

Despite national efforts to facilitate transitions of care and improve interaction between providers, health systems remain fragmented when delivering care. Recent OECD work flags how poor integration undermines the full potential of health care (OECD, 2020[14]). This is especially true for those who transition between care settings with complex health conditions, such as mental illness (OECD, 2021[39]). Poor co-ordination is also reported between health, long-term and social care (OECD, 2020[56]). These failures have been magnified by the COVID-19 pandemic, with fragmented care between hospitals and community care damaging continuity of care and risking the delivery of safe care for the most vulnerable populations (OECD, 2020[57]).

Integrated care can improve patient outcomes and experiences. It also increases value for money by improving co-ordination, while reducing duplicative and unnecessary care. OECD work has identified key mechanisms for improving integrated care: strengthening governance, developing strong information systems, building a skilled workforce and ensuring aligned financial incentives (OECD, 2017[17]).

Indicators such as mortality, readmissions and medication prescriptions after hospitalisation provide insight into the quality of integration between hospital and community care. Stroke and CHF indicators in the year following discharge can be calculated using patient-level hospital records linked to death registries and outpatient prescribing data. However, only three OECD countries (Czech Republic, Finland and Sweden) participating in the OECD pilot data collection on Integrated Care are presently able to link all the data sources for reporting prescription indicators, in addition to all the other indicators.

Figure 6.38 shows the mortality and readmissions outcomes across OECD countries in the year after discharge following ischaemic stroke or CHF in 2018. For patients who suffered an ischaemic stroke, on average, 64% survived and did not return to acute care, 22% survived and were readmitted to hospital (4% for stroke-related and 18% for other reasons) and 14% died in the following year. For CHF patients, on average, 45% who survived did not return to acute care, while 32% survived but were readmitted for CHF related or other causes and 23% died in the following year.

For patients who suffered a stroke and were discharged, 1-year mortality ranged from 2% in Japan to 25% in Estonia. For CHF patients, 1-year mortality varied from 8% in Japan to 33% in Slovenia. 1-year readmissions of stroke patients surviving one year or more ranged from 1% in Italy to 6% in Norway for stroke-related reasons, and from 0% in Costa Rica to 28% in the Czech Republic for non-stroke causes. For patients with CHF surviving one year or more, readmission rates varied from 1% in Italy to 17% in Israel for CHF-related causes and from 0% in Costa Rica to 29% in the Czech Republic for other causes.

Trend analysis can identify changes over time, such as improvements in mortality and readmission rates. Data for 2013-18 are shown for the percentage of discharged stroke and CHF patients readmitted or dying in the year following discharge either for any cause (Figure 6.39) or for the primary diagnosis (Figure 6.40). Most countries demonstrated small improvements over a five-year period. Costa Rica, Sweden and

Israel demonstrated the largest improvements for reducing 1-year readmissions and mortality following an ischaemic stroke, and Costa Rica, Sweden, Japan and Israel for CHF. Similar declines can be seen for 30-day case fatality rates for ischaemic stroke (see indicator "Mortality following ischaemic stroke"). However, some countries reported worsening rates, including Lithuania, Norway and Finland.

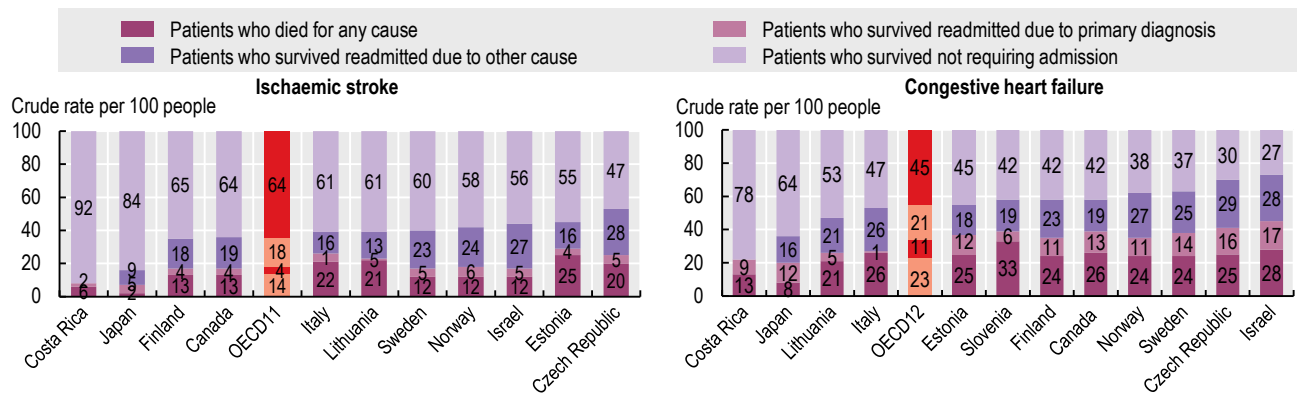
Variation in outcomes across countries can be partly explained by differences in the organisation of care delivery, and differences in access to care, payment mechanisms and information systems. For example, Estonia adopted a new person-centred care network model and Finland defined a new governance model of financing, organisation and information to drive integration of health and social care.

Definition and comparability

The OECD piloted the collection of integrated care indicators to support the international comparison of performance for patients discharged from hospital with ischaemic stroke or CHF. Outcome indicators are calculated for people aged 15 and over at the day of admission presenting with an acute non-elective (urgent) episode of care for a first-time event of ischaemic stroke or CHF. A first-time event is defined among people with no disease-specific hospital admission in the previous five years. Countries applied this "washout" period except the Czech Republic (which only used the first event of primary diagnosis) and Japan (which used a one-year washout). These variations affect the construction of the patient cohort, hinder the possibility of tracing persons who have a history of repeated hospitalisations and reduce data comparability.

All countries use patient unique identifiers. For all countries data are nationally representative, except for Japan. Japan uses a network of providers representing 30% of hospitalisations and only identifies hospital readmissions within this network thus limiting data comparability with other countries. Patient unique identifiers link hospital data (with information on the type and date of admission and discharge and diagnoses) with death registries and with prescribing databases. Definitions of acute urgent care vary across countries. Most countries define acute urgent care as hospital admission via emergency/unplanned care (Costa Rica, Finland, Japan, Israel, Italy, Norway, Slovenia and Sweden) or curative care (Lithuania). Some countries (Estonia) exclude acute care related to rehabilitation, psychiatric or long-term care, or use diagnosis-related groups (Czech Republic) to identify acute episodes. As shown in Figure 6.11 and Figures 6.17-18, CHF hospitalisations and ischaemic stroke mortality demonstrate substantial variability between countries. Caution is advised when making direct comparison between countries using these metrics. See Barrenho et al. (forthcoming[58]) for further analyses.

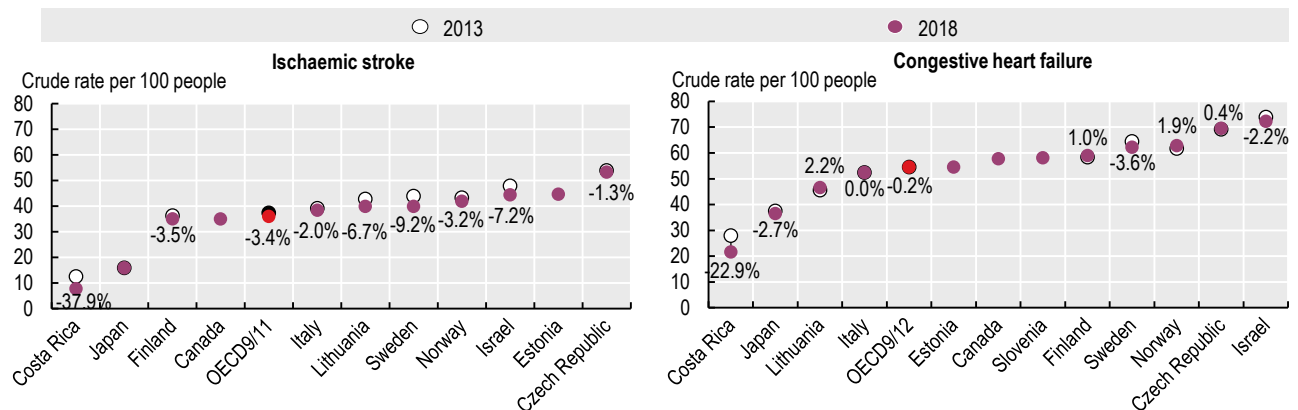
Figure 6.38. Patient outcomes within one year of discharge after ischaemic stroke and congestive heart failure, 2018



Source: OECD HCQO Pilot Data Collection on Integrated Care 2021.

StatLink <https://stat.link/73krij>

Figure 6.39. Patients readmitted or dying due to any cause within one year of discharge after stroke and congestive heart failure, 2013-18 (or nearest year)

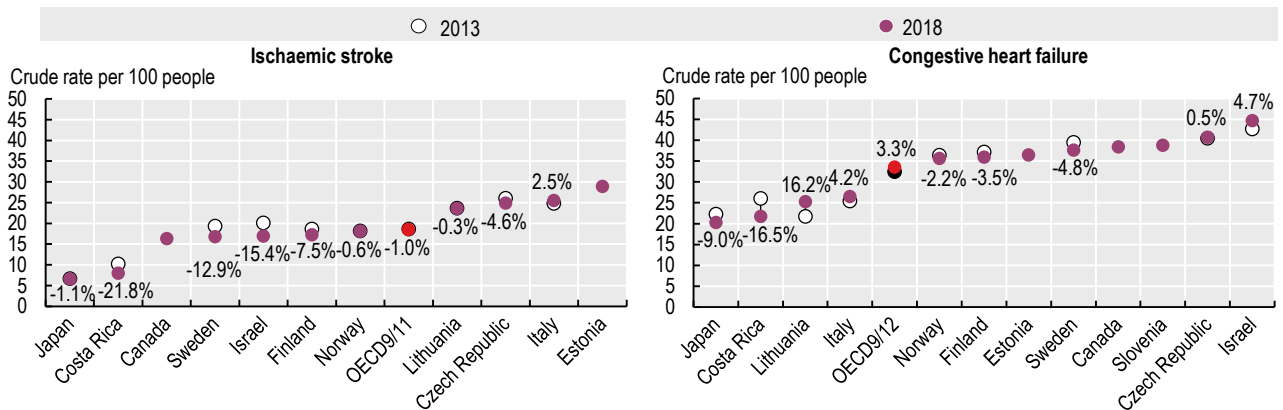


Note: Data labels report relative percentage change, 2013-18. 2013 OECD average does not include data for Canada, Estonia and Slovenia.

Source: OECD HCQO Pilot Data Collection on Integrated Care 2021.

StatLink <https://stat.link/sgwa07>

Figure 6.40. Patients readmitted or dying due to the primary diagnosis within one year of discharge after stroke and congestive heart failure, 2013-18 (or nearest year)



Note: Data labels report relative percentage change, 2013-18. 2013 OECD average does not include data for Canada, Estonia and Slovenia.

Source: OECD HCQO Pilot Data Collection on Integrated Care 2021.

StatLink <https://stat.link/wynqf6>

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