines and to reduce the chance of uneven compliance, e.g. a central repository of electronic meta-data instead of paper guidelines, the sharing of open-source statistical software for the direct calculation of HCQI and common policies for data exchange are recommended.

In terms of trade-offs, this study highlighted the importance of balancing ‘depth and breadth’, ‘aggregation and granularity’ and ‘flexibility and consistency’ when reporting on HCQI. Among these trade-offs, a discussion on the dichotomy between ‘depth’ and ‘breadth’ (i.e. more measures for a specific clinical area vs. measures for a greater variety of clinical areas) was central to reviewing the mapping of indicators to the conceptual framework and led to the identification of areas in need of further indicator development and reporting, e.g. ‘getting better’ for responsiveness, ‘living with illness’ in safety and responsiveness, long-term care and end of life across all dimensions. These aspects have been duly marked for targeted action.

The decision to pursue indicators related to ‘in and out of hospital’ mortality in AC and excess mortality in MH reflects MS interest in improving the availability of clinical outcomes. Trends in the HCQI data collection show that data collection for these indicators is becoming increasingly feasible among MS, indicating that the health information infrastructure is improving. For example, between 2007 and 2013, the number of countries able to report the 30-day mortality rate in and out of hospital for the last year available, requiring linking hospital admissions and death records, increased from 12 to 16 [11, 12].

Increased ‘depth’ has also been requested for comparisons of PEs, such as exploring how organizational aspects improve clinical pathways through integrated and continuous care. While these tasks may draw upon innovative performance measurement approaches, e.g. the work in the UK on Patient Reported Outcome Measures (PROMs), it will need targeted attention on articulated concepts, e.g. integrated and coordinated care across health, social, long-term and home care, taking relevant experiences into account [22].

The broad group also agreed to extend the applicability of HCQI at provider level in 2015, particularly at hospital level.

The issue of ‘aggregation vs. granularity’ particularly applies to the decision to pilot test composite measures for hospital admissions, such as a composite indicator for asthma, COPD, CHF and diabetes hospital admissions.

The trade-off between ‘consistency’ and ‘flexibility’ has been tackled by an ambitious R&D agenda, including targeted work on improved definitions to ensure comparability at all levels. In some cases,

it would require identifying flexible solutions that can be applied under different conditions. A specific case of consistency failure is deep vein thrombosis in specific surgeries, where attempting to specify a precise set has in fact led to greater difficulty in achieving international comparability, rather than less as intended.

An increased attention for the principle of ‘actionability’ has been called upon to orient future activities, based on experts’ recommendations to further uptake HCQI outputs in health systems performance assessment. To this end, the broad group agreed to support an initial survey on experiences on using HCQI (producers, methods and reporting schemes) at both national and subnational level, to monitor the actual usage of the framework and indicators over time.

Finally, intrinsic limitations of the present appraisal are worth outlining.

The conclusions are based on a Delphi panel of limited size, moderated by the same secretariat coordinating the HCQI project, whose final recommendations were produced by a broad group, including experts and representatives of national governments.

A different multidisciplinary setting, composed of a larger pool of experts completely independent from governmental institutions, may likely lead to different results. However, the completely open, transparent and well-structured process put in place by the OECD with the direct participation of MS assures that these results can represent the best possible combination for governments wishing to commit to international comparisons of quality of care.

In conclusion, this appraisal delivered a revised OECD framework for HCQI, a revised set of indicators and a plan for further improvement. A number of countries have already indicated a willingness to work together on moving forward the rich international R&D agenda outlined in this paper. The results of this work will be reflected in future strategies aimed at improving the international comparability of quality indicators in years to come. Such continuous improvements in the data will hopefully lead to more rigorous debates about how policy makers can plan effective action to improve health system performance for the direct benefit of all citizens.

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Appendix

Table A1

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Table A1 Results of the Delphi Panel for all HCQI included in the 2013 data collection: average scores for all criteria included in the questionnaire and number of responses for retention and prioritization of R&D

Area	Description	Valid	Reliable	Relevant	Actionable	Internationally feasible	Internationally comparable	Recommend to keep ^a	Medium/high R&D priority ^a
PC	Asthma hospital admission	7.4	7.2	7.6	7.4	7.6	7.2	5	3
PC	COPD hospital admission	7.4	7.4	7.6	7.2	7.6	7.0	5	2
PC	CHF hospital admission	6.8	7.6	7.2	7.0	7.6	7.0	4	1
PC	Hypertension hospital admission	6.2	5.6	5.8	5.6	7.0	5.0	3	4
PC	Uncontrolled diabetes without complications hospital admission	7.4	5.8	6.6	6.4	7.0	5.8	5	4
PC	Diabetes short-term complications hospital admission	7.4	7.2	7.6	7.4	7.4	7.0	5	3
PC	Diabetes long-term complications hospital admission	7.4	7.0	7.6	7.2	7.4	6.6	5	3
PC	Diabetes lower extremity amputation	7.6	7.0	7.6	6.2	7.2	6.2	5	4
PC	Annual retinal exam for diabetics	6.6	5.0	7.6	7.2	4.0	4.6	3	4
PC	Adequate use of cholesterol lowering treatment in diabetic patients (DDDs)	5.4	5.4	5.2	5.4	4.4	4.4	2	3
PC	First choice antihypertensives for diabetes patients (DDDs)	5.4	5.4	5.4	5.4	4.4	4.4	3	3
PC	Long-term use of benzodiazepines and benzodiazepine-related drugs in the elderly	7.0	6.8	7.2	7.0	5.0	5.4	4	4
PC	Use of long-acting benzodiazepines in elderly patients	7.0	6.8	7.2	7.0	5.0	5.4	4	4
PC	Overall volume of antibiotics for systemic use prescribed (DDDs)	6.4	6.8	6.6	6.8	5.2	5.6	4	4
PC	Volume of cephalosporines/quinolones as a proportion of all systemic antibiotics prescribed (DDD)	6.4	6.8	6.8	6.8	5.2	5.4	3	3
AC	Patient-based AMI 30-day (in-hospital and out of hospital) mortality	8.2	7.8	8.2	7.6	5.8	6.2	5	3
AC	Patient-based AMI 30-day in-hospital (any hospital) mortality	6.4	7.2	7.0	7.2	6.2	5.6	2	4
AC	Admission-based AMI 30-day in-hospital mortality (same hospital)	5.8	6.8	6.8	6.8	7.0	6.0	4	2
AC	Patient-based haemorrhagic stroke 30-day (in-hospital and out of hospital) mortality	8.0	7.8	8.2	7.6	5.8	6.2	5	3
AC	Patient-based haemorrhagic stroke 30-day in-hospital (any hospital) mortality	6.2	7.0	7.0	7.2	6.2	5.6	2	4
AC	Admission-based haemorrhagic stroke 30-day in-hospital mortality (same hospital)	5.6	6.6	6.8	6.8	7.0	6.0	4	2
AC	Patient-based ischaemic stroke 30-day (in-hospital and out of hospital) mortality	8.0	7.6	8.2	7.6	5.8	6.4	5	3
AC	Patient-based ischaemic stroke 30-day in-hospital (any hospital) mortality	6.2	7.0	7.0	7.2	6.2	5.6	2	4
AC	Admission-based ischaemic stroke 30-day in-hospital mortality (same hospital)	5.6	6.6	6.8	6.8	7.0	6.0	4	2
AC	Hip-fracture surgery initiated within 48 h after admission to the hospital	6.6	7.4	7.2	7.4	7.0	6.8	4	3
MH	Any hospital readmissions within 30 days for patients discharged with schizophrenia	6.0	6.8	6.8	5.4	6.2	5.6	2	1
MH	Same hospital readmissions within 30 days for patients discharged with schizophrenia	5.4	6.8	6.4	5.4	6.2	5.4	2	1
MH	Any hospital readmission within 30 days among patients discharged with schizophrenia	6.4	6.6	7.0	6.6	6.4	5.8	4	3
MH	Same hospital readmission within 30 days among patients discharged with schizophrenia	5.8	6.6	6.6	6.6	6.4	5.6	4	3
MH	Any hospital readmissions within 30 days for patients discharged with bipolar disorder	6.0	6.6	6.8	5.4	6.2	5.6	2	1
MH	Same hospital readmissions within 30 days for patients discharged with bipolar disorder	5.4	6.6	6.4	5.4	6.2	5.4	2	1
MH	Any hospital readmission within 30 days among patients discharged with bipolar disorder	6.4	6.4	7.0	6.6	6.4	5.8	4	3
MH	Same hospital readmission within 30 days among patients discharged with bipolar disorder	5.8	6.4	6.6	6.6	6.4	5.6	4	3
MH	In-patient suicides among people diagnosed with a mental disorder	6.0	4.4	7.0	6.4	4.8	5.2	4	3
MH	In-patient suicides among people diagnosed with schizophrenia or bipolar disorder	6.0	4.4	7.0	6.4	4.8	5.2	4	3
MH	Deaths after discharge from suicide among people diagnosed with a mental disorder	6.4	5.0	7.0	5.2	4.4	5.2	5	4
MH	Deaths after discharge from suicide among people diagnosed with schizophrenia or bipolar disorder	6.4	5.0	7.0	5.2	4.4	5.2	5	5
MH	Excess mortality for patients with schizophrenia	7.2	6.2	7.8	6.0	5.2	6.2	5	4
MH	Excess mortality for patients with bipolar disorder	7.2	6.2	7.8	6.0	5.2	6.2	5	4
CC	Breast cancer 5-year relative survival	8.0	7.4	8.2	7.4	7.0	6.4	5	3
CC	Cervical cancer 5-year relative survival	8.0	7.4	8.2	7.4	7.0	6.4	5	3
CC	Colorectal cancer 5-year relative survival	8.0	7.4	8.2	7.4	7.0	6.4	5	3
PS	Retained surgical item or unretrieved device fragment (paediatric)	7.6	4.6	8.0	8.2	7.4	6.2	4	4
PS	Retained surgical item or unretrieved device fragment (adult)	7.6	5.2	8.2	8.2	7.8	6.4	5	4
PS	Accidental puncture or laceration (paediatric)	6.6	5.0	7.6	7.2	7.2	6.6	4	4
PS	Accidental puncture or laceration (adult)	6.6	6.4	7.8	7.2	7.6	6.6	4	5
PS	Postoperative haemorrhage or haematoma (paediatric)	6.4	4.6	7.5	7.5	6.0	5.6	3	4
PS	Postoperative haemorrhage or haematoma (adult)	6.4	5.4	7.6	7.6	6.2	5.6	3	4

Table continues

Table A1 Continued

Area	Description	Valid	Reliable	Relevant	Actionable	Internationally feasible	Internationally comparable	Recommend to keep ^a	Medium/high R&D priority ^a
PS	Postoperative wound dehiscence (paediatric)	7.4	5.4	7.4	7.4	6.0	6.2	3	3
PS	Postoperative wound dehiscence (adult)	7.4	6.4	7.6	7.4	6.2	6.2	3	4
PS	Postoperative PE or DVT—all surgical discharges	6.4	5.8	6.8	7.4	6.8	6.4	5	4
PS	Postoperative PE or DVT—hip and knee replacement discharges	7.4	5.6	8.0	8.2	6.6	5.8	4	5
PS	Postoperative sepsis—all surgical discharges	7.0	7.0	6.6	8.2	7.2	7.0	5	3
PS	Postoperative sepsis—abdominal discharges	7.4	7.0	7.4	8.2	6.8	6.4	4	4
PS	Obstetric trauma vaginal delivery with instrument	7.2	6.4	8.0	7.6	7.4	5.6	5	5
PS	Obstetric trauma vaginal delivery without instrument	7.8	6.8	8.0	7.6	7.4	5.6	5	5
PE	Waiting time of >4 weeks for getting appointment with a specialist	5.8	5.0	6.0	6.0	4.8	4.8	3	3
PE	Waiting time of >1 h on the day of consultation with a doctor	5.2	4.8	5.2	5.2	4.8	5.0	3	4
PE	Consultation skipped due to difficulties in travelling	5.0	4.8	5.8	5.2	4.8	5.0	4	4
PE	Consultation skipped due to costs	5.4	4.8	6.6	5.8	4.8	5.0	4	4
PE	Medical tests, treatment or follow-up skipped due to costs	5.4	4.8	6.6	5.8	4.8	5.0	3	3
PE	Prescribed medicines skipped due to costs	5.4	4.8	6.6	5.4	4.8	5.0	4	4
PE	Doctor spending enough time with patients during the consultation	5.2	5.0	6.0	6.0	4.8	5.0	4	4
PE	Regular doctor spending enough time with patients during the consultation	5.2	5.0	6.0	5.8	4.8	5.0	3	3
PE	Doctor providing easy-to-understand explanations	5.6	5.0	7.0	5.8	4.8	5.0	4	4
PE	Regular doctor providing easy-to-understand explanations	5.6	5.0	7.0	5.8	4.8	5.0	3	3
PE	Doctor giving opportunity to ask questions or raise concerns	5.6	5.0	6.6	5.8	4.8	5.0	4	4
PE	Regular doctor giving opportunity to ask questions or raise concerns	5.6	5.0	6.6	5.8	4.8	5.0	3	3
PE	Doctor involving patients in decisions about care or treatment	5.2	5.0	6.6	5.8	4.8	5.0	4	4
PE	Regular doctor involving patients in decisions about care or treatment	5.2	5.0	6.6	5.8	4.8	5.0	3	3

^aNumber of responses over a maximum achievable of 5.