

1: Demographic and Health Surveys - Wikipedia

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Life expectancy for women. Skill and competency of medical staff. Based on contributions for Albania, Argentina, Austria and 69 more countries and contributions for Australia, Brazil, Germany and 7 more countries and over contributions for Canada, India, United Kingdom and 1 more country. The surveys were conducted by numbeo. See this sample survey for the United States , respondents were asked "How satisfied are you with the skill and competency of the local medical staff? The higher the value, the more survey respondents believe it is high in their country. Responsiveness waitings in medical institutions. See this sample survey for the United States , respondents were asked "How satisfied are you with the responsiveness waitings in medical institutions? Hospital beds include inpatient beds available in public, private, general, and specialized hospitals and rehabilitation centers. In most cases beds for both acute and chronic care are included. Countries compared by average BMI combining male and female population , according to data gathered by researchers at the London School of Hygiene and Tropical Medicine. The calculation is made measuring your weight in kilograms and dividing it twice by your height measured in metres. A high BMI 25 or more is usually associated with a risk of suffering diverse health problems. An estimate of all people adults and children alive at yearend with HIV infection, whether or not they have developed symptoms of AIDS. Adolescent fertility rate is the number of births per 1, women ages Probability at birth of reaching the age of Figures expressed per thousand population for the same year. Equipment for modern diagnosis and treatment. See this sample survey for the United States , respondents were asked "Does hospitals have equipment for modern diagnosis and treatment? An infant death is the death from any cause of a live-born child under one year of age. Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services preventive and curative , family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in current U. Percentage of females aged who give birth, out of all females the same age in the country. Number of births to women aged below twenty. Accuracy and completeness in filling out reports. See this sample survey for the United States , respondents were asked "How satisfied you with the accuracy and completeness in filling out reports? Percentage of live births classified by the OECD as of low birth weight. Data generally for ; in some cases, data is for , , or, in the sole case of Belgium , Refer to the source for details. Incidence of tuberculosis per , people. Incidence of tuberculosis is the estimated number of new pulmonary, smear positive, and extra-pulmonary tuberculosis cases. Incidence includes patients with HIV. The crude birth rate is the number of live births for every 1, people. Physicians include generalist and specialist medical practitioners. Services correspond to ISIC divisions They include value added in wholesale and retail trade including hotels and restaurants , transport, and government, financial, professional, and personal services such as education, health care, and real estate services. Also included are imputed bank service charges, import duties, and any statistical discrepancies noted by national compilers as well as discrepancies arising from rescaling. Value added is the net output of a sector after adding up all outputs and subtracting intermediate inputs. It is calculated without making deductions for depreciation of fabricated assets or depletion and degradation of natural resources. Data are in current local currency. Figures expressed per capita for the same year. Under-five mortality rate is the probability per 1, that a newborn baby will die before reaching age five, if subject to current age-specific mortality rates. Adult mortality rate is the probability of dying between the ages of 15 and that is, the probability of a year-old dying before reaching age 60, if subject to current age-specific mortality rates between those ages. Speed in completing examination and reports. See this sample survey for the United States , respondents were asked "Speed in completing examination and

reports? An estimate of the number of adults and children who died of AIDS during a given calendar year. Friendliness and courtesy of the staff. See this sample survey for the United States , respondents were asked "Friendliness and courtesy of the staff? Depth of hunger or the intensity of food deprivation, indicates how much food-deprived people fall short of minimum food needs in terms of dietary energy. The food deficit, in kilocalories per person per day, is measured by comparing the average amount of dietary energy that undernourished people get from the foods they eat with the minimum amount of dietary energy they need to maintain body weight and undertake light activity. The depth of hunger is low when it is less than kilocalories per person per day, and high when it is higher than kilocalories per person per day. Total number of live births. A live birth refers to a birth after which the baby shows signs of life, however, if the baby dies after showing signs of life, it is still considered a live birth. Data on tobacco consumption - this is a percentage of the total population who smoke at least one cigarette a day. Data for Portugal and Austria is from All other data is from Life expectancy at birth indicates the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life. Per capita figures expressed per 1, population. Healthcare expenditure as percent of GDP. Nurses and midwives per 1, people. Nurses and midwives include professional nurses, professional midwives, auxiliary nurses, auxiliary midwives, enrolled nurses, enrolled midwives and other associated personnel, such as dental nurses and primary care nurses. Convenience of location for you. See this sample survey for the United States , respondents were asked "Convenience of location for you". The percentage of the total population with access to sanitation facilities Services, etc. Births by caesarean section: Number of births by caesarean section per live births year The infant mortality rate is the number of deaths of children under one year of age expressed per 1 live births. Neonatal mortality refers to the death of children under 28 days. Infant mortality rate is the number of infants dying before reaching one year of age, per 1, live births in a given year. The average number of years to be lived by a females in this nation born in the same year, if mortality at each age remains constant in the future. Life expectancy at birth is also a measure of overall quality of life in a country and summarizes the mortality at all ages. It can also be thought of as indicating the potential return on investment in human capital and is necessary for the calculation of various actuarial measures. Number of nurses per 1, people. Data is for Fatalities per population due to motor vehicle accidents Figures expressed per thousand people for the same year. Number of births, in which two children were born. A mother giving birth to twins is counted as one birth. Figures expressed per million people for the same year. Percentage of children under 1 year old immunized against measles. Annual per capita expenditure for healthcare at purchasing power parity. Purchasing power parity compensates for differences in the price level across countries. The average number of years to be lived by amen in this nation born in the same year, if mortality at each age remains constant in the future. The entry includes total population as well as the male and female components. Life expectancy measures how long on average people would live based on a given set of age-specific death rates. However, the actual age-specific death rates of any particular birth cohort cannot be known in advance. If age-specific death rates are falling as has been the case over the past decades in OECD countries , actual life spans will be higher than life expectancy calculated with current death rates. The number of people that will die from cardiovascular diseases out of , people the same age. Teenage pregnancy per million: Figures expressed per million population for the same year. Average number of visits to a doctor per person per year Data is for Standardised death rates per population Health spending per capita: Physicians per people.

2: Health systems by country - Wikipedia

*Comparative statistics on health facilities and population: Metropolitan and nonmetropolitan areas [American Hospital Association] on www.enganchecubano.com *FREE* shipping on qualifying offers.*

She writes on a variety of topics including health, nutrition, art and culture for various websites. Doctors talking together in the office. Descriptive statistics summarize the utility, efficacy and costs of medical goods and services. Increasingly, health care organizations employ statistical analysis to measure their performance outcomes. Hospitals and other large provider service organizations implement data-driven, continuous quality improvement programs to maximize efficiency. Government health and human service agencies gauge the overall health and well-being of populations with statistical information. Video of the Day Health Care Utilization Researchers employ scientific methods to gather data on human population samples. The health care industry benefits from knowing consumer market characteristics such as age, sex, race, income and disabilities. These "demographic" statistics can predict the types of services that people are using and the level of care that is affordable to them. Health administrators reference statistics on service utilization to apply for grant funding and to justify budget expenditures to their governing boards. Resource Allocation Health care economists Rexford Santerre and Stephen Neun emphasize the importance of statistics in the allocation of scarce medical resources. Statistical information is invaluable in determining what combination of goods and services to produce, which resources to allocate in producing them and to which populations to offer them. Health care statistics are critical to allocative and production efficiency. Inevitably, allocation decisions involve trade-offs--the costs of lost or missed opportunities in choosing one economic decision over another. Reliable statistical information minimizes the risks of health care trade-offs. Needs Assessment According to Frederick J. Gravetter and Larry B. Wallnau, statistics "create order out of chaos" by summarizing and simplifying complex human populations. Public and private health care administrators, charged with providing continuums of care to diverse populations, compare existing services to community needs. Statistical analysis is a critical component in a needs assessment. Statistics are equally important to pharmaceutical and technology companies in developing product lines that meet the needs of the populations they serve. Quality Improvement Health care providers strive to produce effective goods and services efficiently. Statistics are important to health care companies in measuring performance success or failure. By establishing benchmarks, or standards of service excellence, quality improvement managers can measure future outcomes. Analysts map the overall growth and viability of a health care company using statistical data gathered over time. Product Development Innovative medicine begins and, sometimes, ends with statistical analysis. Market research studies steer developers toward highly competitive product lines. Statistics indirectly influence product pricing by describing consumer demand in measurable units.

3: OECD Statistics

Quantitative research guides health care decision makers with statistics--numerical data collected from measurements or observation that describe the characteristics of specific population samples. Descriptive statistics summarize the utility, efficacy and costs of medical goods and services.

By providing greater insight to patients, providers, and policy makers into the appropriate application of interventions, and quality and costs of care, these data offer the opportunity to accelerate progress on the six dimensions of quality care—safe, effective, patient centered, timely, efficient, and equitable Chaudhry, ; IOM, , ; Safran et al. Understanding the scale of this potential and of the missed opportunities to improve health and health care due to gaps in data collection or barriers to their use requires an overview of existing healthcare data—the sources, types, accessibility, and uses. Through examples of healthcare data used to manage and drive improvements in care and for healthcare marketing, this chapter explores important aspects of healthcare data in the United States—examines what drives the collection of these data and the accessibility of these data for new clinical insights; reflects on how well these data are used and key barriers to wider use; and focuses attention on how clinical data from all sources—both public and private—could be made more widely useful to monitor clinical effectiveness. As reviewed in this chapter, data are collected on socioeconomic, environmental, biomedical, and genetic factors; individual health status and health behaviors; biomedical and genetic factors, as well as on resource use, outcomes, financing, and expenditures. These data are stored in a variety of electronic health records EHRs , personal medical records, disease registries, and other databases. However, the distribution of clinical data across the healthcare system is highly fragmented, presenting significant opportunity for those offering services that coordinate and aggregate data resources. To generate and organize data for evidence-based decision support, it will be important to explore technologies to enhance inter-operability, data standardization, and compatibility for future data utilities. Leveraging access to both administrative and clinical data may require additional investments in developing linkages across the variety of healthcare data and data warehouses. Given the broad range of data sources and possible applications, a national strategy is needed to develop the requisite infrastructure and fill existing gaps in data collection and use. Speaking from his experience at Kaiser Permanente and in his role as chair of the National Committee on Vital and Health Statistics NCVHS , Simon Cohn offers an overview of current major activities in healthcare data collection and database capacity development, including those related to administrative and claims data, quality indicators, health status and outcomes data, clinical research data, industry-sponsored pre- and postmarket studies, regulatory studies, registries, and emerging datasets. To help frame the discussion, Cohn presents a taxonomy for health data, then reflects on key issues and barriers to address as we move to a learning health system. Cohn highlights the NCVHS recommendations for enhancing protections for secondary uses of data collected electronically as particularly informative for advancing the clinical data agenda. In the area of enhanced health data stewardship, NCVHS recommends that covered entities be more specific about what data will be used, how, and by whom; that notices of privacy practices need to be more meaningful; and that data stewardship needs to extend to personal health data held by noncovered entities in personal health records and similar instruments. Massachusetts Health Quality Partners MHQP aggregates healthcare data to measure and report on physician performance in a more meaningful and transparent way—creating reports on performance at the physician network, medical group, practice site, and individual physician level, for both doctors and consumers. MHQP Executive Director Barbra Rabson shares aspects of this model, including its success in influencing investments in information systems to support quality and incentives for individual physicians and the challenges of engaging consumers. Overall, Rabson suggests, the MHQP experience and similar models hold promise for a world in which EHRs would be more fully and effectively integrated into medical practice, and clinical, claims, and personal data would be more fully integrated for quality improvement initiatives. For decades, researchers and clinicians have taken advantage of

sources of rich clinical and population-based data to generate new insights, stimulate major research programs, and develop robust clinical guidelines. Michael Lauer, director of the Division of Prevention and Population Sciences at the National Heart, Lung, and Blood Institute NHLBI , asserts that to achieve the goal of the IOM Roundtable, clinical data ultimately will need to be integrated across the research and care delivery continuum and be made available to patients, clinicians, and researchers. Examples from abroad and within U. Still, most clinical data are not collected at the point of care, and most are organized in isolated silos that are difficult to access. As data are increasingly integrated within the care continuum, Lauer cautions against using inherently biased observational data in lieu of well-designed experimental data for synthesizing evidence-based policy recommendations. Although confounders in observational data can be statistically controlled to reduce biases somewhat, an ongoing national need remains for enhancing, networking, and analyzing existing data. Three major types of data are used by public and private entities to market healthcare products and services: William Marder, senior vice president of the research and pharmaceutical units of Thomson Healthcare, reports on the use of data assets by providers and pharmaceutical companies, describing business models for the collection and analysis of these data. Chair, National Committee on Vital and Health Statistics Associate Executive Director, The Permanente Federation, Kaiser Permanente This section aims to provide a brief overview of major current activities in healthcare data development and collection—including administrative and claims data, quality indicators, health status and outcomes data, clinical research data, industry-sponsored pre- and postmarket studies, regulatory studies, registries, and emerging datasets. The goal is to lay the groundwork and provide a context for addressing a variety of salient issues surrounding these data sources. Included are general comments about U. It has a year history of advising on national health information policy, including health data, standards, statistics, privacy, and issues related to developing the National Health Information Infrastructure NHII. Members are leaders and experts in their field e. The NCVHS has a well-deserved reputation for open collaborative processes and the ability to deliver timely and thoughtful recommendations. These attributes allow it to work closely and effectively with HHS organizational entities such as the Office of the National Coordinator ONC , with a particular focus on challenging and difficult crosscutting issues. The heart of the vision for the NHII is sharing information and knowledge appropriately so it is available to people when they need it to make the best possible health decisions. The NHIN is only one part of the larger vision: One important part of this report was an early recognition of the importance of HHS leadership, and a call for an office within the HHS reporting to the HHS Secretary, to coordinate and move this effort forward. While not answering all questions, because it is unclear how the NHIN will develop and evolve, the NCVHS is beginning to pose the important questions and to start public discussions. Health and Healthcare Data: Framework and Taxonomy When thinking about evidence-based medicine and about the data or taxonomies needed to support that work, it is important to take a broad view of all possible factors that impact or are impacted by health and health care. This graphic provides a reminder of the many influences on the health of the nation. In the context of this discussion of more traditional health and healthcare data, as well as of issues and barriers, it is important to recognize how much information we do not routinely collect, or if we do, we do not normally integrate it into our vision of health and health improvement. This NCVHS work was an important input to subsequent efforts to develop simpler, more approachable health and healthcare conceptual frameworks internationally. Figure , for example, shows a conceptual frame-work, initially developed by the Australian Institute of Health and Welfare, for health system planning. It was subsequently published by the World Health Organization—which has used the diagram as a tool for healthcare terminology and classification planning Madden et al. This useful tool frames thinking about the data needed for a learning healthcare system as well as the development of sound health policy. In the center are the key concerns we need to monitor and focus on: Impacting these are health system interventions, including prevention and health promotion, and the major activity of the healthcare system—treatment, care, and rehabilitation. Determinants are important inputs into health and well-being such as biomedical and genetic factors, health behaviors, socioeconomic factors, and environmental factors. Impacting our ability to make interventions are

resources and systems—human, economic, and others. This particular graphic begins to frame the discussion as we think about evidence-based medicine and data needs going forward. The taxonomy represented in Box provides more specifics. Used by the HHS Data Council for health data and health statistics planning, this taxonomy is focused on what we would traditionally describe as healthcare data and represents data that are central to a learning health system. One notable component of this taxonomy is its explicit recognition of the importance of longitudinal data. Unless we can understand the key factors that influence outcomes including underlying health status and socioeconomic data and connect them with the interventions and outcomes, it becomes difficult to have a learning health system. The good news is that work is under way on some identified issues and others may be relatively inexpensive to resolve. Later chapters will address the political and competitive barriers and issues regarding a learning health system. A barrier in the current healthcare data environment to implementation of the frameworks and taxonomy discussed is the wide distribution of data across the system and significant fragmentation of the data. Given the fact that the national healthcare enterprise consumes 16 percent of the gross national product and given the complexity of the human organism, it is not surprising that the system would be complex and the data systems complex. Currently, data are collected and held in many places—by the patient, providers, payers, and government repositories for public health and planning purposes, to name a few. Some of the data held are discrete and unique, and in other cases an extract or copy of data produced as a result of a healthcare interaction or event is stored. Few places, however, have comprehensive, longitudinal views about individuals. The inability to connect data that may include risk factors, medical history, and interventions in a comprehensive way is a fundamental flaw in moving forward. The hopeful news is that the vision of the NHIN is intended to help consolidate the data, but we are rife with fragmentation of health and healthcare data at this point. In addition to the fragmentation of data, the data itself represented in the framework and taxonomy are heterogeneous. Laboratory data are becoming increasingly standardized and codified; however, most other data are not available in a computerized form, or are generally in free text even if computerized. Another issue of concern is variation in the timeliness of data. Timing ranges from clinical data coded or not being almost immediately available, at least for caregiving, to coded administrative data, which may take days or weeks to become available, to health statistics in government repositories used for planning purposes or research databases, which may lag by 1, 2, or more years. Lest readers react in despair about the widely distributed nature of the data, uneven data quality, and time delays, previous testimony has highlighted what we have learned from the current distributed environment. This is infrastructure that can be leveraged now to help identify evidence-based best practices. Various initiatives that are also under way to help consolidate healthcare data for important purposes such as quality measurement deserve ongoing support and encouragement. Considerations During the National Transition to EHR To achieve the goal of having most decisions based on evidence as we move toward widespread EHR implementation, two focuses are needed. First, we need to be able to identify those evidence-based best practices, then we need ways to communicate those best practices to the clinician in a way that supports work overflow and high-quality clinical care. The first focus, which is extensively discussed in this roundtable report, relies heavily on access to comparable and standardized data. Such data standardization and comparability, as we move towards fuller use of EHRs, requires uniform healthcare messaging standards. Thus, for some time to come, we will need to consider strategies that can leverage claims, administrative health data, and the more specific, clinically rich information that is expected to come from EHRs. In 2007, the NCVHS looked at this transition issue and recommended a set of clinically rich terminologies to form a core for EHRs, calling for an aggressive mapping strategy between these and the HIPAA-mandated terminologies and classifications. The National Library of Medicine was asked to take the lead on this, but the mappings have been notoriously difficult especially trying to map an archaic ICD classification to more modern clinical terminologies. Another problem is that both sides of the mapping have ongoing changes, so the mapping requires significant upkeep and runs the risk of being inaccurate. Linking administrative classifications and clinical terminologies could become an important tool and part of a

transition strategy to help maximize the use of computerized data through both the transition to EHRs and the newer versions of ICD. Issues of concern remain, however. These include lack of adequate funding—the ICD classification development work, for example, is currently funded mostly by the Japan Hospital Association. It is in our own national self-interest to get behind this as a way to ensure maintenance of the value of our data as we continue the transition to more current classifications and EHRs. A second issue is that U. We need to have a strong voice in how this goes forward because it will be an important piece of the infrastructure. Other data terminology issues remain as we move forward with clinical interoperability and the implementation of standards and clinical terminologies to support MMA e-prescribing and the transition to EHRs and the NHIN. Clinically rich data, all standardized and interoperable, will provide a fertile environment for the learning health system, but many of these terminologies will be stretched to their limits. Unforeseen problems will need to be remedied. The bottom line is that federal terminology development and improvement initiatives are extremely underfunded. Furthermore, we will need adequate funding to fix problems and fill gaps as these standards and terminologies go into wider use. We are not talking about a huge amount of money: The second critical issue is communicating evidence-based best practices to the clinicians in a way that supports workflow and high-quality clinician care—in other words, optimizing clinical decision support CDS. Determination of best practices is critical, but the rate limiting step may be getting that information to the busy care provider at the point of care in a way that is useful and actionable, and will impact decision making. These practices range from flu shot reminders to warnings about potential medication complications, and the number of evidence-based guidelines and recommendations continues to explode. There is no lack of evidence-based practices. Most physicians have binders full of them written by their own organizations, by specialty societies, by accrediting organizations, by governmental organizations, etc. For example, the Agency of Healthcare Research and Quality has guidelines in its national clearinghouse on cardiovascular disease alone. Unfortunately, although CDS exists in many healthcare organizations that have EHRs, it is generally proprietary and nonstandardized, and there is no widespread agreement on how to share CDS information among organizations in an automated fashion. Furthermore, rules themselves are frequently not developed in a way that encourages computerization. Although CDS seems to work well with data entered within an EHR by an individual organization, the ability to merge and leverage data coming from elsewhere, especially administrative data, remains an issue including trust issues. Work is being done in this arena, but significant efforts will be needed to address this important barrier to the vision of a learning healthcare system. This affords an opportunity to assess clinical outcomes over time, but also creates the risk of data being linked to databases that might jeopardize privacy, employment, or insurance eligibility.

4: Comparison of the healthcare systems in Canada and the United States - Wikipedia

Long-term care facilities (including nursing homes, personal care homes, assisted living residences and other residential care facilities) have more than , employees in PA and support a total of more than , total jobs.

Health in Algeria When Algeria gained its independence from France in , there were only around doctors across the whole country and no proper system of healthcare. Over the next few decades, great progress was made in building up the health sector, with the training of doctors and the creation of many health facilities. Today, Algeria has an established network of hospitals including university hospitals , clinics, medical centres and small health units or dispensaries. While equipment and medicines may not always be the latest available, staffing levels are high and the country has one of the best healthcare systems in Africa. Access to health care is enhanced by the requirement that doctors and dentists work in public health for at least five years. The government provides universal health care.

Health in Cape Verde Medical facilities in Cape Verde are limited, and some medicines are in short supply or unavailable. There are hospitals in Praia and Mindelo , with smaller medical facilities in other places. Brava also has limited inter-island ferry service. Researchers at the Overseas Development Institute have identified the high prioritisation of health and education both within the government and amongst Eritreans at home and abroad. Innovative multi-sectoral approaches to health were also identified with the success. Health care and welfare resources generally are believed to be poor, although reliable information about conditions is often difficult to obtain. In , the most recent year for which figures are available, the Eritrean government spent 5. The two-year war with Ethiopia , coming on the heels of a year struggle for independence, negatively affected the health sector and the general welfare. In the decade since , impressive results have been achieved in lowering maternal and child mortality rates and in immunizing children against childhood diseases. In average life expectancy was slightly less than 63 years, according to the WHO. Immunisation and child nutrition has been tackled by working closely with schools in a multi-sectoral approach; the number of children vaccinated against measles almost doubled in seven years, from This has helped to some small extent even out rural-urban and rich-poor inequity in health.

Health in Ethiopia Throughout the s, the government, as part of its reconstruction program, devoted ever-increasing amounts of funding to the social and health sectors, which brought corresponding improvements in school enrollments, adult literacy , and infant mortality rates. These expenditures stagnated or declined during the “ war with Eritrea , but in the years since, outlays for health have grown steadily. In the country counted one hospital bed per 4, population and more than 27, people per primary health care facility. The physician to population ratio was 1: Overall, there were 20 trained health providers per , inhabitants. These ratios have since shown some improvement. Health care is disproportionately available in urban centers; in rural areas where the vast majority of the population resides, access to health care varies from limited to nonexistent. As of the end of , the United Nations UN reported that 4. Malnutrition is widespread, especially among children, as is food insecurity. Because of growing population pressure on agricultural and pastoral land, soil degradation, and severe droughts that have occurred each decade since the s, per capita food production is declining. According to the UN and the World Bank , Ethiopia at present suffers from a structural food deficit such that even in the most productive years, at least 5 million Ethiopians require food relief. A polio vaccination campaign for 14 million children has been carried out, and a program to resettle some 2 million subsistence farmers is underway. In November , the government launched a five-year program to expand primary health care. In January , it began distributing antiretroviral drugs , hoping to reach up to 30, HIV-infected adults.

Health in Ghana In Ghana , most health care is provided by the government, but hospitals and clinics run by religious groups also play an important role. Health care is very variable through the country. The major urban centres are well served, but rural areas often have no modern health care. Patients in these areas either rely on traditional medicine or travel great distances for care. In , Ghana spent 6. In only 62% 65 percent of the population was estimated to have access to safe drinking water and only 69 percent to

sanitation services of some kind; only 8 percent was estimated to have access to modern sanitation facilities. In general government expenditures on health constituted 6. Medical facilities in Mali are very limited, especially outside of Bamako, and medicines are in short supply. There were only 5 physicians per 100,000 inhabitants in the 1980s and 24 hospital beds per 100,000 in 1990. In only 36 percent of Malians were estimated to have access to health services within a five-kilometer radius. Health in Morocco According to the United States government, Morocco has inadequate numbers of physicians 0. The health care system includes hospitals, 2, health centers, and 4 university clinics, but they are poorly maintained and lack adequate capacity to meet the demand for medical care. Only 24, beds are available for 6 million patients seeking care each year, including 3 million emergency cases. The health budget corresponds to 1. Health in Niger Health care system of Niger suffers from a chronic lack of resources and a small number of health providers relative to population. Some medicines are in short supply or unavailable. Government hospitals, as well as public health programmes, fall under the control of the Nigerien Ministry of Health. There were Physicians in Niger in 1990, a ratio of 0. Health in Nigeria Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country. Historically, health insurance in Nigeria can be applied to a few instances: In May 1991, the government created the National Health Insurance Scheme, the scheme encompasses government employees, the organized private sector and the informal sector. Legislative wise, the scheme also covers children under five, permanently disabled persons and prison inmates. In 1993, the administration of Obasanjo further gave more legislative powers to the scheme with positive amendments to the original legislative act. Health in Senegal The health budget in Senegal has tripled between 1990 and 1995, leading to the Senegalese people leading healthier and longer lives "the life expectancy at birth is approximately 55 years. The public system serves the vast majority of the population, but is chronically underfunded and understaffed. This division in substantial ways perpetuates racial inequalities created in the pre-apartheid segregation era and apartheid era of the 20th century. In 1995, South Africa spent 8. Health in Sudan Outside urban areas, little health care is available in Sudan, helping account for a relatively low average life expectancy of 57 years and an infant mortality rate of 69 deaths per 1,000 live births, low by standards in Middle Eastern but not African countries. For most of the period since independence in 1956, Sudan has experienced civil war, which has diverted resources to military use that otherwise might have gone into health care and training of professionals, many of whom have migrated in search of more gainful employment. In the World Health Organization estimated that there were only 9 doctors per 100,000 people, most of them in regions other than the South. Substantial percentages of the population lack access to safe water and sanitary facilities. Malnutrition is widespread outside the central Nile corridor because of population displacement from war and from recurrent droughts; these same factors together with a scarcity of medicines make diseases difficult to control. Child immunization against most major childhood diseases, however, had risen to approximately 60 percent by the late 1980s from very low rates in earlier decades. Spending on health care is quite low "only 1 percent of gross domestic product GDP in latest data. The United Nations suggested, however, that the rate could be as high as 7. Between 1980 and 1990, and 1. As of late 1990s, some 4 million persons in the South had been internally displaced and more than 2 million had died or been killed as a result of two decades of war. Comparable figures for Darfur were 1. Health in Zimbabwe Zimbabwe now has one of the lowest life expectancies on Earth "44 for men and 43 for women, [18] down from 60 in 1980. Infant mortality has risen from 59 per thousand in the late 1980s to per by

5: Comparisons of Health Care Systems in the United States, Germany and Canada

The Substance Abuse and Mental Health Data Archive (SAMHDA) is an initiative funded under contract HHSSC with the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS).

This article has been cited by other articles in PMC. Abstract The purpose of this research paper is to compare health care systems in three highly advanced industrialized countries: The first part of the research paper will focus on the description of health care systems in the above-mentioned countries while the second part will analyze, evaluate and compare the three systems regarding equity and efficiency. Finally, an overview of recent changes and proposed future reforms in these countries will be provided as well. We start by providing a general description and comparison of the structure of health care systems in Canada, Germany and the United States. Health insurance coverage is universal. General taxes finance NHI through a single payer system only one third-party payer is responsible for paying health care providers for medical services. Consumer co-payments are negligible and physician choice is unlimited. Production of health care services is private; physicians receive payments on a negotiated fee for service and hospitals receive global budget payments Method used by third party payers to control medical care costs by establishing total expenditure limits for medical services over a specified period of time. Most of the population lives within miles of the United States border. From the American point of view, Canada provides a good comparison and contrast in terms of the structure of its health care systems. The Canadian health care system began to take on its current form when the province of Saskatchewan set up a hospitalization plan immediately after WWII. The rural, low-income province was plagued by shortages of both hospital beds and medical practitioners. The main feature of this plan was the creation of the regional system of hospitals: In 1947, the federal parliament enacted the Hospital and Diagnostic Services Act laying the groundwork for a nationwide system of hospital insurance. By 1951 all ten provinces and the two territories had hospital insurance plans of their own with the federal government paying one half of the costs. Since the health care system has moved in different directions. While Canada has had publicly funded national health insurance, the United States has relied largely on private financing and delivery. During this period, spending in the United States has grown much more rapidly despite large groups that either uninsured or minimally insured. The provisions of the Canada Health Act define the health care delivery system as it currently operates. Under the Act, each provincial health plan is administered at the provincial level and provides comprehensive first dollar coverage of all medically necessary services. With minor exceptions, health coverage is available to all residents with no out of pocket charges. Most physicians are paid on a fee for service basis and enjoy a great deal of practice autonomy. Private health insurance for covered services is illegal. Most Canadians have supplemental private insurance for uncovered services, such as prescription drugs and dental services. As a result, virtually all physicians are forced to participate and each health plan effectively serves all residents in the province Henderson Patients do not participate in the reimbursement process, and reimbursement exclusively takes place between the public insurer the government and the health care provider. The monetary exchange is practically non-existent between patient and health care provider. The ministry of health in each province is responsible for controlling medical costs. Cost control is attempted primarily through fixed global budgets and predetermined fees for physicians. Specifically, the operating budgets of hospitals are approved and funded entirely by the ministry in each province and an annual global budget is negotiated between the ministry and each individual hospital. Capital expenditures must also be approved by the ministry, which funds the bulk of the spending. Physician fees are determined by periodic negotiations between the ministry and provincial medical associations the Canadian version of the American Medical Association. With the passage of the Canada Health Act of 1984, the right to extra billing was removed in all provinces. Extra billing or balance billing refers to a situation in which the physician bills the patient some dollar amount above the predominated fee set by third party payer.

For the profession as a whole, negotiated fee increases are implemented in steps, conditional on the rate of increase in the volume of services. If volume per physician arises faster than a predetermined percentage, subsequent fee increases are scaled down or eliminated to cap gross billings – the product of the fee and the volume of each service – at some predetermined target. The possible scaling down of fee increases is supposed to create an incentive for a more judicious use of resources. Physicians enjoy nearly complete autonomy in treating patients. In spite of the differences it is fair to say that each provincial plan is a public – sector monopsony, serving as a single buyer of medical services within the province and holding down medical care prices below market rates. The key element in the Canadian strategy to control overall spending is the regionalization of high – tech services. Government regulators make resource allocation decisions. This control extends to capital investment in hospitals, specialty mix of medical practitioners, location of recent medical graduates, and the diffusion of high tech diagnostic and surgical equipment. Access to open heart surgery and organ transplantation is also restricted. That same year the CT scanners in Canada meant one for every , citizens. Recent studies found Canadian deficits in several areas including angioplasty, cardiac catheterization and intensive care. Waiting lists for certain surgical and diagnostic procedures are common in Canada. Nationwide, the average wait for treatment is . If care required diagnostic imaging, waiting times are even longer. Canadians are sacrificing access to modern medical technology for first dollar coverage for primary care. Treatment delays are causing problems for certain vulnerable segments of the Canadian population, particularly the elderly who cannot get reasonable access to the medical care they demand, including hip replacement, cataract surgery and cardiovascular surgery. Several lessons can be learned from the Canadian experience. Products provided at zero price are treated as if they have zero resource cost. Resource allocation decisions become more inefficient over time and government is forced either to raise more revenue or curb services. A second lesson from the Canadian experience is that everything has a cost. The Canadian system delegates this authority to the government. Resource allocation is practiced, not through the price mechanism, but by setting limits on the investment in medical technology. Proponents will argue that using waiting lists as a rationing measure is reasonable and fair. Opponents find the lists unacceptable and an unwelcome encroachment on individual decision-making in the medical sector. Proponents of the single payer alternative must deal with the fact that Canadians face waiting lists for some medical services especially for high – tech specialty care. To avoid delays in treatment, many Canadians travel south to the United States for more advanced treatment. Critics of the Canadian system must deal with the fact that most Canadians support their version of Medicare. The single most important defense of medical care delivery in Canada is that it works relatively well. The German system of social benefits is based on the concept of social insurance as embodied in the principle of social solidarity. This principle is a firmly held belief that government is obliged to provide a wide range of social benefits to all citizens, including medical care, old age pensions, unemployment insurance, disability payments, maternity benefits and other forms of social welfare. Bismarck saw the working class movement of that time as a threat. This concern led him to advocate the expansion of the existing sickness benefit societies to cover workers in all low wage occupations. In , the Sickness Insurance Act was passed, representing the first social insurance program organized on a national level. The German Democratic Republic East Germany was under the influence of the former Soviet Union and adapted the socialist form of government. The Federal Republic of Germany West Germany maintained its connections with the West and continued to utilize the pre-war economic system including the health care delivery system. East and West Germany were reunited in and since that time the former East Germany has been subjected to most West German laws including legislation relating to the medical insurance system. With the combined population of 82 million people, Germany is divided into 16 provinces Laender , each with a great deal of independence in determining matters related to health care. Over the past years the system has grown to the point where virtually all of the population is provided access to medical care. All individuals are required by law to have health insurance. Sickness funds are private, not – for – profit insurance companies that collect premiums from employees and employers. Those earning more than this limit may

choose private health insurance instead. One of every 10 Germans covered by sickness fund insurance also purchases private supplementary insurance to cover co-payments and other amenities. Individual health insurance premiums for workers are calculated on the basis of income and not age or the number of dependents. Premiums are collected through a payroll tax deduction; the average contribution was The social insurance component is organized around some localized sickness funds. The sickness funds are independent and self-regulating. They pay providers directly for services provided to their members at rates that they negotiate with individual hospitals. The sickness funds are required by law to provide a comprehensive set of benefits. These include physician ambulatory care provided by physicians in private practice, hospital care, home nursing care, a wide range of preventive services and even visits to health spas. Patient cost sharing is minimal. The funds, like disability insurance also provide additional cash payments to those who are unemployed as a result of illness. The system is weak in several areas. In particular, public health services and psychiatric services are minimal. As for reimbursement, ambulatory providers are paid on a fee for service basis, hospitals on a prospective basis. Both public and private including for profit hospitals exist, though the public hospitals account for about half the beds. Hospitals tend to use salaried physicians, and unlike the United States physicians in private practice generally do not have admitting privileges. Thus, many doctors have invested in elaborately equipped clinics to compete with hospitals by being able to perform a wide range of procedures. The German experience is especially relevant to the United States. Coverage is provided through a large number of relatively small and independent plans. In this sense, the delivery of health care is similar to that found in the United States where, for the most part, large numbers of employee groups, independent insurers, and providers reach agreements without direct government intervention. Many Americans propose mandated coverage for the working uninsured. Germany relies on a mandated approach where coverage for certain conditions is required by law. Germany also introduced cost controls similar in principle to prospective payment under the U. Government Role and Involvement In the German health care system, each level of government has specific responsibilities.

6: OECD Health Statistics - OECD

Trends in American Indian or Alaska Native population health from Health, United States Tables of Summary Health Statistics from the National Health Interview Survey Timing and Adequacy of Prenatal Care in the United States, [PDF - KB].

It is certainly not considered acceptable to protect or improve the average health of the population, if at the same time inequality worsens or remains high because the gain accrues disproportionately to those already enjoying better health. The responsibility of a health care system is also to reduce inequalities to race, gender, social status and religion. This analysis will compare the US health system with that of the French. Their health system is worth comparing because they are considered a world leader when it comes to their healthcare system. He goes on to explore the mortality and morbidity rates. In , the infant mortality rate was four per live births. The United States population has a much higher percentage of obesity at One can deduct from these statistics that the health care system in the United States has not successfully been able to keep up with the growing population. At this rate of growth in population and the aged population, access to health care services requires strategic attention. The hospital system is profit institutions. This differs greatly from that of the United States, in that the government insures way less individuals leaving the management of care for the people at the direction of primary care physicians participating in a managed care insurance company. The people of the United States not only have access to fewer practicing physicians and physician consultants, they are also required to see only those that belong within their managed care network at the discretion of their primary care physician. For the United States, managed care by private insurance companies has resulted in a failed healthcare system; hence the dire need for reform. But, the problem presented now is reform is being done in reaction to failure. Any industry will show that making change based on a reaction is much less effective and more costly than making change proactively after careful consideration. And, at whose expense will reform come It will come at the expense of the American people. Depressingly for the United States, health care spending makes up a much higher The system is made up of many different bodies and is complicated to understand in detail. Everyone working in France must contribute to the French Social Security system and everyone French or not, working or not, unemployed, child or retired, legal or illegal immigrant is entitled to benefit from it with no exception; the system s rather complex and considered bureaucratic. The system is threefold: Health, Family and Retirement, each of them having different structures and financing; each of them being financially autonomous. The Health system is based on the concept of providing help to anyone for any medical need. The French Health system of insurance differs from that of the United States in that in the United States, not everyone is entitled to benefits. Individuals and their conditions or problems are subject to rules and regulations and standards of practice. The proposed health care reform adds debt to the United States budget; owever where is the true expense being incurred? And, patients and employers will be forced to make decisions regarding health care solely on the basis of costs. These two items only hurt the people of the United States. Should the government take more of a financial stand with the United States health care system? Environmental Influences on the Healthcare System Controlling costs in both France and the United States is at the forefront of the future state of their health care systems. The French have historically allowed reimbursement to physicians to allow for any and all services they provided, giving them full freedom to determine what services they deemed are necessary. As a result, physicians were exceeding their fee schedules on multiple levels. This is the path the United States has been taking for quite some time now, but they are still in a state of flux. The United States government is looking to reform health care to its fullest potential, when in fact it eeds to be rebuilt. There are portions of health care reform that will help the people yet there are others that will hurt the people. Take for instance the focus on quality. Introducing coverage for preventative medicine will reduce long-term negative effects to the body. And, basing physician and hospital payments on quality will only reduce medical errors; therefore improving the life expectancy

COMPARATIVE STATISTICS ON HEALTH FACILITIES AND POPULATION

pdf

within the United States. Summary In summary, contrary to what one could expect from a large, state-owned and centralized organization, the French Health Care System is very efficient and has the statistics to back it up; however placing controls on physicians could lead them in the direction that the United States seems to have failed..

7: WHO | Health statistics and information systems

Population and Health Status Rated "the best health system in the world" by the World Health Organization in , the French Health Care System serves more than 65 million individuals (French Health Care System).

This causes a significant degree of variation in funding and coverage within the country. History[edit] Canada and the US had similar healthcare systems in the early s, [1] but now have a different mix of funding mechanisms. Mexico established a universal healthcare program by November Please help improve this article by adding citations to reliable sources. Unsourced material may be challenged and removed. February Learn how and when to remove this template message The governments of both nations are closely involved in healthcare. The central structural difference between the two is in health insurance. In Canada, the federal government is committed to providing funding support to its provincial governments for healthcare expenditures as long as the province in question abides by accessibility guarantees as set out in the Canada Health Act , which explicitly prohibits billing end users for procedures that are covered by Medicare. Unlike systems with public delivery, such as the UK, the Canadian system provides public coverage for a combination of public and private delivery. Princeton University health economist Uwe E. Reinhardt says that single-payer systems are not "socialized medicine" but "social insurance" systems, since providers such as doctors are largely in the private sector. The federal government also runs the Veterans Administration , which provides care directly to retired or disabled veterans, their families, and survivors through medical centers and clinics. Nearly 27 million of the 45 million uninsured U. For example, the Health Maintenance Organization Act of provided grants and loans to subsidize Health Maintenance Organizations and contained provisions to stimulate their popularity. HMOs had been declining before the law; by there were such plans enrolling 76 million people. Although some doctors work on a purely fee-for-service basis usually family physicians , some family physicians and most specialists are paid through a combination of fee-for-service and fixed contracts with hospitals or health service management organizations. Non-cosmetic dental care is covered for children up to age 14 in some provinces. Outpatient prescription drugs are not required to be covered, but some provinces have drug cost programs that cover most drug costs for certain populations. In every province, seniors receiving the Guaranteed Income Supplement have significant additional coverage; some provinces expand forms of drug coverage to all seniors, [23] low-income families, [24] those on social assistance, [25] or those with certain medical conditions. Also, some procedures are only covered under certain circumstances. For example, circumcision is not covered, and a fee is usually charged when a parent requests the procedure; however, if an infection or medical necessity arises, the procedure would be covered. Albert Schumacher, former president of the Canadian Medical Association, an estimated 75 percent of Canadian healthcare services are delivered privately, but funded publicly. Same thing with labs and radiology clinics The situation we are seeing now are more services around not being funded publicly but people having to pay for them, or their insurance companies. We have sort of a passive privatization. Yet, even if some cannot find a family doctor, every Canadian citizen is covered by the national health care system. The EMTALA law forces emergency healthcare providers to stabilize an emergency health crisis and cannot withhold treatment for lack of evidence of insurance coverage or other evidence of the ability to pay. In Canada, emergency room treatment for legal Canadian residents is not charged to the patient at time of service but is met by the government. According to the United States Census Bureau , The number of chronically uninsured uninsured all year was estimated at between 21 and 31 million in Specifically, immigrants living in Canada were less likely to have timely Pap tests compared with native-born Canadians; in addition, immigrants in the U. In general, immigrants in Canada had better access to care than those in the U. However, immigrants in the U. Cato Institute has expressed concerns that the U. The institute has urged the Congress to restore the right of American seniors to spend their own money on medical care. Goods and Services Tax or Harmonized Sales Tax depending on the province applies to the services of psychotherapists. Under the Affordable Care Act,

most health plans must also cover certain preventive services without a copayment, co-insurance, or deductible. In the United States, access is primarily determined by whether a person has access to funding to pay for treatment and by the availability of services in the area and by the willingness of the provider to deliver service at the price set by the insurer. In Canada, the wait time is set according to the availability of services in the area and by the relative need of the person needing treatment. Because Medicaid payments are low, some have claimed that some doctors do not want to see Medicaid patients. In Dallas, Texas the wait was 45 days the longest wait being days. Nationwide across the U. The average wait time to see a family practitioner in Los Angeles, California was 59 days and in Boston, Massachusetts it was 63 days. Hospital executives in all five countries expressed concerns about staffing shortages and emergency department waiting times and quality. Many Americans have access to quality healthcare. All Canadians have access to similar care at a considerably lower cost. A new approach is targeting waiting times, which are reported on public websites. In July Holmes agreed to appear in television ads broadcast in the United States warning Americans of the dangers of adopting a Canadian-style health care system. The ads she appeared in triggered debates on both sides of the border. In the United States, the various levels of government spend more per capita than levels of government do in Canada. In looking at the insurance element, in Canada, the provincial single-payer insurance system operated with overheads of 1. Medicare and Medicaid program overheads 3. The report concluded by observing that gap between U. Private spending is also far greater in the U. In the nations were much closer, with Canada spending 7. Administrative costs are also higher in the United States than in Canada. However, since this legislation is not fundamental healthcare reform, it is unclear what its effect will be and as the new legislation is implemented in stages, with the last provision in effect in , it will be some years before any empirical evaluation of the full effects on the comparison could be determined. Although Canadians and Americans have each looked to the other for ways to improve their respective health care systems , there exists a substantial amount of conflicting information regarding the relative merits of the two systems. According to health data collected by the OECD , average income for physicians in the United States in was nearly twice that for physicians in Canada. Out of the gross amount, doctors pay for taxes, rent, staff salaries and equipment. S, there were 2. As it is a much larger market, new and cutting-edge sub-specialties are more widely available in the U. However, statistics published in by the Canadian Institute for Health Information CIHI , show that, for the first time since the period for which data are available , more physicians returned to Canada than moved abroad. In Canada all drugs given in hospitals fall under Medicare, but other prescriptions do not. The provinces all have some programs to help the poor and seniors have access to drugs, but while there have been calls to create one, no national program exists. The Canadian system takes advantage of centralized buying by the provincial governments that have more market heft and buy in bulk, lowering prices. By contrast, the U. In addition, price negotiations by Canadian health insurers are based on evaluations of the clinical effectiveness of prescription drugs, [98] allowing the relative prices of therapeutically similar drugs to be considered in context. The Canadian Patented Medicine Prices Review Board also has the authority to set a fair and reasonable price on patented products, either comparing it to similar drugs already on the market, or by taking the average price in seven developed nations. Both countries spend about the same amount of their GDP on pharmaceutical research, about 0. In a study on medical imaging in Canada, [] it was found that Canada had 4. In wait times of up to 22 months for an MRI were alleged in Saskatchewan. These investments led to an increase in the number of scanners across Canada as well as the number of exams being performed. The number of CT scanners increased from to and MRI scanners increased from 19 to more than tenfold between and The total cost of defending and settling malpractice lawsuits in the U. Administrative costs are significantly higher in the U. One recent study comparing administrative costs in the two countries found that these costs in the U. These costs are higher in the U. They concluded, "Available studies suggest that health outcomes may be superior in patients cared for in Canada versus the United States, but differences are not consistent. Of 10 studies with the strongest statistical validity, 5 favoured Canada, 2 favoured the United States, and 3 were equivalent or mixed. Of 28

weaker studies, 9 favoured Canada, 3 favoured the United States, and 16 were equivalent or mixed. The only consistent pattern was that Canadian patients fared better in kidney failure. In an international comparison of 21 more specific quality indicators conducted by the Commonwealth Fund International Working Group on Quality Indicators, the results were more divided. One of the indicators was a tie, and in 3 others, data was unavailable from one country or the other. Canada performed better on 11 indicators; such as survival rates for colorectal cancer, childhood leukemia, and kidney and liver transplants. It should be noted that the 21 indicators were distilled from a starting list of 100. The authors state that, "It is an opportunistic list, rather than a comprehensive list. The OECD found that Americans have slightly higher rates of smoking and alcohol consumption than do Canadians [] as well as significantly higher rates of obesity. The US population is 12% African Americans have higher mortality rates than any other racial or ethnic group for eight of the top ten causes of death. Latinos have higher rates of death from diabetes, liver disease, and infectious diseases than do non-Latinos. Canada has only half the obesity rate that the US system must deal with. Doctors who study cancer epidemiology warn that the diagnosis of cancer is subjective, and the reported incidence of a cancer will rise if screening is more aggressive, even if the real cancer incidence is the same. Statistics from different sources may not be compatible if they were collected in different ways. The proper interpretation of cancer statistics has been an important issue for many years. Barry Kramer of the National Institutes of Health points to the fact that cancer incidence rose sharply over the past few decades as screening became more common. He attributes the rise to increased detection of benign early stage cancers that pose little risk of metastasizing. For example, as doctors in British Columbia adopted new treatments, survival time for patients with metastatic breast cancer increased from 30 days for those diagnosed in 1970, to 180 days for those diagnosed in 1990. Incidence rates for certain types, such as colorectal and stomach cancer, were actually higher in Canada than in the U.S.

8: FastStats - Health of American Indian or Alaska Native Population

The OECD Health Database offers the most comprehensive source of comparable statistics on health and health systems across OECD countries. It is an essential tool to carry out comparative analyses and draw lessons from international comparisons of diverse health systems.

Overview[edit] Since , The Demographic and Health Surveys DHS Program has provided technical assistance to more than demographic and health surveys in over 90 countries. The strategic objective of The DHS Program is to improve and institutionalize the collection and use of data by host countries for program monitoring and evaluation and for policy development decisions. Provide data on bednet ownership and use, prevention of malaria during pregnancy, and prompt and effective treatment of fever in young children. In some cases, biomarker testing for malaria and anemia are also included. Data[edit] The DHS Program works to provide survey data for program managers, health care providers, policymakers, country leaders, researchers, members of the media, and others who can act to improve public health. The DHS Program distributes unrestricted survey data files for legitimate academic research at no cost. Publications[edit] The DHS Program produces publications that provide country specific and comparative data on population, health, and nutrition in developing countries. Most publications are available online for download, but if an electronic version of the publication is not available, a hard copy may be available. By collecting blood for HIV testing from representative samples of the population of men and women in a country, the DHS Program provides nationally representative estimates of HIV rates. The testing protocol provides for anonymous, informed, and voluntary testing of women and men. The program also collects data on internationally recognized AIDS indicators. The project also collects data on the capacity of health care facilities to deliver HIV prevention and treatment services. Malaria[edit] Since , DHS and some AIS surveys have collected data on ownership and use of mosquito nets, treatment of fever in children, and intermittent preventive treatment of pregnant women. In recent years, additional questions on indoor residual spraying, and biomarker testing for anemia and malaria have been conducted. This has however not changed the trend in malaria infections thereby calling for more interventions by researchers and scientists. Questions on gender roles and empowerment are integrated into most DHS questionnaires. For countries interested in more in-depth data on gender, modules of questions are available on specific topics such as status of women, domestic violence , and female genital mutilation. The Youth Corner on the DHS website presents findings about youth and features profiles of young adults ages 15â€”24 from more than 30 countries worldwide. The DHS Program routinely collects geographic information in all surveyed countries. Using GIS, researchers can link DHS data with routine health data, health facility locations, local infrastructure such as roads and rivers, and environmental conditions. Biomarkers[edit] Using field-friendly technologies, the DHS Program is able to collect biomarker data relating to conditions and infections. DHS surveys have tested for anemia by measuring hemoglobin , HIV infection, sexually transmitted diseases such as syphilis and the herpes simplex virus, serum retinol Vitamin A , lead exposure, high blood pressure, and immunity from vaccine-preventable diseases like measles and tetanus. Traditionally, much of the data gathered in DHS surveys is self-reported. Biomarkers complement this information by providing an objective profile of a specific disease or health condition in a population. Biomarker data contributes to the understanding of behavioral risk factors and determinants of different illnesses.

9: Why Are Statistics Important in the Health Care Field? | www.enganchecubano.com

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