

Avoidable hospital admissions

Primary care is expected to serve as the first point of contact of people with health systems, and its functions include health promotion and disease prevention, managing new health complaints, treating the majority of uncomplicated cases, managing long-term conditions and referring patients to hospital-based services when appropriate. A key aim of primary care is to keep people well by providing a consistent point of care over the longer term, treating the most common conditions, tailoring and co-ordinating care for those with multiple health care needs and supporting the patient in self-education and self-management. Good primary care has, therefore, the potential to improve health, reduce socio-economic inequalities in health and make health care systems people-centred, while making better use of health care resources (OECD, forthcoming [1]).

Asthma, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) are three widely prevalent long-term conditions. Both asthma and COPD limit the ability to breathe: asthma symptoms are usually intermittent and reversible with treatment, while COPD is a progressive disease that mainly affects current or prior smokers. CHF is a serious medical condition in which the heart is unable to pump enough blood to meet the body's needs. CHF is often caused by hypertension, diabetes or coronary heart disease.

Common to all three conditions is the fact that the evidence base for effective treatment is well established, and much of it can be delivered by primary care. A high-performing primary care system, where accessible and high-quality services are provided, can reduce acute deterioration in people living with asthma, COPD or CHF. This can avoid the need for hospital admissions to treat these conditions, which are used as a marker of quality and access in primary care.

Figure 6.9 shows hospital admission rates for asthma and COPD together, given the physiological relationship between the two conditions. Admission rates specifically for asthma vary 12-fold across OECD countries, with Mexico, Italy and Colombia reporting the lowest rates and Latvia, Turkey and Poland reporting rates over twice the OECD average. International admission rates specifically for COPD vary 15-fold across OECD countries, with Japan, Italy and Mexico reporting the lowest and Hungary, Turkey and Australia the highest rates. A lower 7-fold variation across countries is seen for the two respiratory conditions combined.

Hospital admission rates for CHF vary 13-fold, as shown in Figure 6.10. Costa Rica, Mexico and Colombia have the

lowest rates, while Poland, Lithuania and the Slovak Republic report rates over twice the OECD average.

Figure 6.11 reveals that in Korea, Lithuania, Mexico and Sweden steady reductions in admission rates for asthma and COPD combined and for CHF have been achieved in recent years, whereas in the Slovak Republic, while rates of admission for asthma and COPD have fallen, rates of admission for CHF have increased. While observed improvements in some countries may represent advances in the quality of primary care, recent reviews undertaken by the OECD indicate that investment in primary care may still not be happening quickly enough (OECD, 2017[2]), potentially resulting in wasteful spending on hospital care (OECD, 2017[3]).

Definition and comparability

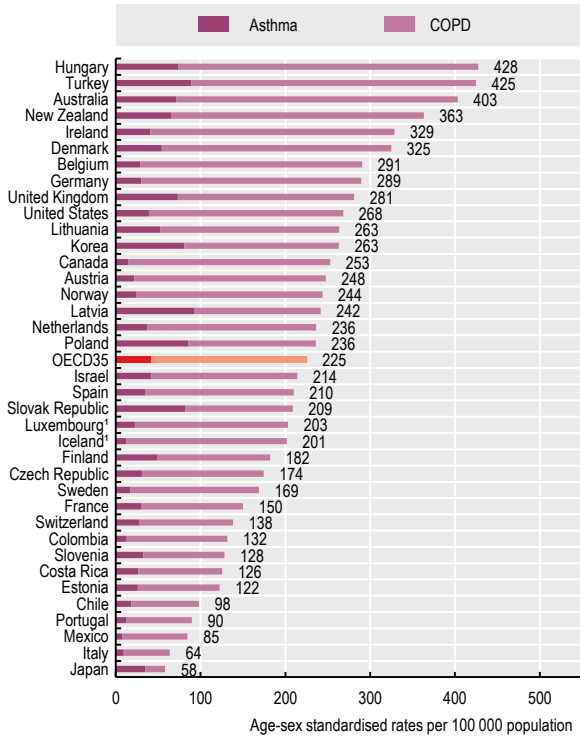
The indicators are defined as the number of hospital admissions with a primary diagnosis of asthma, COPD or CHF among people aged 15 years and over per 100 000 population. Rates are age-sex standardised to the 2010 OECD population aged 15 and over. Admissions resulting from a transfer from another hospital and where the patient dies during admission are excluded from the calculation, as these are considered unlikely to be avoidable.

Disease prevalence and availability of hospital care may explain some, but not all, variations in cross-country rates. Differences in coding practices among countries may also affect the comparability of data. For example, the exclusion of “transfers” cannot be fully complied with by some countries. Differences in data coverage of the national hospital sector across countries may also influence rates.

References

- [1] OECD (forthcoming), *Doing Things Differently: Towards better primary care in the 21st century*, OECD Publishing, Paris.
- [2] 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, <https://dx.doi.org/10.1787/9789264267787-en>.
- [3] OECD (2017), *Tackling Wasteful Spending on Health*, OECD Publishing, Paris, <https://dx.doi.org/10.1787/9789264266414-en>.

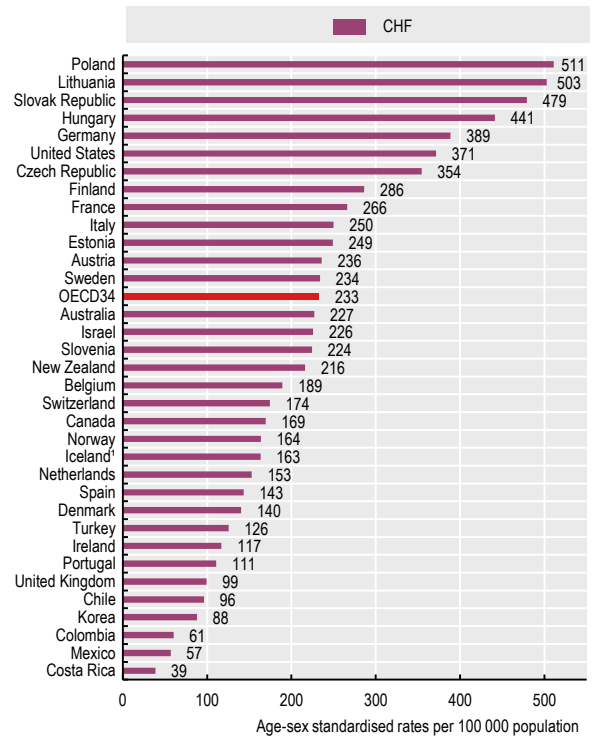
Figure 6.9. Asthma and COPD hospital admission in adults, 2017 (or nearest year)



1. Three-year average.
Source: OECD Health Statistics 2019.

StatLink <https://doi.org/10.1787/888934016113>

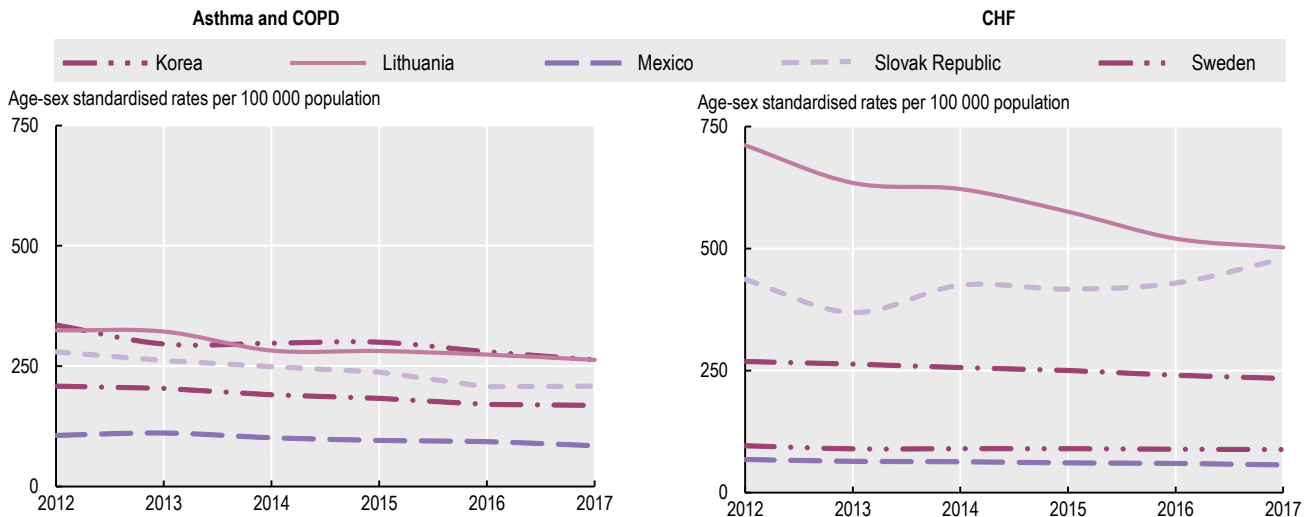
Figure 6.10. Congestive Heart Failure (CHF) hospital admission in adults, 2017 (or nearest year)



1. Three-year average.
Source: OECD Health Statistics 2019.

StatLink <https://doi.org/10.1787/888934016132>

Figure 6.11. Trends in hospital admission in adults, selected countries 2007-17 (or nearest year)



Source: OECD Health Statistics 2019.

StatLink <https://doi.org/10.1787/888934016151>



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