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World's Best Hospitals 2026 – Methodology

Table of contents

- 1 Introduction 1
- 2 Study Design 3
 - 2.1 New features and changes in the 2026 edition..... 3
 - 2.2 Scoring Model – country-specific lists..... 4
 - 2.2.1 Hospital quality metrics 5
 - 2.2.2 Hospital recommendations from peers 6
 - 2.2.3 Patient experience..... 7
 - 2.2.4 Statista PROMs Implementation Survey 8
 - 2.3 Global Top 250 List..... 13
 - 2.4 Specialty Hospitals 14
 - 2.5 The Global Board of Experts 15
- 3 Country-Specific Methodology 16
 - a. United States of America 16
 - b. Germany 30
 - c. Japan..... 33
 - d. South Korea 35
 - e. France..... 37
 - f. Italy 39
 - g. United Kingdom 41
 - h. Brazil..... 43
 - i. Spain..... 44
 - j. Canada 48
 - k. Australia 51
 - l. Saudi Arabia..... 52
 - m. Netherlands..... 53
 - n. Switzerland 54
 - o. United Arab Emirates 56
 - p. Austria 58
 - q. Belgium 59
 - r. Sweden..... 60
 - s. Norway 61
 - t. Denmark 63
 - u. Israel..... 65
 - v. Other Countries..... 67

4 Distribution of participants 69

5 Disclaimer 70

Literature 71

Appendix A 79

Appendix B 80

Appendix C 113

1 Introduction

Patients are faced with the critical and difficult decision of choosing the right hospital for their medical needs, a choice that was often determined solely by word of mouth or the recommendation by a single physician (e.g., their general practitioner) in the past. Structural characteristics of a hospital, such as its number of beds or its number of medical staff, are unreliable indicators for quality of care and therefore not suited as a basis for decision-making. In the last decade, the number of web-based portals, websites, and databases that aim to help with this decision by providing data about hospitals has increased, ranging from relatively short and superficial news articles to specific databases with multiple quality indicators per hospital within a specific country. However, none of the available resources to date have achieved a methodologically sound international ranking of hospitals based on a comprehensive score that gives an indication of where each hospital stands relative to its peers. Most available resources lack a comprehensive overview of the major hospitals even within a single country, tending instead to focus on particular specialties or diseases and rarely offering a comparative ranking.

The **World's Best Hospitals 2026** ranking is a project which aims to close this gap by **ranking the best hospitals across the world**. As of today, this ranking is the best and most comprehensive resource for global top lists in the hospital sector. As of today, this ranking is the best and most comprehensive resource for global top lists in the hospital sector. Thirty-two countries are featured in the 2026 edition: Australia, Austria, Belgium, Brazil, Canada, Chile, Colombia, Denmark, Finland, France, Germany, India, Israel, Italy, Japan, Malaysia, Mexico, the Netherlands, Norway, the Philippines, Saudi Arabia, Singapore, South Korea, Spain, Sweden, Switzerland, Taiwan, Thailand, Turkey, the United Arab Emirates, the United Kingdom, and the United States of America. The countries were selected mainly based on standard of living and life expectancy, population size, number of hospitals, and data availability.

The current 2026 edition of the ranking is an extension and update of the annual World's Best Hospitals ranking, which was first published by Newsweek and Statista in March 2019 and featured the top 1,000 hospitals in 11 countries. In the 2026 edition, **32 countries and 2,530 hospitals are featured in total** - the most extensive and international edition to date. The number of hospitals awarded in each country varies based on the number of existing hospitals, average hospital size (commonly approximated by number of inpatient beds), and data availability in the respective countries. The list lengths vary

by country, with 420 USA-based hospitals included, while Israel and Singapore are represented with 10 hospitals each.

Hospitals that are not accessible to the public and/or are very small were excluded from the ranking, as they were very unlikely to receive enough recommendations to make the final list and are not comparable to general hospitals in the range of services provided. The authors of this study used the average number of beds per hospital in each country as a guideline to identify very small hospitals, resulting in varying thresholds per country. This approach accounts for the substantial differences in average hospital sizes across countries and ensures a base level of comparability of national hospitals.

Every hospital in each country was rated with a score, which is based on four data sources:

- **Hospital quality metrics**
- **Recommendations from medical experts** (doctors, hospital managers, healthcare professionals)
- Existing **patient experience** data
- **Statista Patient-Reported Outcome Measures (PROMs)** Implementation Survey

The national lists are only comparable for hospitals within the same country because different sources for patient experience and hospital quality metrics were examined in each country, and given the complexity of the various data sources, it was not possible to harmonize this data. For the same reason, cross-country comparisons of the raw values of the scores are also not possible (example: a score of 90 in country A does not necessarily mean that this hospital is better than a hospital with a score of 87 in country B).

Nevertheless, one aim of this project was to create a **Global Top 250 ranking**. To achieve this, the number of international recommendations, the national rank, the PROMs implementation excellence, the quality metrics/patient experience excellence, and a bibliometric score based on research output were combined into a global rank, resulting in a Global Top 250 list (see chapter 2.3).

The overall aim of this study is to provide the best possible data-based comparison of hospital reputation and performance across countries.

To this end, the World's Best Hospitals 2026 ranking is intended to be a resource to help patients make a more informed and data-driven decision when choosing the right hospital for their medical needs, as well as to provide a composite benchmark for hospitals that is indicative of their relative performance when compared to their national and international peers.

2 Study Design

The following sections provide an overview of the study design and the underlying methodology used to determine the various rankings. First, the newly implemented features and changes in this year's edition will be described. Second, the scoring model is outlined in chapter 2.2, followed by the approaches that were used to create the Global Top 250 list and a specialized hospital list (chapter 2.3 and 2.4), and a description of the role of the global board of medical experts (chapter 2.5). This section is followed by a more in-depth description of specific rankings in chapter 3.

2.1 New features and changes in the 2026 edition

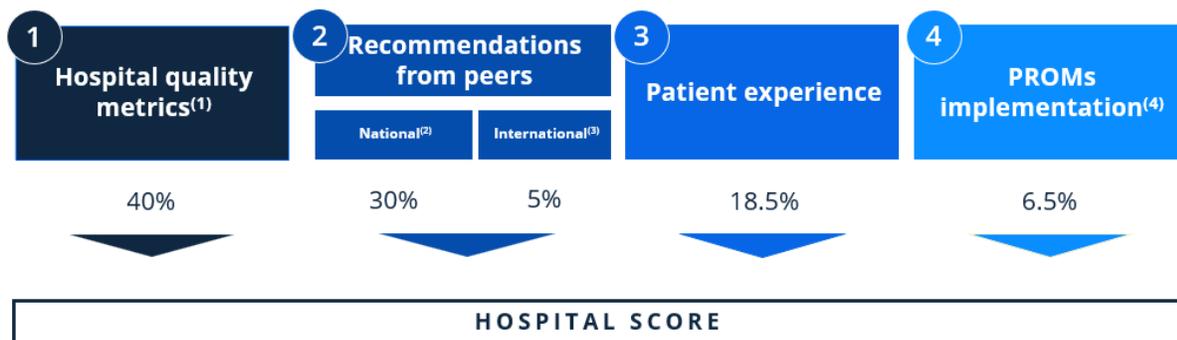
The following list provides a brief overview of all major changes in this year's edition compared to the World's Best Hospitals 2025 ranking:

- **Adjustment of the scoring weighting:** This year, the weighting of the hospital quality metrics pillar was increased again within the scoring model to reflect the emphasis on medical key performance indicators. In addition, the weighting of the PROMs implementation pillar was increased.
- **Addition of two new countries:** Hospitals from the Philippines and Turkey were now included in the World's Best Hospital ranking. One goal of this project is to increase the global coverage to provide the reader with the most comprehensive ranking of the World's Best Hospitals. The additional countries were primarily chosen based on data availability and comparability of high-quality health care systems.
- **Inclusion of new accreditations:** Accreditations reflect a range of structural and/or quality requirements that are relevant for the national rankings (see chapter 3). Examples of new accreditations are the American Accreditation Commission International (AACI) (for India, Thailand, Turkey), Europe Qualicore (for the Netherlands), Philippine Health Insurance Corporation (PhilHealth) (for the Philippines) and Türkiye Health Care Quality and Accreditation Institute (TÜSKA) (for Turkey).

- **Statista PROMs Implementation Survey:** The survey, eligibility thresholds, and display of participating hospitals have been updated.
- **New hospital quality metrics data sources:** Several new hospital data sources were added, most notably data from the Observatorio de resultados del Servicio Madrileño de Salud and Agència de Qualitat i Avaluació Sanitàries de Catalunya (AQuAS) for Spain and from the Department of Health - Abu Dhabi (DOH) for the United Arab Emirates (see chapter 2.s and 2.t for details)
- **New patient experience data sources:** New patient experience data were added from the Observatorio de resultados del Servicio Madrileño de Salud and Agència de Qualitat i Avaluació Sanitàries de Catalunya (AQuAS) for Spain and the Ministry for Health for Saudi Arabia (see chapter 2.s and 2.u)
- **New quality metrics for the USA ranking:** Leapfrog Hospital Safety and Quality Data have been included, as well as additional metrics from CMS relevant to hospital harm, and to venous thromboembolism and antithrombotic care.

2.2 Scoring Model - country-specific lists

The scoring model of the World's Best Hospitals 2026 project is based on four pillars: The hospital quality metrics score, the national recommendation score, the international recommendation score, the patient experience score, and the PROMs implementation score, using different weights for the individual components, as shown in this overview:



The hospital score is the weighted average of the available scores for each hospital. Based on this score and the chosen cut-off for list length in the given country, hospitals are ranked from top to bottom in each country. The results of this ranking are displayed in the country lists published by Newsweek:

Result tables of the best hospitals in each country

World's Best Hospitals – United States

Rank	Hospital	Score	City
1	Mayo Clinic - Rochester	96.28%	Rochester
2	Cleveland Clinic	92.13%	Cleveland
3	Massachusetts General Hospital	91.96%	Boston
4	The Johns Hopkins Hospital	89.77%	Baltimore
5	Ronald Reagan UCLA Medical Center	89.68%	Los Angeles

[...]

World's Best Hospitals - Germany

Rank	Hospital	Score	City
1	Charité - Universitätsmedizin Berlin	92,59%	Berlin
2	Universitätsklinikum Heidelberg	86,90%	Heidelberg
3	LMU Klinikum	83,15%	Munich
4	Klinikum rechts der Isar der Technischen Universität München	81,44%	Munich
5	Universitätsklinikum Hamburg-Eppendorf	80,27%	Hamburg

[...]

2.2.1 Hospital quality metrics

Hospital quality metrics from a variety of public sources were collected for most countries. These metrics differ greatly between countries. Some examples of indicators are:

- Data on quality of care for specific treatments, such as hip replacement or closure of inguinal hernia
- Data on hygiene measures and patient safety
- Data on staffing, e.g., number of patients per doctor/nurse

An overview of the hospital quality metrics used in each country is provided in chapter 3.

The data sources were identified through an extensive research process in each country and through consultation with local experts. Some publicly available data sources were excluded for reasons mostly related to data quality and/or availability (e.g., certain data was available only for a small number of hospitals in a given country or the number of missing values in the hospital quality metrics was too high to perform a valid analysis). As a result of this process, hospital quality metrics were not available for Chile, Colombia, India, Finland, Malaysia, Mexico, the Netherlands, the Philippines, Saudi Arabia, Singapore, Taiwan, Thailand and Turkey¹. For each country with available data, a hospital quality metrics score (0–100%) was calculated based on the characteristics of the specific dataset.

¹ Hospital quality metrics were not available for some parts of Belgium, Spain and United Arab Emirates

When a country lacks hospital quality metrics, weights are re-proportioned based on the model's original weighting across the pillars for which data are available, ensuring the total equals 100%

2.2.2 Hospital recommendations from peers

Newsweek and Statista invited **over 100,000 medical experts (doctors, hospital managers, and other healthcare professionals, such as nurses) in the 32 countries surveyed to participate** in the online survey.

The data was collected by Newsweek and Statista during an initial survey period from September to November 2025. The survey was also promoted on newsweek.com. Participants were asked to recommend hospitals in their own country as well as in other countries. The questionnaire did not suggest a list of recommended hospitals; therefore, respondents were free to suggest any hospital they deemed recommendable (merely aided by an autocomplete function for convenience). Self-recommendations were not allowed. Statista performed plausibility checks on all data to prevent self-nomination. Answers were then weighted based on (a) the type of respondent by profession (with doctors receiving the highest weight) and (b) the confidence respondents had in their vote (0–100%). The survey period resulted in more than 70,000 individual hospital recommendations.

Finally, the combined data was analyzed, and a national, as well as an international, recommendation score (0–100%) was calculated for every hospital in each country based on the weighted number of national and international recommendations. The hospital with the highest number of weighted national recommendations always received a national recommendation score of 100%. The next best hospitals, in general, received a score relative to the number of weighted national and international votes they received (e.g., when hospital A received the most votes with 100, hospital B with 80 votes received a score of $\frac{80}{100} = 80\%$). In some cases, mostly for smaller countries, where one hospital would accumulate significantly more votes than the next best hospitals, the scoring curve was smoothed slightly to reduce the drop-off in relative scores (e.g., the above-mentioned hospital B would be adjusted to around 85% or 90% in the same situation, but always less than the leading hospital). Since the achieved score is relative only to other hospitals within the same country, it is reasonable to grade hospitals by the number of recommendations received.

This year, the recommendations from the past two years were considered. Recommendations from the 2023 and 2024 survey period were given less weight compared to those from 2025.

2.2.3 Patient experience

Publicly available data from existing patient surveys were used to analyze patient experience. Patient experience surveys are typically conducted by insurance companies among patients after their hospitalization, as well as by hospitals. Depending on the country and available data, these surveys range from basic satisfaction questions to more sophisticated patient experience measurements using validated instruments (for specifics, see country sections in chapter 3).

Examples of survey topics include:

- General satisfaction with hospital
- Recommendation of hospital
- Satisfaction with medical care
- Satisfaction with service and organization

As a dimension of perceived quality, **patient experience reflects both the quality of care** (from the patient's perspective) **as well as the patient's satisfaction with the hospital stay**, including service factors such as friendliness of the staff or quality of food. Although there is some overlap between medical outcomes and hospital quality metrics, we consider patient experience a separate quality dimension as has been established in scientific literature on patient-reported outcomes and patient-reported experiences in recent years.

An overview of the patient experience data used in each country is provided in chapter 3.

Data on patient experience from official sources was not available for hospitals in Australia, Austria, Belgium (all regions excluding Flanders), Brazil, Canada, Chile, Colombia, Finland, India, Japan, Malaysia, Mexico, Norway, the Philippines, Singapore, Spain (all regions excluding Madrid and Catalonia), Sweden, Taiwan, Thailand, Turkey, the United Arab Emirates and the United Kingdom. In these countries, Google reviews serve as a substitute but were considered with a lower weight in the scoring model because these are less reliable as a data source, the weight of patient experience in the scoring model was reduced to 7.5 %.

When a country lacks patient experience data, weights are re-proportioned based on the model's original weighting across the pillars for which data are available, ensuring the total equals 100%.²

Based on the available data, a patient experience score (0–100%) was calculated for every hospital in each country using the weighted sum of indicators available in the specific data set. To enable comparability across facilities with differing review volumes, facility scores were adjusted using a Bayesian weighted scoring approach that accounts for variation in the number of reviews.

2.2.4 Statista PROMs Implementation Survey

Importance of Patient-Reported Outcome Measures

Patient-reported outcome measures (PROMs) are standardized, psychometrically validated questionnaires completed directly by patients to assess their health status, symptoms, functional outcomes, and health-related quality of life (Dawson et al., 2010; Churruca et al., 2021; Kingsley et al., 2017). Unlike traditional clinical indicators, PROMs capture aspects of health that are best known by patients themselves, such as pain, functioning, and overall well-being, and therefore provide insights that cannot be adequately obtained through clinical observation or administrative data alone (Dawson et al., 2010; Al Sayah et al., 2021; Kluzek et al., 2022). Over the past few decades, PROMs have become an increasingly important component of patient-centered and value-based healthcare frameworks, reflecting a broader emphasis toward measuring outcomes that matter most to patients (Bianchim et al., 2023; Orr et al., 2021; Bates et al., 2023; Cheville et al., 2022).

Evidence has shown that the systematic collection and use of PROMs can improve communication between patients and clinicians, support shared decision-making, and enhance the quality of care (Chen et al., 2013; Marshall et al., 2006; Santana et al., 2014; Nelson et al., 2015). PROMs data can facilitate the early identification of symptom worsening, highlight unmet patient needs, and support timely adjustments to treatment in clinical practice (Bonsel et al., 2024; Consolo et al., 2023; Meehan et al., 2025). Beyond individual patient care, aggregated PROMs data increasingly contribute to supporting hospital performance monitoring and benchmarking across providers and regions, as well as driving quality improvement initiatives (Bonsel et al., 2024; Kendir et al., 2025).

International organizations and health systems have emphasized PROMs as essential tools for measuring healthcare quality (Organisation for Economic Co-operation and

² There was no redistribution for the 7.5% of the Google Star rating

Development (OECD), 2025a). PROMs have been incorporated into national registries, clinical programs, and outcome-based payment and performance frameworks in multiple countries, reflecting their growing role in evaluating and improving healthcare delivery (Kendir et al., 2025; Ruseckaite et al., 2023; Steinbeck et al., 2021). At the same time, the extent to which PROMs are implemented, systematically reported, and actively used varies widely across hospitals and healthcare systems, underscoring the need for structured approaches to assess the maturity and depth of PROMs implementation in clinical institutions (Steinbeck et al., 2021; Williams et al., 2016; Ernst et al., 2022).

In this context, Statista developed the PROMs Implementation Survey to systematically assess the status, scope, and quality of PROMs implementation in hospitals worldwide. The survey aims to capture not only the presence of PROMs measurement, but also the organizational structures, reporting practices, validation mechanisms, and real-world use of PROMs data to improve healthcare delivery.

Survey Development and Expert Governance

The Statista PROMs Implementation Survey is developed and continuously refined with methodological input from Statista's global board of medical experts. The board consists of senior clinicians, healthcare leaders, and subject-matter experts with extensive experience in outcome measurement, quality improvement, and value-based healthcare. Their role is to ensure that the survey reflects current clinical practice, methodological rigor, and international best practices in PROMs implementation.

Each year, the expert board reviews the existing survey structure and provides recommendations for updates, refinements, and expansions. For the 2026 ranking cycle, the survey underwent a comprehensive overhaul to reflect the increasing maturity and complexity of PROMs use in hospital settings. This redesign was driven by expert feedback emphasizing the need to assess not only whether PROMs are collected, but how they are validated, reported, audited, and actively used to inform care and decision-making.

The revised survey therefore expands both the breadth and depth of assessment, covering organizational responsibility, instrument selection, case-mix adjustment, response rates, reporting practices, audits, and multiple dimensions of PROMs data utilization. Throughout the development process, expert input ensured that the questions capture meaningful differences in PROMs implementation while remaining applicable across diverse healthcare systems and hospital types.

Survey Structure

The PROMs Implementation Survey is designed to evaluate the extent and maturity of PROMs implementation in hospitals. It assesses the use of both generic and condition-specific PROMs across clinical departments, as well as the hospital's processes for reporting, validating, and applying PROMs data.

The survey covers several core domains, including:

- PROMs implementation status within the hospital
- Organizational responsibility, including designated teams or individuals responsible for PROMs
- Measurement practices, including the number and type of standardized PROMs instruments used across departments
- Methodological rigor, including scientific validation, case-mix adjustment, response rates, and follow-up intervals
- Internal reporting, including reporting to clinicians, hospital management, and patients
- External reporting, including public reporting, scientific publications, national and international registries
- Data auditing, including internal and external audits
- Use of PROMs data, including quality improvement, real-time therapeutic decision-making, shared decision-making, benchmarking, research, and innovation initiatives

A detailed overview of all survey questions, definitions, and documentation requirements is provided in the full questionnaire, which is included in Appendices A and B.

Data Collection

The survey was distributed to hospitals via email during fall/winter 2025, with additional participation possible through dedicated survey portals on newsweek.com and rankings.statista.com. The survey remained open between September and December 2025, allowing hospitals sufficient time to compile and submit the required information and documentation.

A key enhancement in the 2026 cycle was the introduction of extensive proof requirements as a validation measure. To ensure the accuracy and credibility of the data, hospitals were required to substantiate nearly all survey responses with supporting documentation. Depending on the question, this included such documents as PDF samples of PROMs instruments used, examples of internal and external PROMs reports, links or

documents demonstrating data reporting, evidence of data audits, documentation of PROMs use in clinical programs, research, benchmarking, or innovation initiatives, and more.

Survey responses without adequate proof documentation submitted were not eligible for scoring. This approach was implemented to ensure that scores reflect verified PROMs practices rather than stated intentions alone.

Senior Management Validation

As an additional safeguard to ensure data validity, all survey submissions required formal validation by a member of the hospital's senior management. This validation confirmed that the submitted responses accurately reflected the hospital's PROMs implementation to the best of the validating individual's knowledge.

Eligible validators included senior executives or hospital management (e.g., CEOs, CMOs, etc.), who could provide validation either via a signed PDF form or an official confirmation email.

Data Review, Verification, and Validation

During the analysis phase, Statista's team of analysts conducted a thorough review of each survey submission, involving a detailed assessment of all responses and accompanying proof documents to determine whether the criteria required for each question were met.

Points were awarded only when sufficient and appropriate proof was provided. In cases where documentation was incomplete, unclear, or partially met the criteria, hospitals either received partial points or were asked to submit additional information. Analysts engaged in direct communication with hospitals to clarify responses, request supplementary documentation, and ensure that hospitals received the points they were eligible for based on their actual level of PROMs implementation.

A further enhancement in the 2026 cycle was the introduction of structured validation checks after submission. These included validation calls and follow-up emails with hospitals where additional clarification was needed. During these interactions, senior staff or PROMs-responsible teams explained their PROMs processes in detail, allowing Statista to integrate this information into the final evaluation and thereby strengthening the robustness of the methodology.

Scoring and Ribbon Allocation

Each survey question and sub-question contributed to the overall PROMs implementation score through a weighted point system. Points were aggregated across all survey domains to produce a final PROMs score expressed as a percentage of the maximum achievable score.

Based on this final score and relevant subscores, hospitals were assigned between one and five ribbons to reflect their level of PROMs implementation:

- 1 Ribbon: <43%
- 2 Ribbons: 43 to <58%
- 3 Ribbons: 58 to <76% *AND* internal or external reporting subscore > 0%
- 4 Ribbons: 76 to <92% *AND* internal reporting subscore > 0%
- 5 Ribbons: 92 to 100% *AND* auditing subscore > 0%

One ribbon indicates a basic level of PROMs implementation and replaces the checkmark used in previous years. Higher ribbon levels reflect progressively more advanced, comprehensive, and integrated PROMs practices. Hospitals achieving five ribbons demonstrated a high degree of maturity across nearly all assessed dimensions, including measurement, reporting, validation, and use of PROMs data.

Hospitals that completed the survey but do not measure PROMs did not receive a ribbon.

Please note that for the current ranking cycle, the PROMs Implementation Survey was significantly expanded and the scoring methodology revised, including stricter proof requirements and a transition from a 3-ribbon system (and including a checkmark designation for basic levels of implementation) to a 5-ribbon scale. As a result, ribbon allocations may differ from previous years even in cases where hospitals have maintained comparable levels of PROMs implementation, as performance is now assessed across a broader and more detailed set of criteria.

For the *World's Best Hospitals* ranking, PROMs implementation is assessed at the hospital level; therefore, if PROMs were measured and documented in at least one clinical department, the resulting PROMs score was applied to the hospital as a whole.

Knowledge Partnership with ICHOM

Since 2024, Statista has partnered with the International Consortium for Health Outcomes Measurement (ICHOM) as a knowledge partner. ICHOM is the world's leading non-profit organization dedicated to transforming healthcare through the applied use of standardized patient-centered outcomes measurement. ICHOM convenes and empowers patients and clinical leaders to identify and standardize the most important clinical,

quality of life, function, and experience results for healthcare, and enables transparent, large-scale use by various stakeholders to achieve patient-centric health system transformation. By working with partners around the world, ICHOM builds evidence-based, patient co-created resources—the standardized sets of patient-centered outcome measures—that help all actors in healthcare design, deliver, and evaluate care based on outcomes that matter to patients. ICHOM sets cover a large variety of medical conditions and account for nearly 60% of the global burden of disease. They have been implemented in over 500 care settings across more than 42 countries. Drawing from their widely recognized expertise and experience in the field of clinical and patient-reported outcome measures, ICHOM is contributing to the future development of the PROMs Implementation Survey and to the wider advancement of value-based care worldwide.

More information about ICHOM is available at: www.ichom.org

2.3 Global Top 250 List

In addition to the country lists (see chapter 2.2), a global list was created to identify the Top 250 best hospitals worldwide.

The **Global Top 250 List** is determined by six metrics:

- International recommendations
- National rank
- Quality metrics excellence
- Patient experience excellence
- PROMs implementation excellence
- Bibliometric scores

The first component concerns the international recommendations received by hospitals in the peer recommendation survey. As this pillar is irrespective of respondents' nationality, it provides a standardized metric that is comparable across countries. The second component incorporates hospitals' positions within their respective national rankings. The rationale underlying the international scoring model is that hospitals with higher national rankings should not be placed lower globally than their national peers, thereby ensuring internal validity. For example, a hospital ranked first in country A was positioned above the hospital ranked second in country A on the global list.

The third and fourth pillars refer to the excellence levels of hospitals within their respective national rankings. Hospitals whose performance within the quality metrics and/or patient experience pillars was in the top 20% for the respective country were eligible for the quality metrics excellence and patient experience excellence pillars, respectively.

The fifth pillar incorporated is the *PROMs Implementation Survey*. Hospitals that meet the grading threshold were eligible for the PROMs implementation excellence pillar within the global list, to equally reflect the importance of PROMs and value-based healthcare within our rankings.

The final pillar is the bibliometric score. This component was incorporated as a proxy for institutional reputation based on quantitative indicators more closely associated with research output, rather than on expert opinion. For this pillar, data was sourced from Exaly³. Exaly is a nonprofit project that compiles a database containing scientometric indices, such as impact factor, h-index, g-index, number of publications, etc., at several levels, including authors, schools, and institutions. For the bibliometric score, data on the h-index, number of citations, and number of publications at the institution level were analyzed.

The global list does not include specialized hospitals for the same reasons they were separated from the national rankings. Hospitals that were distinguished in this Global Top 250 List are the very best hospitals in each country and, therefore, across the world. Out of 2,530 hospitals included in the 2026 World's Best Hospitals Ranking, this elite group represents the top 10% of all hospitals, making this the most prestigious ranking available to date.

2.4 Specialty Hospitals

The study is aimed at rating the reputation and performance of general hospitals. Accordingly, the hospital quality metrics and patient experience scores used in this study are based on general hospital indicators that enable comparability across general hospitals and do not reflect specialty-specific outcomes (e.g., cancer-specific indicators).

Due to the open design of the survey, participants could not be restrained from recommending specialized hospitals. However, because the survey does not collect recommendations for specific indications or patient groups, specialized hospitals were not ranked by performance within their respective medical fields; for example, there is no ranking among hospitals specializing in cancer care, as respondents were not asked to recommend hospitals specifically for cancer patients.

Hospital quality metrics and patient experience data were also compiled for specialized hospitals using the same types of data sources as for general hospitals. However, these general indicators are not designed to assess performance within a given specialty and therefore do not allow conclusions about how well a specialized hospital performs in its

³ Relevant data points (publications, citations, h-index) were sourced from [Exaly](#).

specific medical field. In addition, specialized hospitals differ substantially from general hospitals in scope of services and case mix. For these reasons, specialized hospitals are not included in the main national ranking of general hospitals, and the composite score calculated using the approach described in chapter 2.2 is not used to assign rank positions to specialized hospitals.

At the same time, some specialized hospitals received a sufficient number of peer recommendations and performed well on the applied general quality metrics and patient experience measures. For transparency, these specialized hospitals are therefore not omitted completely; instead, they are displayed at the end of each country list. This section is sorted alphabetically. No conclusions should be drawn from the order of specialized hospitals within this section, as specialties are highly heterogeneous with respect to treatments/procedures and patient populations (e.g., heart clinics compared to psychiatric clinics). Given the limited number of hospitals represented per country, inclusion in this section indicates that these specialized hospitals were recommended by peers frequently enough—and showed strong results on the applied general indicators—to stand out compared with other specialized hospitals in the same country that are not listed.

2.5 The Global Board of Experts

The following section outlines the function of the global board of medical experts founded by Statista to support the World's Best Hospitals project.

The idea behind the global board of medical experts is to create an independent body that is tasked with the continuous development of the quality and scope of the project. The global board of medical experts is therefore tasked with providing guidance and input for the development and future expansions of the methodology. This includes input regarding new data sources, future methodological considerations, and the ongoing development of the *PROMs Implementation Survey*. The members of the global board of medical experts were carefully chosen based on their national and international expertise, decades-long experience in their respective medical fields, as well as their scientific output. Current members of the global board of medical experts are:

A global board of renowned experts supports the continuous development of the methodology



The global board of medical experts and the Statista team also gather for an annual conference where they discuss the status quo as well as new ideas and future improvements to the methodology in person.

3 Country-Specific Methodology

The following section expands on the general methodology outlined in chapter 2 by describing country-specific lists and data sources for countries with hospital quality metrics and/or patient experience data.

a. United States of America

There are currently around 6,093 hospitals in the USA, according to the American Hospital Association (American Hospital Association, 2025). The majority of hospitals (around 84%) are classified as community hospitals, which are defined as all nonfederal, short-term general hospitals, as well as other specialized hospitals. Hospitals that are not accessible to the general public, such as prison hospitals or college infirmaries, are excluded. The number of total staffed beds in all community hospitals in the U.S. is currently 781,148 (American Hospital Association, 2025).

Community hospitals differ in terms of ownership type, with around 2,987 being non-government not-for-profit community hospitals, 1,214 being for-profit community hospitals, and the remaining 920 being state and local government community hospitals. There is also a smaller number of other hospitals, such as federal government hospitals

(around 207) and nonfederal psychiatric hospitals (around 654). Texas and California have the highest number of community hospitals, with 498 and 352 respectively, while Delaware and the District of Columbia have the fewest, with 10 hospitals each. (American Hospital Association, 2025)

The hospital quality metrics used for the USA ranking is based on four sub-pillars. The data sources used for these sub-pillars include data from the Centers for Medicare & Medicaid Services (CMS), data from the Leapfrog Hospital Survey, data from American Hospital Association Annual (AHA) Survey, and relevant hospital accreditations.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) publicly reports hospital-level information for over 4,600 U.S. hospitals through the Care Compare program. These data include hospital characteristics, clinical quality measures, patient experience metrics, and performance indicators, with related Medicare utilization and payment data available through public datasets. The most recent data, published November 2025, is used to determine the CMS quality score.

The framework for the CMS sub-pillar is based on the CMS Star Rating methodology, which provides a conceptual reference for our approach⁴. We adopt the CMS classification of quality indicators into categories, each representing a distinct domain of care quality, and apply the underlying logic of category weighting, with adaptations where necessary to align with the objectives of this analysis. In addition, we broaden the scope of measurement by incorporating indicators beyond those included in the CMS Star Ratings. These supplementary indicators are assessed using a consistent methodological approach and are fully integrated into the final composite score, ensuring a comprehensive and nuanced evaluation while maintaining comparability with the CMS framework.

The following indicators are grouped into CMS categories for evaluation:

	Mortality	Measure code	Data collection	
			From	Through
1.	Death rate for heart attack patients	MORT_30_AMI	7/1/2021	6/30/2024
2.	Death rate for coronary artery bypass graft (CABG) surgery patients	MORT_30_CABG	7/1/2021	6/30/2024
3.	Death rate for chronic obstructive pulmonary disease (COPD) patients	MORT_30_COPD	7/1/2021	6/30/2024

⁴ The Star Rating methodology is publicly available through the CMS website: <https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/>

4.	Death rate for heart failure patients	MORT_30_HF	7/1/2021	6/30/2024
5.	Death rate for pneumonia patients	MORT_30_PN	7/1/2021	6/30/2024
6.	Death rate for stroke patients	MORT_30_STK	7/1/2021	6/30/2024
7.	Deaths among patients with serious treatable complications after surgery	PSI_04	7/1/2022	6/30/2024

Safety of Care		Measure code	Data collection	
			From	Through
1.	Central line-associated bloodstream infections (CLABSI)	HAI-1	1/1/2024	12/31/2024
2.	Catheter-associated urinary tract infections (CAUTI)	HAI-2	1/1/2024	12/31/2024
3.	Surgical site infections from colon surgery (SSI: Colon)	HAI-3	1/1/2024	12/31/2024
4.	Surgical site infections from abdominal hysterectomy (SSI: Hysterectomy)	HAI-4	1/1/2024	12/31/2024
5.	Methicillin-resistant <i>Staphylococcus Aureus</i> (MRSA) Blood Laboratory-identified Events (Bloodstream infections)	HAI-5	1/1/2024	12/31/2024
6.	<i>Clostridium difficile</i> (<i>C. diff.</i>) Laboratory-identified Events (Intestinal infections)	HAI-6	1/1/2024	12/31/2024
7.	Rate of complications for hip/knee replacement patients	COMP-HIP-KNEE	4/1/2021	3/31/2024
8.	Serious complications	PSI_90	7/1/2022	6/30/2024

Readmission		Measure code	Data collection	
			From	Through
1.	Hospital return days for heart attack patients	EDAC-30-AMI	7/1/2021	6/30/2024
2.	Rate of readmission for coronary artery bypass graft (CABG) surgery patients	READM-30-CABG	7/1/2021	6/30/2024
3.	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients	READM-30-COPD	7/1/2021	6/30/2024

4.	Hospital return days for heart failure patients	EDAC-30-HF	7/1/2021	6/30/2024
5.	Rate of readmission after hip/knee surgery	READM-30-HIP-KNEE	7/1/2021	6/30/2024
6.	Hospital return days for pneumonia patients	EDAC-3-PN	7/1/2021	6/30/2024
7.	Hybrid Hospital-Wide All-Cause Readmission Measure (HWR)	Hybrid_HWR	7/1/2023	6/30/2024
8.	Rate of unplanned hospital visits after an outpatient colonoscopy	OP-32	1/1/2021	12/31/2023
9.	Rate of unplanned hospital visits for patients receiving outpatient chemotherapy	OP-35-ADM	1/1/2023	12/31/2023
10.	Rate of emergency department (ED) visits for patients receiving outpatient chemotherapy	OP-35-ED	1/1/2023	12/31/2023
11.	Ratio of unplanned hospital visits after hospital outpatient surgery	OP-36	1/1/2023	12/31/2023

Timely and Effective Care		Measure code	Data collection	
			From	Through
1.	Percentage of healthcare workers given influenza vaccination	IMM_3	10/1/2024	3/31/2025
2.	Percentage of patients who left the emergency department before being seen	OP_22	1/1/2023	12/31/2023
3.	Head CT results	OP_23	1/1/2024	12/31/2024
4.	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy	OP_29	1/1/2023	12/31/2023
5.	Percentage of patients who received appropriate care for severe sepsis and septic shock.	SEP_1	1/1/2024	12/31/2024
6.	Average (median) time patients spent in the emergency department before leaving from the visit	OP_18b	1/1/2024	12/31/2024

7.	Safe Use of Opioids - Concurrent Pre-prescribing	SAFE_USE_OF_OPIOIDS	1/1/2024	12/31/2024
8.	Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments first, such as physical therapy	OP-8	7/1/2023	6/30/2024
9.	Percentage of outpatient CT scans of the abdomen that were “combination” (double) scans	OP-10	7/1/2023	6/30/2024
10.	Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery	OP-13	7/1/2023	6/30/2024

Patient Reported Outcomes		Measure code	Data collection	
			From	Through
1.	Total Hip Arthroplasty and/or Total Knee Arthroplasty	THA/TKA PRO-PM	1/1/2024	6/30/2023

Supplementary indicators		Measure code	Data collection	
			From	Through
1.	Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate	Hybrid_HWM	7/1/2023	6/30/2024
2.	Hospital Harm - Severe Hypoglycemia	HH_HYPO	1/1/2024	12/31/2024
3.	Hospital Harm - Severe Hyperglycemia	HH_HYPER	1/1/2024	12/31/2024
4.	Hospital Harm - Opioid Related Adverse Events	HH_ORAE	1/1/2024	12/31/2024
5.	Discharged on Antithrombotic Therapy	STK_02	1/1/2024	12/31/2024
6.	Venous Thromboembolism Prophylaxis	VTE_1	1/1/2024	12/31/2024
7.	Intensive Care Unit Venous Thromboembolism Prophylaxis	VTE_2	1/1/2024	12/31/2024

Within each CMS category, scores were calculated as such: All categorical CMS indicators (e.g., with each hospital performing better than, no different, or worse than the national

average) are assigned points according to their designation, with a maximum of 1 point for indicators better than average, 0.75 point for indicators no different to the average, and 0.5 points for indicators worse than average. For all numerical indicators assigned by CMS, the percentile position of each hospital is calculated (i.e., the percentile into which the hospital falls compared to all other hospitals), with points allotted according to the indicators' distribution. For indicators where lower scores indicate better performance (e.g., OP_18b), the maximum of one point is awarded for hospitals in the 5th percentile or lower. For indicators where higher scores are better (e.g., SEP_1), the maximum of 1 point is awarded to hospitals in the 95th percentile or higher. Hospitals at or below the 10th percentile receive a base score of 0.5. All other hospitals receive a continuously scaled score between 0.5 and 1. This approach ensures a nuanced and equitable distribution of scores according to relative performance. Hospitals participating in the PROs reporting received 1 point.

Finally, the points of all measures within each category were averaged to build a single category-level score for each facility. These category scores were then combined to calculate a single CMS composite score for each hospital using a weighted aggregation approach. For the four core categories, Mortality, Safety of Care, Readmissions, and Timely & Effective Care, the relative weighting follows the CMS Star Rating methodology; however, the weights were proportionally reweighted to accommodate the inclusion of additional categories in this analysis. The remaining categories, Patient-Reported Outcomes, and Supplementary Indicators, were assigned weights reflecting their analytical relevance, while preserving the relative importance of the CMS core categories. The resulting category weights applied in the final score calculation are shown below.

Category	Weight
Mortality	25.4%
Safety of care	25.4%
Readmission	25.4%
Timely & Effective care	13.8%
Supplementary	7.5%
PRO	2.5%

For a hospital to qualify for the CMS score, it must report data in at least three out of the key CMS categories, with at least one category being either Mortality or Safety - which

are considered critical indicators of hospital performance. Hospitals which have received a 1-Star CMS rating were excluded from the ranking entirely.

Information on the CMS datasets can be found here:

<https://data.cms.gov/provider-data/topics/hospitals>

The CMS score was worth 60% of the quality metrics score.

Leapfrog Hospital Safety and Quality Data

The Leapfrog Group supports the ranking as a data partner. The following paragraph is included for contextual information only and is not part of the methodological framework or scoring approach.

The Leapfrog Hospital Survey was created and is administered by The Leapfrog Group (<https://www.leapfroggroup.org/>), a leading independent, national not-for-profit organization advocating for hospital transparency. They strive to make giant “leaps” forward in the U.S. by promoting transparency through their data collection and public reporting initiatives. With their goal of saving lives by reducing errors, injuries, accidents, and infections, The Leapfrog Group focuses on measuring and publicly reporting hospital performance through the annual Leapfrog Hospital Survey. The survey is a trusted, transparent and evidence-based national tool in which over 2,400 hospitals voluntarily participate free of charge. The Leapfrog Group advocates for public access to quality and safety data from all U.S. hospitals.

The Leapfrog Hospital Survey is a voluntary, annual assessment designed to collect comprehensive, evidence-based information directly from U.S. hospitals. It covers a broad range of safety and quality measures. The survey is organized into multiple sections, each containing clearly defined specifications, reporting periods, and measurement criteria to ensure hospitals can provide accurate and consistent responses. The measure selection is guided by scientific advisors and expert panels and reflects the latest evidence in patient safety. Only measures relevant to the services offered at each facility are collected, ensuring meaningful and comparable benchmarking across hospitals.

The following Leapfrog indicator groups were included in the quality metrics score⁵:

Section 1: Patient Rights and Ethics

ID	Indicator name	Definition
43	HealthEquity_Results	Overall Score: Health Care Equity
44	InformedConsent_Results	Overall Score: Informed Consent

Section 2: Medication Safety

ID	Indicator name	Definition
52	CPOE_Results	Overall Score: CPOE
56	BCMA_Results	Overall Score: BCMA
62	MedRec_Results	Overall Score: Medication Reconciliation

Section 3: Adult and Pediatric Complex Surgery

ID	Indicator name	Definition
65	Carotid_Results	Overall Score: Carotid Endarterectomy
68	Mitral_Results	Overall Score: Mitral Valve Repair and Replacement
74	OpenAortic_Results	Overall Score: Open Aortic
77	Lung_Results	Overall Score: Lung Resection for Cancer
80	Esoph_Results	Overall Score: Esophageal Resection for Cancer
83	Pancr_Results	Overall Score: Pancreatic Resection for Cancer
86	Rectal_Results	Overall Score: Rectal Cancer Surgery
89	Bariatric_Results	Overall Score: Bariatric Surgery for Weight Loss
93	Knee_Results	Overall Score: Total Knee Replacement Surgeries
97	Hip_Results	Overall Score: Total Hip Replacement Surgeries
108	SafeCheckInp_Results	Overall Score: Safe Surgery Checklist - Adult and Pediatric Complex Surgery

Section 5: Physician and Nurse Staffing

ID	Indicator name	Definition
142	Adult_IPS_Results	Overall Score: Adult ICU Physician Staffing

⁵ Sections 4 and 8 of the Leapfrog Survey were not included in the analysis, as the associated indicators are outside the scope of the ranking framework.

149	NurseTotalHours_Results	Overall Score: Total Nursing Care Hours per Patient Day
153	NurseRNHours_Results	Overall Score: RN Hours per Patient Day
162	NurseBSN_Results	Overall Score: Percentage of RNs who are BSN-Prepared

Section 6: Patient Safety Practices

ID	Indicator name	Definition
164	SP1_Results	Overall Score: Leapfrog NQF Safe Practice #1
166	SP2_Results	Overall Score: Leapfrog NQF Safe Practice #2
168	HH_Results	Overall Score: Hand Hygiene

Section 7: Managing Serious Errors

ID	Indicator name	Definition
177	NeverEvents_Results	Overall Score: Never Events

Section 9: Outpatient Procedures

ID	Indicator name	Definition
263	SafeCheckOut_Results	Overall Score: Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures
265	MedAllergy_Results	Overall Score: Medication Safety for Outpatient Procedures

Leapfrog assigns each measure a performance category based on predefined scoring criteria. The Leapfrog scoring algorithm can be accessed [here](#).

For each Leapfrog measure group, the percentage of reported measures that met the established standards was calculated. Points were assigned to each measure based on the hospital's performance category:

- 1.0 point for *Achieved the Standard*
- 0.75 points for *Considerable Achievement*
- 0.5 points for *Some Achievement*
- 0.4 points for *Limited Achievement*

For each hospital, the total points earned were divided by the number of measures reported per section, resulting in seven sub scores. For each sub score, the hospitals' percentile position within the national distribution was calculated.

Each Leapfrog survey section contributes differently to a hospital's overall safety and quality profile. To reflect these variations in clinical relevance, evidence strength, and patient impact, the final score applies differentiated weights to each section. These weights are designed to balance structural, process, and outcome-driven indicators, ensuring a comprehensive evaluation of hospital performance. To calculate the final score the categories are weighed the following:

Section	Weight
Sect 1: Patient Rights and Ethics	5%
Sect 2: Medication Safety	20%
Sect 3: Adult and Pediatric Complex Surgery	20%
Sect 5: Physician and Nurse Staffing	15%
Sect 6: Patient Safety Practices	25%
Sect 7: Managing Serious Errors	10%
Sect 9: Outpatient Procedures	5%

Information on the Leapfrog hospital survey can be found here:

<https://www.leapfroggroup.org/survey-materials/survey-login-and-materials>

The Leapfrog score was worth 25% of the quality metrics score.

American Hospital Association Annual Survey of Hospitals

The AHA Annual Survey of Hospitals Database is a comprehensive database that has been sustained through annual surveys of over 6,100 hospitals in America. The database consists of over 1,300 data points, that have been collected for over 75 years (American Hospital Association, 2025). The most recent data from FY2023, published in May 2025, is used to determine the AHA quality score.

Structural and organizational data of hospital facilities was included in the hospital quality metrics score. The following indicator groups of the AHA Annual Survey of Hospitals Database 2023 were used as part of the quality metrics score:

General indicators

- Clinical services and care

- Health research and screening
- Workforce strategic planning

Health equity

- Health equity goals
- DEI disaggregated data
- Health equity strategic plan

Technologies and Innovation

- Diagnostic technology
- Telehealth and virtual care
- AI and automation

Staffing

- Number of full-time and part-time employed physicians, technicians
- Nursing to bed ratio

For each category, indicators are divided into categorical and continuous types. Categorical indicators are assigned points according to presence of said service, e.g., presence of oncology services. Continuous metrics are scored relatively based on percentile performance. Hospitals in the top 20th percentile receive the maximum score of 1, while hospitals that score up to the 80th percentile are assigned a continuous score between 0.4 and 1, which ensures relative comparability across hospitals. Final scores are combined across all categories, forming the AHA quality score for each hospital. Information on the AHA database can be found here:

<https://www.ahadata.com/aha-annual-survey-database>

The AHA score was worth 10% of the quality metrics score.

Accreditations

Additionally, we incorporated within the scoring model the **Joint Commission** accreditation and the **Planetree accreditations**.

The list of Joint Commission accredited institutions can be found here:

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

The list of Planetree accredited institutions can be found here:

<https://www.planetree.org/partners/locations/united-states#top>

The Accreditations contributed 5% to the total quality metrics score.

Patient experience

In the U.S., the patient experience score is based on Medicare HCAHPS data. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is a standardized survey of hospital patients in the USA regarding their experiences during a recent inpatient hospital stay (HCAHPS, 2025). The most recent dataset available is the November 2025 edition and is based on surveys from patients discharged in 2024. Based on the collected survey data, the CMS reports 11 HCAHPS Star Ratings on Hospital Compare: 10 for the publicly reported HCAHPS measures, as well as an HCAHPS Summary Star Rating. The specific measures are derived from certain items in the HCAHPS survey as shown below:

HCAHPS composite topics	Questions
1. Nurse communication	1, 2, 3
2. Doctor communication	5, 6, 7
3. Responsiveness of hospital staff	4, 11
4. Communication about medicines	13, 14
5. Discharge information	16, 17
6. Care transition	20, 21, 22

HCAHPS individual topics	Questions
7. Cleanliness of hospital environment	8
8. Quietness of hospital environment	9

HCAHPS global topics	Questions
9. Hospital rating	18
10. Willingness to recommend hospital	19

Hospitals are required to have at least 100 complete HCAHPS surveys over a given four-quarter period to receive a score.

For each HCAHPS measure, the percentile position of each hospital is calculated. As higher scores indicate better performance, hospitals at or above the 95th percentile receive the maximum score of 1 point, while hospitals at or below the 10th percentile receive a base score of 0.5. All other hospitals receive a continuously scaled score between 0.5 and 1. Measure-level scores are then combined across all available HCAHPS measures using an arithmetic mean to derive the final patient experience score. This approach ensures a nuanced and equitable distribution of scores based on relative performance.

The full methodology for the CMS HCAHPS Star Rating is published at:

<https://hcahponline.org/en/hcahps-star-ratings/>

Patient Experience Award

Hospitals with an outstanding performance in patient experience are recognized with a patient experience award, highlighting their dedication to delivering high-quality, patient centered care. To qualify for the award, hospitals must demonstrate exceptional performance across all evaluated metrics. This is assessed in the following way:

- Only hospitals that report all 10 HCAHPS measures and are within the top 40% per measure are eligible, ensuring a solid baseline of care quality.
- At least three of the ten measures must be rated in the top 15%, highlighting areas of outstanding achievement.
- In addition to the above, hospitals must also rank within the top 10% (90th percentile or higher) on at least four of the ten measures, underscoring the hospital's commitment to excellence in critical performance areas.

Infection Prevention Award

The methodology for this award consists of two components: (1) CDC-reported infection measures published via CMS, and (2) Leapfrog-reported hand hygiene performance. Hospitals that satisfy both the CDC infection measure criteria and the Leapfrog hand hygiene criteria qualify for the Best Infection Prevention Award.

Hospitals in the U.S. are required to report data about certain infections to the Centers for Disease Control and Prevention (CDC). This data includes the following measures:

- Catheter-associated urinary tract infections
- Central line-associated bloodstream infection
- *Clostridium difficile* laboratory-identified events
- MRSA bacteremia laboratory-identified events
- Surgical site infection - abdominal hysterectomy
- Surgical site infection - colon surgery

For each measure and hospital, a Standardized Infection Ratio is calculated by the CDC and compared to the national average, resulting in a value that is either “above national average”, “same as national average”, or “below national average.”

A hospital needs to meet the following criteria to qualify for the Best Infection Prevention award (U.S. only):

- At least four of the six measures need to be available for the 2024 data collection period.
- None of the available measures equals the value “below national average.”
- At least one available measure equals the value “above national average.”

In addition, hospitals must report hand hygiene data through the Leapfrog Hospital Survey. Leapfrog assesses hand hygiene performance across five domains:

- Monitoring
- Feedback
- Training and Education
- Infrastructure
- Culture

For each domain, Leapfrog determines whether the hospital meets the respective requirements. To meet the Leapfrog hand hygiene criteria for the award, hospitals must:

- Reporting hand hygiene measures via the Leapfrog Hospital Survey.
- At least two of the five measures meet the requirements in the respective domain.

This award highlights the hospital’s commitment to reducing healthcare-associated infections and strengthening patient safety through both measurable infection outcomes and effective prevention practices.

Information on the data was accessed from and is available at:

<https://data.cms.gov/provider-data/dataset/77hc-ibv8>

<https://www.leapfroggroup.org/survey-materials/survey-login-and-materials>

b. Germany

Germany currently has 1,841 hospitals (Statistisches Bundesamt, 2024) which can be classified into four groups defined by the type and level of care provided. This classification is based on existing health policy regulations:

- Basic and standard care hospitals
- General care hospitals
- Maximum/tertiary care hospitals
- Specialized hospitals

Basic and standard care hospitals are usually the smallest types of hospitals, providing only general services or basic surgeries. They usually do not have specialty wards. Because of these limitations, they are mostly not represented in the World's Best Hospitals ranking for Germany.

General care hospitals usually have several specialty wards and even provide maternity care. They usually do not have highly specialized specialty wards, instead referring their patients to specialized hospitals or maximum care hospitals if needed.

Maximum care hospitals usually treat the most complex and resource-intensive cases. They are therefore most often equipped with expensive and cutting-edge technical and diagnostic equipment as well as specialized physicians. Many maximum care hospitals are university hospitals.

Specialized hospitals, while often providing a range of general services, are focused on certain specialties (e.g., cardiology) or complex diagnoses (e.g. cancer). They are represented in the national ranking for Germany relatively often (compared to other countries) because the German hospital landscape is still relatively heavy on specialized hospitals known for their expertise in certain medical fields. Their number has been slowly decreasing over the last several years, with a tendency towards centralization into larger and more diversified medical centers.

Hospitals in Germany can be differentiated further by ownership type, with 29% of hospitals being under public, 31% under private non-profit, and 40% under private for-profit ownership (Statistisches Bundesamt, 2024). The average size of a hospital in Germany is

254 inpatient beds, with public hospitals on average being by far the largest and private hospitals being the smallest on average.

The 2026 edition of the World's Best Hospitals list for Germany ranks the top 220 hospitals, which is the second longest list due to the large number of recommendations and the good quality of available hospital quality metrics and patient experience data (see below).

German hospitals are required to publish freely available annual **quality reports** online since 2005 (originally published biannually from 2005–2012); therefore, data on wide-ranging hospital quality metrics for German hospitals is readily available. The quality reports provide in-depth information about the structure and services of each hospital, such as the range of diagnoses and number of provided treatments, number of staff, hygiene measures, number of complications, or barrier-free accessibility. The reports not only feature descriptive information but also quality indicators that give an indication of the quality of the care provided in each hospital. The quality reports of 2023 are the most recent ones available. Further information about hospital quality reports in Germany is available at:

The data used is available at:

<https://www.g-ba.de/institution/themenschwerpunkte/qualitaetssicherung/qualitaetsdaten/qualitaetsbericht/>

The following hospital quality metrics from the quality reports were used for the World's Best Hospitals ranking in Germany because they are most comparable across hospitals and representative of a hospital's general performance:

- Medical Staffing: Number of cases per doctor
- Nurse Staffing: Number of cases per nurse
- Patient Safety & Hygiene: Number of measures to increase patient safety (e.g., standardized pre-surgery checklists) and number of measures to increase hygiene (e.g., hospital infection surveillance system)
- Emergency Care Levels

Additionally, quality of care data from **Qualitätssicherung mit Routinedaten (QSR)** and **Institut für Qualitätssicherung und Transparenz im Gesundheitswesen (IQTIG)** were used for the ranking. QSR is based on claims data from the large German health insurer AOK and includes a substantial number of indicators for a range of surgeries

which are analyzed in regard to quality of care. The 13 publicly reported measures considered in the scoring model are:

- Hip replacement (osteoarthritis)
- Surgery for a femoral fracture near the hip joint
- Knee replacement (osteoarthritis)
- Hip fracture
- Gallbladder removal for gallstones
- Appendectomy
- Therapeutic cardiac catheter (PCI) in patients without a heart attack
- Surgery for benign prostate enlargement
- Complete prostate removal for prostate cancer
- Closure of inguinal hernia
- Hip replacement (not for fracture or infection)
- Knee replacement (not for fracture or infection)
- Transcatheter aortic valve implantation (TAVI)

German hospitals are required to document quality-relevant data on their patients. IQTiG evaluates these data comparatively. The quality indicators documented by a hospital are rated by IQTiG as "Unobtrusive," "Conspicuous," and "Other." These results were taken into account in the scoring model.

The data used for the 2026 ranking was published by the AOK in October 2025 and includes surgeries performed in 2021 to 2023 (with follow up treatment including up until 2024). Additional information about QSR and IQTiG are available at:

<http://www.qualitaetssicherung-mit-routinedaten.de/>

<https://iqtig.org/>

Additionally, the quality results from **Initiative Qualitätsmedizin** (IQM) were used for the ranking. About 500 hospitals from Germany and Switzerland are involved in the IQM to improve the quality of medicine. In total 50 publicly reported mortality rates were considered in the scoring model. For example:

- Deaths with primary diagnosis of myocardial infarction
- Deaths with primary diagnosis of heart failure

- Deaths from all forms of stroke
- Cerebral infarction deaths
- Deaths with primary diagnosis of pneumonia
- COPD deaths

Hospitals participating in the IQM received an additional score as part of their hospital quality metrics score.

The quality results of 2024 are the most recent ones available. Further information about hospital quality results in Germany and Switzerland is available at:

<https://www.initiative-qualitaetsmedizin.de/qualitaetsmethodik>

Patient Experience

The AOK and other participating health insurance companies have been performing a patient satisfaction survey since 2011. The survey is based on the Patients' Experience Questionnaire (PEQ), which has been validated scientifically. So far, around 900,000 evaluations have been received nationwide. The survey includes 39 questions, covering the following areas:

- Satisfaction with information
- Satisfaction with organization and waiting time
- Satisfaction with facilities and cleanliness
- Satisfaction with restfulness and privacy
- Satisfaction with communication
- Satisfaction with handling of needs and expectations
- Overall impression

Results are calculated for each department and aggregated to a total score per hospital. Results are reported for hospitals that have at least 75 completed surveys (or at least 50 for a single department). The detailed description of the survey can be found at the AOK website:

<https://www.aok.de/pk/gesundheitsnavigator/glossar/#services-with-P>

c. Japan

There are currently approximately 8,001 hospitals in Japan, including acute care and specialized facilities, within a universal health insurance system regulated by the Ministry of

Health, Labour and Welfare (MHLW, 2025). These hospitals operate under national standards with prefectural planning to ensure geographic access to care. The high total reflects Japan's emphasis on inpatient and comprehensive medical services, with around 1.52 million hospital beds nationwide. The number of hospital beds in relation to the population is one of the highest worldwide with roughly 1192 beds per 100,000 people (MHLW 2024) The hospital quality metrics for Japanese hospitals from the Diagnosis Procedure Combination (DPC) are published by the Ministry of Health, Labour and Welfare in Japan. Diagnosis Procedure Combination (DPC) is a Japanese evaluation system for healthcare costs, length of hospital stays, and healthcare needs. DPC hospitals are hospitals that meet the defined criteria. For this project, the hospital quality metrics score was calculated with the Function Evaluation Coefficient II data. The following data from May 2025 was used, which was the most current data at the time of the ranking process:

- Coefficient of efficiency
- Coefficient of complexity
- Coefficient of coverage
- Coefficient of emergency

The **efficiency coefficient** reflects how effectively a hospital manages patient length of stay. It compares the hospital's average length of stay to the average across all DPC hospitals, with higher values indicating more efficient patient management.

The **complexity coefficient** measures the proportion of patients with complex or resource-intensive cases treated by the hospital. A higher value signifies that the hospital handles more medically demanding cases.

The **coverage coefficient** represents the variety of DPC case categories that the hospital can diagnose and treat relative to all DPC hospitals. A higher value indicates a broader range of medical services offered.

The **emergency adjustment coefficient** evaluates the hospital's capacity for handling emergency patients, defined as cases admitted within the first two days of hospitalization. Higher values reflect greater involvement in emergency care and responsiveness.

All used data was accessed from and is available at: <https://www.mhlw.go.jp/index.html>

Additionally, **Joint Commission International** and **Japan Council for Quality Health Care (JQ)** accreditations were considered as a part of the hospital quality metrics score.

More information and the lists of accredited organizations can be found under the following links:

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

<https://www.report.jcqhc.or.jp/>

d. South Korea

The healthcare system in South Korea has two components, health insurance and medical aid. The national health insurance system provides coverage to all citizens, and it is managed comprehensively in the form of social insurance (Health Insurance Review & Assessment Service, 2023). According to the Korean Statistical Information Service, in 2023, the country had 45 tertiary hospitals, 331 general hospitals and 1,403 hospitals (Korean Statistical Information Service, 2025). According to the Ministry of Health and Welfare (2023), there are 94 specialized hospitals. The number of hospital beds in relation to the population is one of the highest worldwide, with 13.8 beds per 1,000 inhabitants (Korean Statistical Information Service, 2025).

The hospital quality metrics used for ranking South Korean hospitals are published by the national Health Insurance Review & Assessment Service (HIRA). Besides other activities, HIRA monitors the healthcare system through on-site investigations of hospitals, quality assessments, medical claim reviews, etc. HIRA provides an open-data platform with assessments of different quality indicators. For this project, the following indicators from hospital investigations were used:

- ICU evaluation
- Acute disease evaluation
- Chronic disease evaluation
- Cancer disease evaluation
- Drug evaluation

HIRA publishes ratings for each category, based on the results of their evaluation. The ratings for each indicator are presented on a 5-point ranking scale, with lower numbers representing better performance.

All used data was accessed from and is available at:

<https://www.data.go.kr/tcs/dss/selectApiDataDetailView.do?publicDataPk=15094093>

Additionally, two accreditations were considered as a part of the hospital quality metrics score. More information and the lists of accredited organizations can be found under the following links:

- **Korea Institute for Healthcare Accreditation**
<https://www.koiha.or.kr/web/en/staus/accStatus.do>
- **Joint Commission International**
<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

Patient Experience

The HIRA conducts patient experience evaluations to spread a patient-centered medical culture and to improve the quality of care experienced by the public. The target institutions are high-level general hospitals and general hospitals with more than 300 beds. For this ranking, survey data from 2023 was used. The patients were asked to rate the hospitals for the following criteria:

- Nurse services
- Physician services
- Dosing and treatment process
- Hospital environment
- Guarantee of patient rights
- Overall evaluation

The evaluation results are released as a 100-point score for each of the six areas.

All used data was accessed from and is available at:

<https://www.hira.or.kr/ra/eval/getDia-gEvIView.do?pgmid=HIRAA030004000100&WT.gnb=%EB%B3%91%EC%9B%90%ED%8F%89%EA%B0%80>

e. France

According to the most recent OECD data (OECD, 2025b), France currently has approximately **2,976 hospitals** nationwide. Public institutions account for **about 45%** of these facilities, while **around 33%** are private for-profit and approximately **22%** are private non-profit providers, based on the most recent available breakdown from national hospital statistics (DREES, 2024). To calculate the hospital quality metrics score for French hospitals, publicly available data from the Haute Autorité de Santé (HAS) was analyzed. HAS is an independent public authority that contributes to the regulation of the French health system and assures quality standards in healthcare measurements. It publishes data regarding the quality and safety of French hospitals, following a consistent methodology to guarantee validated and comparable data measures. HAS also measures patient satisfaction and experience, resulting in a comprehensive dataset allowing for a detailed comparison of different hospitals.

The certification of hospitals is carried out every four years. The reference frame from 2014 was replaced in favor of a new system published in 2021. Since the assessment rhythm of a hospital is every four years, the results of the hospital quality metrics and patient experience include hospitals that were certified under the old system and hospitals that are already certified under the new system.

For the World's Best Hospitals ranking, nine different hospital quality metrics were used. If available, the following metrics were used to calculate an overall score (reference frame 2014):

- Patient rights
- Patient journey
- Medication management
- Quality and risk management
- Infection risk
- Patient records
- Management of emergencies
- Organization of the operating rooms
- Safety of endoscopy patients

The measures above were chosen due to their availability for most hospitals as well as for their relevance as a measure of the general quality of a hospital. HAS used a four-

point grading scale system, where A is the best achievable grade and D is the worst. **Patient rights** assesses whether a hospital is treating the patients according to their rights, respecting their privacy and ensuring the confidentiality of their data. **Patient journey** refers to the organization of a patient's entire journey during their stay. The rating received is an indicator of the continuity and coordination of care, the cooperation between different teams, as well as the accessibility of information by all healthcare professionals. **Medication management** shows if a hospital ensures patient security at all stages of medical treatment, including adequate information regarding the treatment. **Quality and risk management** assesses whether a hospital has a well-defined policy for improving the quality and safety of care. **Infection risk** is an indicator for measures that are taken by a hospital to avoid infections during hospitalizations. Hospitals also get a higher score if their employed personnel are correctly trained in hygiene regulations. The correct use of antibiotics also contributes to the control of the infection risk. **Patient records** measure the traceability of information in the patient's file, which is important to guarantee coordinated and continuous care. **Management of emergencies** assesses whether the establishment is organized to receive patients in the emergency department 24 hours a day, 7 days a week. It involves reception by trained professionals, care adapted according to the degree of emergency, reorientation, or transfer, and knowledge of the availability of hospital beds. **Organization of the operating rooms** indicates whether a hospital has set up an organization in the operating room to ensure maximum patient safety. Since operating rooms often handle difficult, complex cases, a highly structured organization is crucial for patient safety. **Safety of endoscopy patients** assesses whether the hospital has identified the major risks that may arise at each stage of an endoscopy. Endoscopy is a medical examination that explores the interior of an organ or a body cavity by inserting a small camera.

For hospitals that were already assessed according to the new reference system, three different hospital quality metrics were used. If available, the following metrics were used to calculate an overall score:

- Facility
- Patient
- Care teams

The three hospital quality metrics are composed of several sub-scores. For example, the metric "Patient" includes scores for "Involvement of the patient," "Involvement of relatives and/or carers," "Respect for the patient," and "The patient's living conditions and

social ties are taken into account." HAS assigns a score between 0 and 100 for each of the three metrics mentioned. All the data and the description of the hospital quality metrics are also available at:

<https://www.has-sante.fr/>

Patient Experience

Patient experience data was also used in determining the overall score of French hospitals. HAS provides comprehensive data from patient surveys. For this project, the overall score given by hospitalized patients was used, as well as the share of patients who would recommend the hospital that they were treated in. The overall score is calculated using a range of different variables such as the level of support from doctors and/or nurses, the organization of the whole treatment process, the quality of food, patient satisfaction with the accommodation, etc. The recommendation of a hospital was assessed by asking the patients whether they would recommend the respective hospital to friends and family members.

All the data and the description of patient experience are available at:

<https://www.has-sante.fr/>

f. Italy

There are currently around 1,051 hospitals in Italy. The healthcare system is based on a national health service known as Servizio Sanitario Nazionale (SSN). 568 hospitals are publicly owned, while 483 hospitals are owned by private organizations accredited with the SSN (Italian National Institute of Statistics (ISTAT), n.d.).

To provide measures for these hospitals, publicly available data was used for both hospital quality metrics and patient experience.

The data for hospital quality metrics derives from the National Outcome Assessment Program (PNE), managed by the National Agency for Regional Health Services on behalf of the Ministry of Health, and published at *Micuro*. For this project, only the indicators that are comparable to the national reference values are used. These reference values are recognized and validated by the Italian Ministry of Health. All quality indicators that are published fulfill the same criteria—scientific validity, expressiveness, and operational feasibility—making it possible to compare them on a national level. The individual indicators are rated using a two-point scale.

The number of available indicators differs from hospital to hospital, based on their size and range of treatment. In general, all indicators can be divided into four different categories:

- Effectiveness
- Safety
- Appropriateness
- Competence

Hospital quality metrics from the category **Effectiveness** indicate whether a hospital achieves the expected results in terms of patient health. An example for this category is the indicator “Survival 30 days after surgery”. It measures the percentage of patients who survive for 30 days after surgery, compared to the total number of patients who underwent the same surgery. The higher the relative number of patients who survived, the higher the value for this indicator. Hospital quality metrics that belong to the category **Safety** measure how well a hospital avoids or prevents adverse events during the care process. One of the indicators in this category is “complications within 30 days after surgery,” which measures the number of patients that experience at least one complication in the 30 days following a surgery. The third category, **Appropriateness**, comprises measures that indicate if a hospital offers adequate clinical services to a patient. The services offered should meet the needs of a patient and aim for the best medical outcome. An example for this case would be the measure “percentage of deliveries with primary caesarean section.” Sometimes caesarean delivery is performed without there being a need (medical indication) and therefore exposes the mother and unborn child to an avoidable risk. A low number of caesarean sections may therefore indicate a higher degree of appropriateness. The last category, **Competence**, lists indicators that can be associated with the competence and experience of the hospital’s personnel. A typical indicator in this category is the “annual volume of a specific type of surgery.” A higher volume of the same surgical procedure indicates more experienced physicians and a higher level of routine for the given procedure. Still, it cannot be associated with the outcome of a single surgery (Micuro, n.d.).

The data used is available at:

<https://pne.agenas.it/home>

The data is published at:

<https://www.micuro.it/>

Additionally, the **Joint Commission** accreditations were taken into account, for which the list of accredited institutions can be found here:

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

Furthermore, the Emergency Care Levels provided by the Ministero della Salute were considered, for which the list can be found here:

<https://www.salute.gov.it/new/it/banche-dati/elenco-strutture-della-rete-dellemergenza-ospedaliera/>

Hospitals that were on these lists had the categories as a part of their hospital quality metrics score.

Patient Experience

Micuro also provides an online platform for patients to rate their hospital stay from 1 to 5 in different areas. Examples of categories are: Overall recommendation to family and friends, cleanliness, privacy, general quality, availability and kindness of the staff, medical information received, administrative organization, food, and visits.

All the data and the description of patient experience are available at:

<https://www.micuro.it/>

g. United Kingdom

In the UK, there are currently around 1,148 hospitals (Interweave Healthcare, 2023). Of these, 930 are owned by the government and operated by the National Health Service (NHS). Among these NHS hospitals, 704 are located in England, 105 in Scotland, 84 in Wales, and 37 in Northern Ireland. In addition, there are 218 private hospitals across the UK. The healthcare system is tax-based and guarantees universal coverage for all UK citizens.

The data used for this project is derived from the Care Quality Commission (CQC) database as of November 2025. CQC is an independent regulator of health and social care in England. The commission monitors, inspects, and rates health services that are provided to the public. After a comprehensive inspection, CQC publishes a rating on a location-by-location basis in five different categories:

- Safe
- Effective
- Caring
- Responsive
- Well-led

For each of these categories, a healthcare organization can be graded as “outstanding,” “good,” “requires improvement,” or “inadequate.” The achieved grade is a result from findings during the inspection, done by a professional team. **Safe** is an indicator for the overall protection of patients. The inspectors gather evidence that patients are protected from abuse and avoidable harm. Several different factors play a role in the patient’s safety, e.g., an appropriate number of staff, the correct use of medicine, prevention of infections, etc. **Effective** assesses whether a patient’s treatment and the support they receive lead to good outcomes and promote a good quality of life. This metric also results from the inspection of different variables: level of training and experience of staff, assessment of patient needs, cooperation with other organizations to secure the best outcome, etc. The next category, **Caring**, refers to the compassion, kindness, dignity, and respect that patients are treated with during their stay. Inspectors determine whether patients’ equality, diversity, and privacy are respected, and whether they are involved in decisions regarding their care. For the fourth category, **Responsive**, CQC is looking for evidence that the service meets patients’ needs. This is the case if a hospital meets the individual needs of their patients, if the staff is learning from and responding to complaints and concerns, and if the hospital is planning ahead in order to improve access and flow. The last category, **Well-led**, is an indicator for the quality of leadership, management, strategy, and improvement of the inspected organization. Organizations receive a higher grade if the management is promoting a person-centered and open culture, if they are being clear about their roles, if they work in partnership with others to improve outcomes, and if they are continuously improving their service.

Since CQC only rates hospitals in England, data is not available for hospitals in Scotland, Wales, and Northern Ireland.

All used data was accessed from and is available at:

<https://www.cqc.org.uk/>

h. Brazil

In Brazil, healthcare is structured in a National Healthcare System, resulting in universal, free coverage for all permanent Brazilian residents. Currently operating around 7,191 hospitals, of which 2,725 are provided by public institutions and 4,466 by private institutions (Confederação Nacional de Saúde, 2022). Despite the large number of hospitals, the average hospital size is quite small. The density of hospital beds is also quite low, with 1.99 hospital beds per 1,000 inhabitants in 2022 (Confederação Nacional de Saúde, 2022).

In addition to the peer recommendations, hospital quality metrics were used to calculate the overall score. The analyzed hospital quality metrics were published by the Brazilian National Supplementary Health Agency (Agência Nacional de Saúde Suplementar (ANS)), which is responsible for the health insurance sector in the country. For the analysis, participation in the Qualification Program for Health Service Providers (Programa de Qualificação dos Prestadores de Serviços de Saúde - QUALISS) was evaluated for general hospitals in the following subgroups:

- Patient Safety
- Quality Monitoring Program
- Notivisa Incident Reporting Program

The **Patient Safety** group displays the hospitals that are officially registered patient safety centers at ANVISA (Agência Nacional de Vigilância Sanitária). ANVISA is the Brazilian regulatory agency responsible for the approval and supervision of pharmaceuticals, health services, medical devices, and other areas. The **Quality Monitoring Program** is an initiative of the ANS, which aims to encourage improvements in the quality of services through monitoring and evaluating the performance and quality of care in hospitals. The **Notivisa Incident Reporting Program** is the national system for reporting and recording incidents, adverse events, and technical complaints related to the use of technologies and care processes.

Additionally, seven accreditations were considered as part of the hospital quality metrics score. More information and the lists of accredited organizations can be found under the following links:

- **Joint Commission**
<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

- **Quality Global Alliance**
<https://qga.global/instituicoes-acreditadas/>
- **Organização Nacional de Acreditação (ONA)**
<https://www.ona.org.br/mapa-de-acreditacoes>
- **Agencia de Calidad Sanitaria de Andalucía (Acreditação ACSA – Grupo IBES)**
<https://ibes.ac-page.com/clientes-acsa-padi.org.br/servicos-acreditados/>
- **Consórcio Brasileiro de Acreditação (CBA)**
<https://cbacred.org.br/site/acreditacao/instituicoes-acreditadas/>
- **IAHCS Acreditação**
<https://www.iahcs.org.br/>
- **PADI**
<https://padi.org.br/servicos-acreditados/>

i. Spain

Spain has a predominantly public, tax-funded healthcare system known as the Sistema Nacional de Salud (SNS), which provides universal health coverage to all residents. At the national level, the Ministry of Health is responsible for setting overall health policy, coordination, and regulation. However, the 17 autonomous communities have primary responsibility for the planning, funding, and management of healthcare services (European Observatory on Health Systems and Policies, 2024).

As of 2024, Spain has approximately 778 hospitals, of which around 59,8% are publicly operated within the SNS, while 40,2 % hospitals belong to the private sector. In terms of infrastructure, Spain has about 160,000 hospital beds, corresponding to roughly 2.9 hospital beds per 1,000 inhabitants. The majority of these beds (approximately 68,2 %) are located in the public sector, while around 31,8 % beds are provided by private hospitals (Instituto para el Desarrollo e Integración de la Sanidad, 2024; Ministry of Health, 2025; OECD, 2025c). Hospital quality metrics and patient experience data used for hospitals in Madrid and Catalonia are provided by Observatorio de resultados del Servicio Madrileño de Salud and Agència de Qualitat i Avaluació Sanitàries de Catalunya (AQuAS) respectively. The following provides an overview of the newest available metrics which were considered for the analysis.

Hospital Quality Metrics

The hospital quality metrics for Madrid are grouped into four categories and include following indicators:

- **Patient Safety**
 - Medical and surgical Complications
 - Post-surgical sepsis
 - Overall infection prevalence
 - Surgical site infection in colon surgery
 - Surgical site infection in knee prosthesis surgery
 - Surgical site infection in hip prosthesis surgery
 - Chronic wounds / pressure ulcers in hospitalized patients
 - Incidence of Falls in hospitalized patients
- **Mortality**
 - Aggregate Mortality Index
 - Mortality from Acute Myocardial Infarction
 - Mortality from Heart Failure
 - Mortality from Pneumonia
 - Mortality from Stroke
 - Mortality from Gastrointestinal Bleeding
 - Mortality from Hip Fracture
- **Readmissions**
 - Readmissions for Surgical Causes within 7 Days
 - Readmissions for COPD within 30 Days
 - Readmissions for Heart Failure within 30 Days
- **Efficiency**
 - Potentially Avoidable Hospitalizations
 - Potentially Avoidable Hospitalizations for Diabetes
 - Stroke Patients with Length of Stay >20 Days
 - Hip Fracture Patients with Length of Stay >20 Days

The hospital quality metrics for Catalonia are grouped into four categories and include following indicators:

- **Emergency Care**
 - Emergency patients returning within 72 hours
 - Patients with STEMI treated within 120 minutes (ECG-to-balloon time)
 - Door-to-needle time for intravenous thrombolysis in ischemic stroke patients
- **Patient Safety & Readmission**
 - Falls in hospitalized patients

- Pressure ulcers
- 30-day readmissions
- **Infection prevention**
 - Appropriate prophylaxis in elective surgery
 - Surgical site infection (organ/space level)
- **Mortality**
 - In-hospital mortality
 - 30-day mortality
 - Mortality in Diagnosis-Related Groups (DRGs) with low expected mortality
 - Mortality in patients who developed surgical complications
 - Three-month survival with complete recovery after isolated intravenous thrombolysis for ischemic stroke
 - Three-month mortality after isolated intravenous thrombolysis for ischemic stroke

Patient Experience

The patient experience data for Madrid are grouped into five categories and include following indicators:

- **Overall Satisfaction**
 - Satisfaction Index: Average satisfaction in the areas of hospitalization, outpatient consultations, outpatient surgeries, and emergency care
 - Recommendation Index: Average of recommendations for inpatient admission, outpatient consultations, outpatient surgeries and emergency care
- **Information**
 - Average satisfaction with information received during hospitalization about the disease, medical treatment, and discharge from hospital. Humanization
- **Humanization**
 - Satisfaction index regarding humanization in the hospital: Average satisfaction in the six dimensions the treatment and friendliness of the medical staff, the information provided at various points during treatment, the time and commitment of the medical staff, respect for privacy, peace and quiet at night, and pain management
 - Satisfaction index with the humanization of emergency care: Average satisfaction in the six dimensions treatment and friendliness of medical staff,

the information provided, time and dedication of medical staff, respect for privacy, waiting times and support, and pain management

- **Staffing**
 - Satisfaction with care provided by the medical professionals during their hospital stay
 - Satisfaction with care provided by the nursing staff during their hospital stay
- **Amenities**
 - Overall Room Satisfaction

The patient experience data for Catalonia are grouped into four categories and include following indicators:

- **Overall Satisfaction**
 - General satisfaction with the hospital
- **Waiting Time**
 - Satisfaction with time on waiting list
- **Recommendation**
 - Patient loyalty (willingness to return or recommend)
- **Service & Amenities**
 - Willingness of staff to listen and take responsibility
 - Feeling in good hands (trust in care)
 - Ability to rest calmly at night
 - Hospital food quality
 - Comfort of the hospital room

Due to the differing indicators and categories used in the two regions of Madrid and Catalonia, the values were standardized to enable a more accurate and fair comparison between the regions.

All used data was accessed from and is accessible at:

<https://observatorioresultados.sanidadmadrid.org/HospitalesResultados.aspx> (for Madrid)

<https://aguas-gencat.shinyapps.io/centralderesultats/> (for Catalonia)

Additionally, the **Joint Commission International accreditation** was taken into account, for which the list of accredited institutions can be found here:

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

The analysis utilized the previously mentioned hospital quality metrics for hospitals in the Madrid and Catalonia region. For the remaining regions the analysis continues to rely on PROMs, accreditations from the Joint Commission, as well as Google Scores and recommendations from medical experts. Due to the structure of the analysis, hospitals lacking quality metrics due to regional differences are not at a disadvantage compared to those with additional data.

j. Canada

In total, there are 1,087 hospital establishments in Canada as of 2024. The hospitals are funded publicly, acting as independent institutions incorporated under provincial Corporations Acts. The most populated provinces in Canada, Ontario and Quebec, also have the largest number of hospitals (319 in Ontario and 163 in Quebec). Prince Edward Island, on the other hand, has only eight hospitals (Government of Canada, 2025).

The hospital quality metrics used for the ranking of Canadian hospitals are published by the **Canadian Institute for Health Information (CIHI)**. In Canada, hospitals in all provinces except Quebec submit data to the Discharge Abstract Database (DAD) and/or the National Ambulatory Care Reporting System (NACRS) that is governed by CIHI. In Quebec, hospitals submit their data to the Maintenance et Exploitation des Données pour l'Étude de la Clientèle Hospitalière (MED-ÉCHO) database (<https://www.msss.gouv.qc.ca/professionnels/documentation-sources-de-donnees-et-indicateurs/sources-de-donnees-et-metadonnees/med-echo/>), which in turn submits their data to CIHI. The combined data is entered into the Hospital Morbidity Database (HMDB) and contains a wide range of risk-adjusted clinical indicators that measure health system performance. Data is reported only if a certain number of cases per treatment/measure is met or if certain stability criteria (based on the risk adjustment) are satisfied. CIHI also applies statistical outlier analysis to detect values that lie outside of the range of acceptable indicator values and subsequently removes these outliers to prevent bias in the reported averages.

The data used is based on the most recent reporting period for 2024/2025 (except for Quebec, where only data from 2023/2024 was available). The 22 indicators used to determine the score were:

- All Patients Readmitted to Hospital

- Hip Fracture Surgery Within 48 Hours
- Hospital Deaths (Hospital Standardized Mortality Ratio)
- Hospital Deaths Following Major Surgery
- Medical Patients Readmitted to Hospital
- Obstetric Patients Readmitted to Hospital
- Obstetric Trauma (With Instrument)
- Pediatric Patients Readmitted to Hospital
- Emergency Department Wait Time for Physician Initial Assessment
- Experience Pain in Long-Term Care
- Experiencing Worsened Pain in Long-Term Care
- Falls in the Last 30 Days in Long-Term Care
- Improved Physical Functioning in Long-Term Care
- In-Hospital Sepsis
- Potentially Inappropriate Use of Antipsychotics in Long-Term Care
- Restraint Use in Long-Term Care
- Surgical Patients Readmitted to Hospital
- Total Time Spent in Emergency Department for Admitted Patients
- Worsened Depressive Mood in Long-Term Care
- Worsened Physical Functioning in Long-Term Care
- Worsened Pressure Ulcer in Long-Term Care
- Low-Risk Caesarean Sections

All Patients Readmitted to Hospital is a measure for the risk-adjusted rate of urgent readmissions within 30 days of discharge for obstetric, pediatric, surgical, and medical patients. **Hip Fracture Surgery Within 48 Hours** is the risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of a patient's initial admission to an acute care hospital. **Hospital Deaths** or Hospital Standardized Mortality Ratio (HSMR) refers to the ratio of the observed number of in-hospital deaths to expected in-hospital deaths, based on the types of patients treated in the respective hospital. **Hospital Deaths Following Major Surgery** measures the rate of in-hospital deaths due to all causes within 30 days after a major surgery.

Medical Patients Readmitted to Hospital is the indicator for the risk-adjusted rate of readmission for medical patients within 30 days. Similarly, **Obstetric Patients Readmitted to Hospital** measures the risk-adjusted rate of urgent readmissions for obstetric patients. **Obstetric Trauma (with Instrument)** measures the rate of obstetric trauma for instrument-assisted vaginal deliveries. **Pediatric Patients Readmitted to Hospital** refers to the risk-adjusted rate of urgent readmissions for patients aged 17 and younger. The **Emergency Department Wait Time for Physician Initial Assessment** measures the time interval between registration and initial assessment in the emergency department in hours (90% of patients spent less than the recommended maximum waiting time).

As some hospitals in Canada also perform long-term care, **Experiencing Pain in Long-Term Care** (in %) was used for those hospitals. **Experiencing Worsened Pain in Long-Term Care** refers to the percentage of long-term care residents who experienced worsened pain. Worsened pain is connected to a resident's health status and the quality of care received. **Falls in the Last 30 Days in Long-Term Care** is an indicator of the percentage of residents in long-term care who fell in the last 30 days before their quarterly clinical assessment. Fewer falls indicate higher safety and quality of care for residents.

Improved Physical Functioning in Long-Term Care indicates the percentage of long-term care residents who improved or remained independent in transferring and locomotion. This is an indicator of overall health status and autonomy of the resident. **In-Hospital Sepsis** refers to the risk-adjusted rate of sepsis after admission.

The percentage of residents on antipsychotics without a diagnosis of psychosis is captured by the **Potentially Inappropriate Use of Antipsychotics in Long-Term Care** indicator. A lack of careful monitoring might indicate concerns about safety and quality of care. **Restraint Use in Long-Term Care** measures how many long-term residents are in daily physical restraints. A high rate carries potential physical and psychological risks. The indicator **Surgical Patients Readmitted to Hospital** measures the risk-adjusted rate of urgent readmissions for surgical patients within 30 days. Furthermore, **Total Time Spent in Emergency Department for Admitted Patients** is used to determine the time interval between registration, admissions, and release from the emergency department (90% of patients spent less than the recommended maximum waiting time). **Worsened Depressive Mood in Long-Term Care** indicates the percentage of long-term care residents whose mood from symptoms of depressions worsened, whereas **Worsened Physical Functioning in Long-Term Care** indicates the percentage of residents whose transfer and locomotion functioning worsened or remained completely dependent. **Worsened Pressure Ulcer in Long-Term Care** shows the percentage of long-term

care residents whose stage 2 to 4 pressure ulcer worsened since the previous assessment. Lastly, **Low-Risk Caesarean Sections** measures the rate of deliveries via caesarean section (C-section) among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labor.

In order to account for differences in patient characteristics across hospitals, CIHI uses established regression-based risk-adjustment methods to control for patient characteristics and other risk factors that may affect outcomes. As a result, risk-adjusted indicators report the risk-adjusted rate (e.g., by dividing the observed number of cases by the expected number of cases, multiplied by the Canadian average).

Not all indicators were relevant for all hospitals, depending on the type of patients treated. For example, if the hospital does not have any or enough ulcer patients, the indicator does not apply (applies mostly to long-term care indicators). Only relevant indicators were incorporated in the calculation of the hospital quality metrics score for each hospital.

All used data was accessed from and is available at:

<https://www.cihi.ca/en/access-data-and-reports/indicator-library/download-indicator-data>.

Additionally, the **Accreditation Canada** was taken into account, for which the list of accredited institutions can be found here:

<https://accreditation.ca/>

Hospitals that were on this list had the category as a part of their hospital quality metrics score.

k. **Australia**

According to the Australian Institute of Health and Welfare, there are 1,334 hospitals in Australia as of December 2025. Of these, 701 are public, while 633 are private hospitals. The total number of available hospital beds per 1,000 inhabitants is 2.5 (AIHW, 2025).

For the World's Best Hospitals ranking, the following data provided by the Australian Institute of Health and Welfare was used for comparison:

- Time spent in emergency departments
- Healthcare-associated bloodstream infections
- Waiting times for elective surgery

The available dataset for **Time spent in emergency departments** displays data for public Australian hospitals in the time period between 2024 and 2025. It measures how many

patients from the emergency department were seen within the recommended maximum waiting time. Recommended maximum waiting times vary depending on the triage level and are clustered into five different categories: resuscitation, emergency, urgent, semi-urgent, and non-urgent. For each reporting unit, the percentage of patients seen on time is compared to their peer group average. The hospitals are clustered into seven different peer groups: large metropolitan hospitals, large regional hospitals, major hospitals, medium metropolitan hospitals, medium regional hospitals, small hospitals, and children's hospitals. The differentiation by urgency levels and hospital sizes allows for a fairer basis of comparison and more precise measures. **Healthcare-associated bloodstream infections** measures how many bloodstream infections can be associated with care provided at a hospital. Hospitals are also clustered into different peer groups for better comparison: major hospitals, large hospitals, medium hospitals, small hospitals and children's hospitals. Private hospitals are listed in their own peer group. The infection is displayed as a rate per 10,000 patient days, next to the peer group average. The available data relates to the time period between 2023 and 2024. The last indicator, **waiting times for elective surgery**, measures the percentage of elective surgeries within the recommended maximum waiting time. The hospitals are clustered in the same peer groups as in the first described indicator. Additionally, the treating doctor determines how urgently surgery is needed and then assigns the patient to one of three urgency categories: recommended within 30 days, recommended within 90 days, or recommended within 365 days. Each hospital then has three values that are comparable to their peer group average. The data derives from the time period between 2024 and 2025.

All used data was accessed from and is available at:

<https://www.aihw.gov.au/>

I. Saudi Arabia

In Saudi Arabia the key regulatory bodies are The Saudi Health Council and The Saudi Central Board for Accreditation of Healthcare Institutions (Central Board for Accreditation of Healthcare Institutions (CBAHI), 2025). The Saudi Health Council is the high-level regulatory body that aligns key stakeholders to improve and integrate healthcare services (Saudi Health Council, 2026), while CBAHI is responsible for setting quality standards and granting accreditation to all healthcare facilities. Currently, there are 474 hospitals in Saudi Arabia (CBAHI) (Central Board for Accreditation of Healthcare Institutions (CBAHI), 2025). Of these, around 290 hospitals are operated by the Ministry of Health,

59 by other government providers, and 150 by the private sector (U.S.-Saudi Business Council, 2024). In 2022, there was an estimated 2.43 beds per 1,000 inhabitants (Kattan, W., & Alshareef, N., 2024).

Key regulatory bodies are The Saudi Health Council and The Saudi Central Board for Accreditation of Healthcare Institutions (Central Board for Accreditation of Healthcare Institutions (CBAHI), 2025). The Saudi Health Council is the high-level regulatory body that aligns key stakeholders to improve and integrate healthcare services (Saudi Health Council, 2026), while CBAHI is responsible for setting quality standards and granting accreditation to all healthcare facilities.

For the hospital ranking in Saudi Arabia, patient experience data was used. This data was collected by the Ministry of Health and accessed via the National Health Information Center. This patient experience indicator is the percentage of patients surveyed who respond, "strongly agree" or "agree" to the statement, *"They give me exactly the help I want [and need] exactly when I want [and need] it."* (National Health Information Center, 2025)

All used data was accessed from and is available at:

<https://nhic.gov.sa/kpis/chart-details/1/2024/en>

Additionally, **CBAHI** and the **Joint Commission** accreditations were considered, for which the lists of accredited institutions can be found here:

<https://portal.cbahi.gov.sa/en/health-accreditation/accreditation/status-of-health-facilities/accreditation-status-of-health-facilities/>

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

m. Netherlands

There are 113 hospitals in the Netherlands: 98 of them are general hospitals, eight are University Medical Centers, and seven are specialized pediatric clinics (Rijksinstituut voor Volksgezondheid en Milieu (RIVM), 2024). Healthcare is managed by the government and is universal for all Dutch citizens. Anyone living or working in the Netherlands must obtain basic level health insurance from a private insurance company.

For the hospital ranking in the Netherlands, patient experience data was used. This data is provided by Patiëntenfederatie Nederland (Patients Federation of the Netherlands). The data is available on ZorgkaartNederland, an online platform where patients can

provide (subjective) ratings of hospitals where they received treatment. Hospitals can obtain a grade between 1 and 10, based on the number of recommendations they receive from patients.

All used data was accessed from and is available at:

<https://www.zorgkaartnederland.nl/>

Additionally, the **Joint Commission and Qualicore Europe** accreditation were taken into account, for which the list of accredited institutions can be found here:

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

<https://www.qualicor.eu/accreditatie/>

n. Switzerland

The Swiss healthcare system is highly decentralized, divided among three levels of the government: the federal level, the canton level, and the municipal level. As healthcare insurance is mandatory for every citizen, coverage is universal. According to the Swiss Federal Office for Statistics (Bundesamt für Statistik, 2024), there are 270 hospitals in Switzerland as of 2024; 98 are classified as general hospitals and 172 as specialized hospitals.

The Federal Office of Public Health (Bundesamt für Gesundheit (BAG)) publishes standardized mortality ratios for each hospital, which are used as a part of the hospital quality metrics for the Swiss national ranking. Until the end of 2025, the most recent data available was from 2023. The mortality rates are risk-adjusted by age and sex.

All used data was accessed from and is available at:

<https://www.bag.admin.ch/de/qualitaetsindikatoren-der-schweizer-akutspitaeler>

Additionally, several quality indicators derived from the National Association for Quality Development in Hospitals and Clinics (Nationaler Verein für Qualitätsentwicklung in Spitalern und Kliniken (ANQ)) and published on Spitalfinder were used to evaluate the hospital quality metrics score:

- Postoperative wound infections
- Pressure ulcers
- Falls

- Avoidable re-hospitalization rate

Postoperative wound infections rates measure infections that occur typically within one month after surgery in tissues, organs, or cavities. A **pressure ulcer** is localized damage to the skin and underlying tissue. It can be caused by care errors and is therefore used as an indicator of the care provided in a hospital. Likewise is the number of **falls** an indicator of the quality of nursing care in a hospital. The **avoidable hospital rehospitalization rate** measures potentially avoidable rehospitalizations in relation to the total number of rehospitalizations. Rehospitalizations are considered potentially avoidable if they occur unexpectedly within 30 days and are due to an already-known problem.

The data used is available at:

<https://www.anq.ch/de/>

The data is published at:

<https://www.spitalfinder.ch/>

The quality results from Initiative Qualitätsmedizin (IQM) were also used for the ranking. About 500 hospitals from Germany and Switzerland are involved in the IQM to improve the quality of medicine. Hospitals that participate in the Initiative Qualitätsmedizin receive a bonus to their quality metrics score.

Further information about hospital quality results in Germany and Switzerland is available at:

<https://www.initiative-qualitaetsmedizin.de/qualitaetsmethodik>

Patient Experience

In Switzerland, the ANQ is a national association for quality improvement in Swiss hospitals. They have measured patient experience in general hospitals among adults since 2009. Patient experience is assessed in different categories. The following were used for this ranking:

- Quality of treatment
- Questions asked
- Answers given
- Medication management
- Hospital discharge
- Hospital length of stay

For all categories, patients could rate their hospital stay from 1 to 5, with 5 being the highest grade possible. For the first question, patients were asked how satisfied they were with their **quality of treatment** in general. **Questions asked** assesses whether patients had the possibility to ask questions of the medical staff. **Answers given** asks the patient if they received satisfying and understandable answers to their questions. **Medication management** relates to whether the use of medication at home was explained to the patient in an understandable way. **Hospital discharge** evaluates the patient's experience of the discharge process. Finally, patients were asked about their perception of the **length of stay** in the hospital.

The data used is available at:

<https://www.anq.ch/de/>

The data is published at:

<https://www.spitalfinder.ch/>

o. **United Arab Emirates**

The United Arab Emirates has a dual healthcare system comprising public and private sectors. At the federal level, the ministry of health and prevention (MOHAP) sets national policy, regulates providers while individual emirates manage their local health facilities (e.g., Dubai and Abu Dhabi have distinct regulatory frameworks). (Ministry of health and prevention, 2025). In the United Arab Emirates, there are a total of 173 hospitals, the majority of which, 117 hospitals, are classified as private, while 56 hospitals are publicly owned. In 2023, there were 1.73 hospital beds per 1,000 inhabitants in the United Arab Emirates, of which 9,514 beds were in the public sector and 8,983 beds were in the private sector. (Ministry of Health and Prevention, n.d.) (IMF, 2025).

Hospital quality metrics used for UAE hospitals are provided by the Department of Health— Abu Dhabi (DOH). The following metrics were taken into account for the analysis, including five waiting-time related indicators and four quality indicators:

- **Waiting-time metrics:**
 - Hospital Wait at Point of Arrival
 - Percentage of first available appointment for Consultant or specialist (excluding cancer)
 - Seeing a doctor in emergency department or urgent care center (Door to Doctor Time)

- 72 hours-Re attendance rate to emergency department or urgent care center
- Left Without Being Seen (LWBS) by an emergency department or urgent care doctor
- **Quality metrics:**
 - Rate of Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)
 - Rate of Healthcare-Associated Multidrug-Resistant Organism (MDRO) Bloodstream Infection (All inpatients)
 - 30-Day All-Cause Unplanned Hospital Readmission Rate for Medical And Surgical Patients
 - Rate of healthcare associated infection (HAI) Clostridium Difficile Infection (CDI) in all adult inpatients

Additionally, three accreditations were considered for which the lists of accredited organizations can be found here:

- **Joint Commission**
<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>
- **Accreditation Canada** <https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations><https://accreditation.ca/find-intl-accredited-service-provider/>
- **Planetree**
<https://www.planetree.org/person-centered-care-certified-sites>

The analysis utilized the previously mentioned hospital quality metrics for hospitals in the Emirate of Abu Dhabi region. Since such data, or comparable data, is not publicly available for hospitals in other parts of United Arab Emirates, their analysis continues to rely on PROMs, accreditations from the Joint Commission, Accreditation Canada, Planetree, as well as Google Scores and recommendations from medical experts. Due to the structure of the analysis, hospitals lacking quality metrics due to regional differences are not at a disadvantage compared to those with additional data.

p. Austria

The healthcare system in Austria is publicly funded and follows the principle of statutory health insurance, leading to a 99% coverage of all Austrian citizens. In 2025, a total of 259 hospitals existed in Austria, 110 of which were general hospitals (BMSGPK, 2025).

The hospital quality metrics used for the national ranking of Austrian hospitals are published by the Austrian Federal Ministry of Social Affairs, Health, Care and Consumer Protection. There are seven quality indicators for 51 different medical treatments available. These quality indicators are derived from a nationwide quality measurement program, the Austrian Inpatient Quality Indicators (A-IQI), where hospitals must provide information at regular intervals. The results are published at [Kliniksuche.at](https://kliniksuche.at). The following indicators were used as part of the hospital quality metrics score:

- Patient orientation
- Complaint/feedback management
- Patient safety/risk management
- Discharge management
- Safety in the operating room
- Hospital hygiene
- Minimum requirements for quality management

For each indicator, a degree of fulfillment is displayed, categorized as: a) fulfilled, b) partially fulfilled, or c) not fulfilled.

Additionally, the length of stay compared to the nationwide average is used to calculate the overall hospital quality metrics score. The median serves as the statistical method to indicate whether a hospital is (a) equal to/above the national comparison value, or (b) below the nationwide comparison value. The indicator for the length of stay is shown only if a hospital treated more than 10 cases within the given time frame.

The data used is available at:

<https://gesundheitsfonds-steiermark.at/qualitaetsarbeit/qualitaetsberichterstattung/>
<https://www.sozialministerium.at/>

The data is published at:

<https://kliniksuche.at/>

q. Belgium

In Belgium, there are a total of 103 hospitals, the majority of which, 72 hospitals, are classified as not-for-profit private hospitals. 31 hospitals are publicly owned. (Federal Public Service Health, 2025) Health Insurance is provided through five private, not-for-profit national associations of sickness funds, one public sickness fund and one fund for railway personnel. There are 5.4 hospital beds available per 1,000 inhabitants, which is above the EU average of 4.2 (OECD, 2025d).

In 2017, the Vlaams Instituut voor Kwaliteit van Zorg (VIKZ) was established to enhance transparency and drive improvements in the quality of care and patient safety within the Flanders region. The following hospital quality metrics were taken into account for the analysis:

- Key requirements for effective hand hygiene
- Verification of the patient's identification band
- Checklist for safe surgeries
- Unplanned emergency readmissions
- Assessment of pressure ulcer risk

All used data was accessed from and is accessible at:

<https://www.zorgkwaliteit.be/algemeen-ziekenhuis>

Patient Experience

The Vlaams Instituut voor Kwaliteit van Zorg (VIKZ), in collaboration with the Vlaams Patiëntenplatform and consultations with experts and patient representatives, developed a patient survey to measure and improve patient experience. The questionnaire includes 28 questions about patient experience across various dimensions, focusing on the care received by the patients.

Measurements used for the calculation of the patient experience score in the World's Best Hospitals ranking for Belgium were:

- General Satisfaction Score
- Recommendation of the hospital for family and friends

The data for the 2024 survey is available at:

<https://www.zorgkwaliteit.be/algemeen-ziekenhuis>

Additionally, accreditation from the **Joint Commission and Accreditation Canada** were considered, for which the list of accredited institutions can be found here:

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

<https://accreditation.ca/find-intl-accredited-service-provider/>

The analysis utilized the previously mentioned hospital quality metrics and patient experience data for hospitals in the Flanders region. Since such data, or comparable data, is not publicly available for hospitals in other parts of Belgium, their analysis continues to rely on accreditations from the Joint Commission, Accreditation Canada and Google Scores.

Due to the structure of the analysis, hospitals lacking quality metrics and patient experience data due to regional differences are not at a disadvantage compared to those with additional data.

r. Sweden

Sweden currently has about 100 hospitals (International Trade Administration, n.d.). The Swedish counties are grouped into six healthcare regions to facilitate cooperation and maintain a high level of medical care. Emergency services are provided by two-thirds of the regional hospitals and the university hospitals. The latter are also focused on specialized care (The Commonwealth Fund, 2020). Sweden has a low density of hospital beds per inhabitant, with 1.9 beds per 1,000 inhabitants in 2022 (OECD, 2025a).

The hospital quality metrics used for Swedish hospitals are based on data published by regional governments and local municipalities and are published at *Vården i siffror* (*Vården i siffror*, 2025). Indicators are selected by Swedish officials in cooperation with different data holders, such as specific registry data or the National Board of Health and Welfare in Sweden. However, not all indicators are published at the hospital level (e.g., only at the regional level), and others are not comparable across hospitals. Therefore, the most generally applicable indicators for the process were selected to determine the hospital quality metrics score, which was calculated using the most current data:

- Waiting time in emergency room for patients 19 years and older (2024)
 - Data used is available at: Socialstyrelsen, Patientregistret (<https://www.socialstyrelsen.se/statistik-och-data/register/patientregistret/>)
- Waiting time in emergency room for patients 80 years and older (2024)

- Data used is available at: Socialstyrelsen, Patientregistret (<https://www.socialstyrelsen.se/statistik-och-data/register/patientregistret/>)
- Mortality rate 28 days after hospitalized stroke (2023)
 - Data used is available at: Socialstyrelsen, Dödsorsaksregistret (<https://www.socialstyrelsen.se/statistik-och-data/register/dodsorsaksregistret/>)
- Transfers to another intensive care unit (ICU) due to lack of resources (2024)
 - Data used is available at: Svenska Intensivvårdsregistret (SIR) (<https://www.icuregswe.org/>)
- Risk-adjusted mortality after ICU care (2024)
 - Data used is available at: Svenska Intensivvårdsregistret (SIR) (<https://www.icuregswe.org/>)

The data from the available data sources is published at:

<https://vardenisiffror.se/>

Hospitals with two nearby sites that report their quality metrics as a single unit were ranked as one entity.

s. Norway

In Norway, healthcare is publicly tax-financed, providing universal coverage for all residents. The public healthcare system is structured into four different regional health authorities (RHAs), with each authority operating several trusts. The majority of all hospital stays in Norway occur in public hospitals, with private not-for-profit and for-profit hospitals offer some alternative services. Private hospitals and RHAs can have tender agreements (OECD, 2023).

Hospital quality metrics for Norwegian hospitals are provided by the Norwegian Directorate of Health. The directorate is an executive agency and professional authority under the Ministry of Health and Care Services, which aims to improve the quality of health services and to promote factors that ensure the population remains in good health (Helsedirektoratet, 2024). Data about the quality of hospitals can be displayed for each hospital or hospital trust. The following hospital quality metrics were used:

Group	KPIs
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Hospital	Postponement of planned operations
	Proportion of patients placed in corridors
	Discharge summaries sent within 7 days of discharge
30 Day Infection Follow Up	Gallbladder removal
	Insertion of hemiprosthesis (hip)
	Insertion of total arthroplasty (hip)
	Caesarean
	Colon surgery
Postoperative infections occurring within 30 days	Gallbladder removal
	Insertion of hemiprosthesis (hip)
	Insertion of total arthroplasty (hip)
	Caesarean
Hip Fracture	30-day survival after hospitalization for hip fracture
	Surgery within 24 hours
	Surgery within 48 hours

The first group of indicators are related to general hospital metrics. **Postponement of planned operations** indicates how many planned operations were not executed on time, while the **proportion of patients placed in corridors** indicates how often more patents are admitted above the hospital’s normal capacity due to accidents or disasters. Finally, the **discharge summaries sent within 7 days of discharge** measures how quickly hospitals send updated discharge summaries (epicrisis) to relevant healthcare providers after a patient’s discharge to ensure timely, continuous, and safe follow-up care.

The **30-day infection follow-up rate** group of metrics shows the percentage of patients who were assessed for infection within 30 days of their surgery. It is reported for five different procedures: gallbladder removal, colon surgery, hemiprosthesis insertion (hip), total arthroplasty (hip), and caesarean section.

The **postoperative infections occurring within 30 days** shows the percentage of patients who had either a superficial infection or a deep cavity/organ infection within 30

days of surgery. It is reported for four different procedures: gallbladder removal, hemi-prosthesis insertion (hip), total arthroplasty (hip), and caesarean section.

The final group of metrics are related to hip fractures. The **30-day survival rate after hip fracture** shows the percentage of patients who survived a time period of 30 days after their discharge from the hospital. **Surgery within 24 hours and 48 hours** indicates the proportion of patients with hip fractures who have undergone surgery within 24 and 48 hours of admission.

The most recent data was available for all the metrics is for 2024.

All used data was accessed from and is available at:

<https://www.helsedirektoratet.no/>

t. Denmark

The Danish health system is decentralized and largely tax-funded. The national government provides block grants from tax revenues to the regions and municipalities providing health services. All residents are entitled to publicly funded care, including largely free primary, specialist, hospital, psychiatric, preventive, and long-term care services. Approximately 97 percent of hospital beds are publicly owned. Private hospitals are relatively small and provide mostly specialized care. Patients can choose between public hospitals, and payment follows the patient to the receiving hospital if the facility is located in another region (The Commonwealth Fund, 2020).

The Danish Healthcare Quality Institute (DHQI) is a national body that works with the Danish health system to secure data-driven quality of care, effective prioritization, and better use of resources for patients. It focuses on developing clinical guidelines, evaluating treatment methods, running clinical quality registries, and managing the Danish Patient Safety Database (SundK, 2026). Hospital quality metrics from two databases were taken into account for the analysis of the ranking: the Danish Intensive Database (DiD) and the Database for Acute Hospital Contacts (DAH).

The **Danish Intensive Database (DiD)** is a nationwide clinical quality database whose purpose is to record the incidence and results of intensive therapy to assess whether treatment and treatment results are up to the desired level, and to maintain or improve the achieved level of treatment. The most recent report was published in June 2025 and took patient data from 2024 into account. The following measures were part of the analysis:

- Share of readmissions to intensive care units within 48 hours of discharge for patients admitted >24 hours
- Proportion of readmissions to intensive care unit within 48 hours after discharge to permanent ward for patients admitted ≤24 hours
- Proportion of patients transferred to another intensive care unit due to capacity problems

The **Database for Acute Hospital Contacts (DAH)** is a national quality monitoring database of acute patient procedures in Danish hospitals to ensure uniformly high quality of treatment in acute patient care. The most recent report was published in June 2025 and took patient data from 2024 into account. The following measures were part of the analysis:

- Proportion of acute hospital stays of ≥12 hours duration where the patient dies within 7 days after arrival
- Proportion of acute hospital stays >1 and <12 hours duration where the patient dies within 7 days after arrival
- Proportion of acute hospital stays <24 hours duration that results in a new acute hospital stay ≤72 hours
- Time from hospital arrival to administration of pain medication
- Time from hospital arrival to surgery for hip fractured in patients arriving with hip fractures
- Time from hospital arrival to thrombolysis in patients with ischemic stroke – for patients whose first contact was at the hospital that performed thrombolysis.
- Time from hospital arrival to thrombolysis for patients with ischemic stroke – for patients whose first contact was not at the hospital that performed thrombolysis.

All data was accessed from and is accessible at:

<https://www.rkkp.dk/kvalitetsdatabaser/>

Patient Experience

In Denmark, patient experience data is collected using the Landsdækkende Undersøgelse af Patientoplevelser (LUP) survey, a collaboration between the five Danish regions and the Ministry of the Interior and Health. The survey was first conducted in 2000, and since 2022, data has been collected on a monthly basis for planned hospitalizations, emergencies, and outpatient procedures. The data from planned hospitalizations from 2024 were used in the ranking. Patient experience is assessed based on ten questions that can be grouped into the following categories:

- Staff friendliness
- Information and engagement from staff
- Quality of treatment
- Quality of hospitalization

For all categories, patients could respond with an answer from 1 to 5, with 5 being the highest score possible.

The data used is available at:

<https://www.regionh.dk/patientinddragelse/LUP/aktuel-undersogelse/Sider/LUP-2024.aspx>

u. **Israel**

There are currently 88 hospitals in Israel, of which 45 are general hospitals. Thirty-seven are classified as public hospitals, 26 as non-profit private hospitals, and 25 as for-profit private hospitals. The density of beds per inhabitant is comparable to most other countries in the ranking, with 3.0 beds per 1,000 inhabitants in 2025 (OECD, 2025e).

Since 2013, **the Israeli National Program for Quality Indicators (INPQ) has** promoted continuous improvement in Israeli healthcare quality, by both measuring the quality of care in major care and treatment areas and publicizing the results (Ministry of Health Israel, 2025). For this year's analysis, the evaluation for Israel incorporates an updated and expanded set of hospital quality indicators collected and published by the Israeli Ministry of Health. These indicators reflect performance across acute care, surgical quality, infection prevention, diagnostics, and continuity of care. The following metrics were included in the assessment:

- Dialysis adequacy
- Prophylactic antibiotic administration for hip/knee joint replacement
- Administration of antithrombotic therapy for hysterectomy surgery
- Rate of colonoscopies
- Prophylactic antibiotic administration for hip fracture surgery
- Carotid duplex scan within 72 hours for patients diagnosed with TIA (Transient Ischemic Attack)
- Time to head CT for stroke patients
- Body temperature in the recovery room

- Body temperature management for premature infants
- Recommendation for cardiac rehabilitation
- Appropriate prophylactic antibiotic administration for colon surgery
- Vitamin D level evaluation after hip fracture
- Statin therapy after coronary artery bypass graft (CABG) surgery
- CHADS score documentation for patients with atrial fibrillation (stroke-risk assessment)

These indicators represent key elements of clinical quality and patient safety and are used to compare hospital performance across Israel for the World's Best Hospitals ranking.

All used data was accessed from and is accessible at:

<https://www.gov.il/he/pages/quality-national-prog-2013-2024>

Patient Experience

The Ministry of Health performs a biannual National Patient Experience Survey in general hospitals in Israel. The latest survey was conducted from November 2024 to March 2025. Patients over the age of 18 who were hospitalized for at least two nights were surveyed. Approximately 12,000 patients from 27 hospitals were interviewed.

Respondents were asked about their hospital experience using a comprehensive questionnaire covering key aspects of care and service.

The questionnaire assessed a wide range of patient-reported experiences, including:

- Feeling "in good hands" during hospitalization
- Attitude and respect shown by staff
- Quality of communication and information provided
- Discharge process
- Effort required to obtain information or assistance
- Physical conditions and environment

The data for the 2024 survey is available at:

<https://www.gov.il/he/pages/patient-experience-inpatient-departments-survey-findings-2024-2025>

Additionally, the **Joint Commission accreditation** was taken into account, for which the list of accredited institutions can be found here:

<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>

v. Other Countries

Hospital quality metrics and patient experience data were not available for some countries. These countries are:

- Belgium (all regions excluding Flanders)
- Chile
- Colombia
- Finland
- India
- Malaysia
- Mexico
- the Philippines
- Singapore
- Spain (all regions excluding Madrid and Catalonia)
- Taiwan
- Thailand
- Turkey
- United Arab Emirates (all regions excluding Abu Dhabi)

For those countries, the national score is based on national and international recommendations as well as Google-Scores, albeit with a lower weight (7.5%) than the preferable patient experience data sources. Additionally, the following national accreditations and certifications were taken into account:

- **Accreditation Canada** (for Belgium and the United Arab Emirates):
<https://accreditation.ca/find-intl-accredited-service-provider/>

- **American Accreditation Commission International (AACI)** (for India, Thailand, and Turkey): <https://aacihealthcare.com/accredited-certified-organizations/>
- **Joint Commission** (for Belgium, Colombia, Chile, India, Malaysia, Mexico, Saudi Arabia, Spain, Taiwan, Thailand, and the United Arab Emirates):
<https://www.jointcommission.org/en/about-us/recognizing-excellence/find-accredited-international-organizations>
- **National Accreditation Board for Hospitals & Healthcare Providers (NABH)** (for India): <https://www.nabh.co/frmViewAccreditedHosp.aspx>
- **Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI)** (for Saudi Arabia): <https://portal.cbahi.gov.sa/ar/health-accreditation/accreditation/status-of-health-facilities/accreditation-status-of-health-facilities/>
- **Healthcare Accreditation Institute (HAI)** (for Thailand):
<https://www.ha.or.th/EN/Hospitals/Certificate%20Status>
- **The Malaysian Society for Quality in Health (MSQH)** (for Malaysia):
<https://www.msqh.com.my/web/index.php/en/>
- **National Accreditation Superintendencia de Salud (SIS)** (for Chile):
<https://www.supersalud.gob.cl/acreditacion/673/w3-propertyvalue-4710.html>
- **Philippine Health Insurance Corporation (PhilHealth)** (for the Philippines):
<https://www.philhealth.gov.ph/partners/providers/facilities/accredited/>
- **Planetree** (Colombia, Malaysia, Saudi Arabia, Chile, Turkey):
<https://www.planetree.org/person-centered-care-certified-sites>
- **The Colombian Institute of Technical Standards and Certification (ICONTEC)** (for Colombia) <https://acreditacionensalud.org.co/instituciones/>
- **American Nurses Credentialing Center (ANCC) Magnet Organization certification** (Mexico):
<https://www.nursingworld.org/organizational-programs/magnet/find-a-magnet-organization/>

- **Türkiye Health Care Quality and Accreditation Institute** (for Turkey):
<https://tuska.tuseb.gov.tr/en>

The length of these lists is relatively short compared to the total number of hospitals in these countries to reflect the fact that less data was available than for the other countries.

4 Distribution of participants

Professional activity	% Share of participants
Medical doctor	51%
Healthcare professional	32%
Hospital manager/director	17%

The table above shows the percentage share of all participants by professional activity. In accordance with the study design, the majority of survey participants were medical doctors, followed by healthcare professionals (e.g., nurses).

In several participating countries, the distribution of survey participants was slightly different:

While for some countries, such as Chile, Finland, and Italy, the survey participants were all medical doctors, the biggest group of participants from Brazil were healthcare professionals (e.g., nurses, paramedics, physiotherapists, midwives), accounting for 57% of participants. The share of medical doctors from Saudi Arabia was 31%, and the share hospital managers/directors was 12%. On the other end of the spectrum, in the United States of America, 94% of the participants were medical doctors, 4% of all survey participants were healthcare professionals, and just 1% were hospital managers/directors. On the other hand, a relatively high number of hospital managers/directors participated in Taiwan with 44%.

In conclusion, in all participating countries, except for Saudi Arabia, most participants were medical doctors. The percentage share of healthcare professionals and hospital

managers/directors differed across participating countries, but these variations did not significantly impact voting behavior in any of the national samples.

5 Disclaimer

The rankings are comprised exclusively of hospitals that are eligible regarding the scope described in this document. A mention in the ranking is a positive recognition based on peer recommendations and publicly available data sources at the time. The ranking is the result of an elaborate process which, due to the interval of data collection and analysis, is a reflection of the last calendar year. Furthermore, events preceding or following the period 01/01/2025–31/12/2025 and/or pertaining to individual persons affiliated/associated to the facilities were not included in the metrics. As such, the results of this ranking should not be used as the sole source of information for future deliberations. The information provided in this ranking should be considered in conjunction with other available information about hospitals or, if possible, accompanied by a visit to a facility. The quality of hospitals that are not included in the rankings is not disputed.

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Appendix A

PROMs Implementation Survey section	Weight
PROMs status assessment	5%
PROMs team	5%
Number of standardized PROMs	4%
Condition-specific PROMs - Case mix adjustment	6%
Condition-specific PROMs - Scientifically validated	5%
Condition-specific PROMs - Response rate	6%
Condition-specific PROMs - Follow-up rate	6%
Reporting PROMs results internally to clinicians	4%
Reporting PROMs results internally to management board	4%
Reporting PROMs results internally to patients	4%
Provide patients with individual reports of PROMs data	4%
Reporting PROMs results to the public	11%
Audit before publishing the data	6%
Using PROMs data to optimize care processes	7%
Using PROMs data to support therapeutic decisions in real-time	7.5%
Using PROMs data for shared decision making	7.5%
Sharing and comparing PROMs data with other institutions	8%

Appendix B

Questionnaire Regarding Patient Reported Outcome Measures (PROMs) Implementation

This survey aims to evaluate how Patient Reported Outcome Measures (PROMs) are implemented in your hospital. PROMs are standardized, validated questionnaires completed by patients to capture their perception of functional well-being and quality of life during or after an episode of care.

Examples include the **EQ-5D** (a generic PROM) and the **EORTC QLQ-C30** (a condition-specific PROM for oncology). For more background, we can recommend the resources of [ICHOM](#), [NHS](#), [PROMIS](#)

In recent years, PROMs have become a cornerstone of patient-centered care and a key topic in healthcare systems worldwide. To reflect this, Newsweek and Statista are surveying leading hospitals on PROMs implementation. Responses will contribute to the **2026 Statista Hospital Rankings**.

To ensure validity, participants will be asked to complete a short verification form at the end of the survey.

Please note: This survey refers exclusively to PROMs (Patient Reported Outcome Measures), not PREMs (Patient Reported Experience Measures).

Thank you in advance for your participation.

Information about the timing of deleting personal data, the countries where we save data (e.g., U.S., EU, UK, Singapore), and the companies we collaborate with can be found in our [privacy statement](#).

1 General Information

1.1 What type of hospital or healthcare facility do you work in?

- General or specialist hospital (physical/somatic care)
- Psychiatric hospital /facility
- Psychiatric department within general hospital
- Other (please specify)

1.1.1 [if no mental health care facility] Please state which hospital you are providing information for:

Hospital Name	
Address	
City	
Country	

1.1.2 [if mental health care facility] Please state which hospital you are providing information for:

Hospital Name	
Address	
City	
Country	

1.1.3 [if no mental health care facility] Please provide your own contact details as the person completing this survey: *(This information will only be used for follow-up questions related to the survey, if necessary.)*

Title: [Textfield]

First name: [Textfield]

Middle name: [Textfield] **[optional]**

Last name: [Textfield]

Position:

[Dropdown:

- I am a hospital manager / director.
- I am a medical director.
- I work in the quality assurance department.
- I am the chief physician of the department.
- I am the office assistant of the chief physician of the department.
- Other: **[Specify]**

Email: [Textfield]

Phone: [Textfield] **[optional]**

1.1.4. [if mental health care facility] Please provide your own contact details as the person completing this survey: *(This information will only be used for follow-up questions related to the survey, if necessary.)*

Title: [Textfield]

First name: [Textfield]

Middle Name: [Textfield] [optional]

Last name: [Textfield]

Position: [Dropdown: I am a hospital manager / director.

- I am a hospital manager / director.
- I am a medical director.
- I work in the quality assurance department.
- I am the chief physician/psychiatrist/psychologist of the department.
- I am the office assistant of the chief physician of the department.

Other: [Specify]

Email: [Textfield]

Phone: [Textfield] [optional]

1. 2 Does your hospital currently hold a Level 1 ICHOM Accreditation?

- Yes
- No

Status Assessment

Patient-Reported Outcome Measures (PROMs) are standardized tools that allow patients to report directly on their health status, symptoms, and the impact of treatment on quality of life- offering insights that go beyond traditional clinical outcomes.

In hospitals, PROMs are typically measured using validated questionnaires or electronic surveys tailored to specific conditions, ensuring that the data reflects patient experiences accurately and helps guide individualized care.

Implementing PROMs assists in aligning treatment with patient priorities by utilizing instruments specifically designed for this purpose.

2.1 Please indicate the overall status of PROMs implementation within your hospital:

- We routinely assess PROMs data within the hospital across multiple departments

- We are piloting PROMs implementation in select departments
- The hospital is currently in the preparatory phase of implementing PROMs but has not yet started implementation [screenout]
- No, we do not implement PROMs at all. [screenout]

3. PROMs Section 1

3.1 Is there a team or person specifically designated to measure PROMs?

- Yes, internal
- Yes, external
- No

3.1.1 Please state the name of the team/person, email address, the department name, and the department URL.

[if yes on internal/external]

Name of main contact/PROMs team	
Email address of main contact/PROMs team	
Name of second contact (optional)	
Email address second contact (optional)	
Name of third contact (optional)	
Email address of third contact (optional)	
Department name	

Department URL	
-----------------------	--

4 PROMs Section 2

4.1 [if no mental health care facility] Does your hospital measure standardized PROMs instruments?

(Standardized PROMs mouseover: Standardized PROMs are validated patient-reported outcome measures that are consistently applied across different patient populations and clinical settings to ensure reliable, comparable data on health outcomes. When translated, certified providers must ensure the translations maintain the validity and reliability of the original questionnaire.)

- Yes
- No

If yes, please select the departments you are measuring for and indicate the number of standardized PROMs used in each department:

Check departments that apply:

Department	Number of standardized PROMs measured
Cardiology	
Cardiac Surgery	
Endocrinology	
Gastroenterology	
General	
Maternity	
Neurology	
Neurosurgery	
Obstetrics & Gynecology	
Oncology	
Ophthalmology	
Orthopedics	
Pediatrics	
Psychiatry	
Psychology	
Pulmonology	
Urology	
Other	

4.2 [if mental health care facility] Does your hospital measure standardized PROMs instruments?

(Standardized PROMs mouseover: Standardized PROMs are validated patient-reported outcome measures that are consistently applied across different patient populations and clinical settings to ensure reliable, comparable data on health outcomes. When translated, certified providers must ensure the translations maintain the validity and reliability of the original questionnaire.)

- Yes
- No

If yes, please select the departments you are measuring for and state the number of standardized PROMs per department

Check departments that apply:

Department/Program/Unit	Number of standardized PROMs measured
Adult Psychiatry Child and Adolescent Psychiatry Geriatric Psychiatry Addiction Disorders Other	

4.3 [if no mental health care facility] Please list the condition-specific PROMs instruments implemented in your hospital, and the department/medical field in which they are implemented (if applicable).

Please indicate if you take case-mix adjustment into account, whether the PROMs are scientifically validated, the percentage of patients that complete the PROMs questionnaire as well as the average follow-up interval for each condition.

Please do not enter the name of the condition or a quality metric in this table (e.g. hip replacement, or length of stay). Only PROMs instruments will be considered for the score:

PROMs instruments (Patient-Reported Outcome Measures) are standardized, validated questionnaires completed directly by patients to measure their health status, quality of life, symptoms, or functional outcomes related to a specific condition or treatment. Examples include the Oxford Hip Score, the Knee Injury and Osteoarthritis Outcome Score (KOOS), or the EORTC QLQ-C30 for cancer patients.

Please note: Please list the name of the PROMs instruments themselves—not the medical condition or treatment they relate to.

(PROMs instrument mouseover: Please note: Please list the name of the PROMs instruments themselves—not the medical condition or treatment they relate to.

(Case-mix adjustment mouseover: Adjustment of the PROMs results to patient severity profiles to improve statistical analyses and reduce selection biases)

(Scientifically validated mouseover: Calibration is published in the literature in the language it is being used)

(Response rate: percentage of eligible patients invited to complete the baseline PROMs questionnaire who submitted a fully completed questionnaire prior to treatment).

(Follow-up interval mouseover: Period of time between the date of the index procedure (or baseline assessment) and the subsequent collection of patient-reported outcome measures (PROMs). If your interval differs from the listed options, please select the closest match)

	PROMs Instrument	Department/Medical Field	Tool is scientifically validated	Case-mix adjustment	Response rate (%)	Follow-up interval (or closest match)	Comment
PROM 1		[Dropdown department] Cardiology Cardiac Surgery Endocrinology Gastroenterology General Maternity Neurology Neurosurgery Obstetrics & Gynecology Oncology Ophthalmology Orthopedics Pediatrics	[Checkbox] Yes/No	[Checkbox] Yes/No	[Dropdown Response rate] 0%-5% 6%-25% 26%-50% 51%-75% More than 75%	[Dropdown Response rate] No follow-up conducted after initiating treatment At discharge Within 30 days after treatment 3 months after initiating treatment 6 months after initiating treatment 12 months after initiating treatment/annual	

		Psychiatry Psychology Pulmonology Urology Other				24 months or longer after initiating treatment Other (Please state the follow-up interval in the comment section)	
PROM 2							
PROM 3							
PROM 4							
PROM 5							
PROM 6							
PROM 7							
PROM 8							
...	Further text boxes will appear						

4.4 [if ICHOM certification] Please list the condition-specific PROMs instruments implemented in your hospital, if they are different from the ICHOM set required for the Level 1 ICHOM Accreditation. If applicable, also indicate the department or medical field where each instrument is used.

Please indicate if you take case-mix adjustment into account, whether the PROMs are scientifically validated, the percentage of patients that complete the PROMs questionnaire as well as the average follow-up interval for each condition.

Please do not enter the name of the condition or a quality metric in this table (e.g. hip replacement, or length of stay). Only PROMs instruments will be considered for the score:

PROMs instruments (Patient-Reported Outcome Measures) are standardized, validated questionnaires completed directly by patients to measure their health status, quality of life, symptoms, or functional outcomes related to a specific condition or treatment. Examples include the Oxford Hip Score, the Knee Injury and Osteoarthritis Outcome Score (KOOS), or the EORTC QLQ-C30 for cancer patients.

Please note: Please list the name of the PROMs instruments themselves—not the medical condition or treatment they relate to.

(PROMs instrument mouseover: Please note: Please list the name of the PROMs instruments themselves—not the medical condition or treatment they relate to.

(Case-mix adjustment mouseover: Adjustment of the PROMs results to patient severity profiles to improve statistical analyses and reduce selection biases)

(Scientifically validated mouseover: Calibration is published in the literature in the language it is being used)

(Response rate: percentage of eligible patients invited to complete the baseline PROMs questionnaire who submitted a fully completed questionnaire prior to treatment).

(Follow-up interval mouseover: Period of time between the date of the index procedure (or baseline assessment) and the subsequent collection of patient-reported outcome measures (PROMs). If your interval differs from the listed options, please select the closest match)

	PROMs Instrument	Department/Medical Field	Tool is scientifically validated	Case-mix adjustment	Response rate (%)	Follow-up interval (or closest match)	Comment
PROM 1		[Dropdown department] Cardiology Cardiac Surgery Endocrinology Gastroenterology General Maternity Neurology Neurosurgery Obstetrics & Gynecology Oncology Ophthalmology Orthopedics Pediatrics Psychiatry	[Checkbox] Yes/No	[Checkbox] Yes/No	[Dropdown Response rate] 0%-5% 6%-25% 26%-50% 51%-75% More than 75%	[Dropdown Response rate] No follow-up conducted after initiating treatment At discharge Within 30 days after treatment 3 months after initiating treatment 6 months after initiating treatment 12 months after initiating treatment/annual	

		Psychology Pulmonology Urology Other				24 months or longer after initiating treatment Other (Please state the follow-up interval in the comment section)	
PROM 2							
PROM 3							
PROM 4							
PROM 5							
PROM 6							
PROM 7							
PROM 8							
PROM 9	Further text boxes will appear						

Please upload a PDF sample of the PROMs instrument(s) currently used in your hospital, such as a blank copy of the questionnaire (e.g., EQ-5D, PROMIS, KOOS).

[IF Follow-up interval] To validate that your hospital conducts follow-up PROMs, please provide supporting documentation. Acceptable forms of proof include SOPs or policy documents, blank follow-up questionnaires, an official confirmation letter from a department lead, or other equivalent documentation demonstrating follow-up practices.

4.5 [if mental health care facility] Please list the condition specific PROMs instruments implemented in your hospital, and the department/medical field in which they are implemented (if applicable).

Please indicate if you take case-mix adjustment into account, whether the PROMs are scientifically validated, and the percentage of patients that complete the PROMs questionnaire for each condition.

Please do not enter the name of the condition or a quality metric in this table (e.g. depressive disorder, or length of stay). We will only consider PROMs instruments for the score:

PROMs instruments (Patient-Reported Outcome Measures) are standardized, validated questionnaires completed directly by patients to assess their mental health status, quality of life, symptom severity, or functional outcomes related to a specific mental health condition or treatment. Examples include the PHQ-9 (Patient Health Questionnaire-9 for depression), the GAD-7 (Generalized Anxiety Disorder-7), the BDI-II (Beck Depression Inventory-II), or the WHOQOL-BREF (World Health Organization Quality of Life brief version).

Please note: we are looking for the name of the PROMs instruments themselves — not the mental health condition or treatment they relate to.

(PROMs instrument mouseover: a standardized survey designed to measure patients' self-reported health outcomes, perspective of their health status and quality of life.)

(Case-mix adjustment mouseover: Adjustment of the PROMs results to patient severity profiles to improve statistical analyses and reduce selection biases)

(Scientifically validated mouseover: calibration is published in the literature in the language it is being used)

(Response rate: percentage of eligible patients invited to complete the baseline PROMs questionnaire who submitted a fully completed questionnaire prior to the procedure).

	PROMs Instrument	Department/ Program/Unit	Tool is scientifically validated	Case-mix adjustment	Response rate (%)	Follow-up interval (or closest match)	Comment
PROM 1	[Dropdown PROMs Instruments] Goal-Based Outcomes (GBO) GDS/GDS-15 CORE-OM PHQ-9 GAD-7 DSM-5 Cross-Cutting Symptom Measure PROMIS Mental Health Scales PCL-5 Audit/Audit-C DAST-1	[Dropdown department] Adult Psychiatry Child and Adolescent Psychiatry Geriatric Psychiatry Community Mental Health Substance Use Disorders Eating Disorders Forensic Psychiatry Other	[Checkbox] Yes/No	[Checkbox] Yes/No	[Dropdown Response rate] 0%-5% 6%-25% 26%-50% 51%-75% More than 75%	[Dropdown Response rate] No follow-up conducted after initiating treatment At discharge Within 30 days after treatment 3 months after initiating treatment 6 months after initiating	

						treatment 12 months after initi- ating treat- ment/an- nual 24 months or longer after initi- ating treat- ment Other (Please state the follow-up interval in the com- ment sec- tion)	
PROM 2							
PROM 3							
PROM 4							

PROM 5							
PROM 6							
PROM 7							
PROM 8							
PROM 9							
...	Further text boxes will appear automatically.						

4.6. [if mental health care facility & ICHOM certification] **Please list the condition-specific PROMs instruments implemented in your hospital, if they are different from the ICHOM set required for the Level 1 ICHOM Accreditation. If applicable, also indicate the department or medical field where each instrument is used.**

Please indicate if you take case-mix adjustment into account, whether the PROMs are scientifically validated, and the percentage of patients that complete the PROMs questionnaire for each condition.

Please do not enter the name of the condition or a quality metric in this table (e.g. depressive disorder, or length of stay). We will only consider PROMs instruments for the score:

PROMs instruments (Patient-Reported Outcome Measures) are standardized, validated questionnaires completed directly by patients to assess their mental health status, quality of life, symptom severity, or functional outcomes related to a specific mental health condition or treatment. Examples include the PHQ-9 (Patient Health Questionnaire-9 for depression), the

GAD-7 (Generalized Anxiety Disorder-7), the BDI-II (Beck Depression Inventory-II), or the WHOQOL-BREF (World Health Organization Quality of Life brief version).

Please note: we are looking for the name of the PROMs instruments themselves — not the mental health condition or treatment they relate to.

(PROMs instrument mouseover: a standardized survey designed to measure patients' self-reported health outcomes, perspective of their health status and quality of life.)

(Case-mix adjustment mouseover: Adjustment of the PROMs results to patient severity profiles to improve statistical analyses and reduce selection biases)

(Scientifically validated mouseover: calibration is published in the literature in the language it is being used)

(Response rate: percentage of eligible patients invited to complete the baseline PROMs questionnaire who submitted a fully completed questionnaire prior to the procedure).

	PROMs Instrument	Department/ Program/Unit	Tool is scientifically validated	Case-mix adjustment	Response rate (%)	Follow-up interval (or closest match)	Comment
PROM 1	[Dropdown PROMs Instruments] Goal-Based Outcomes (GBO) GDS/GDS-15 CORE-OM PHQ-9 GAD-7 DSM-5 Cross-Cutting Symptom Measure	[Dropdown department] Adult Psychiatry Child and Adolescent Psychiatry Geriatric Psychiatry Community Mental Health Substance Use Disorders Eating Disorders Forensic Psychiatry Other	[Checkbox] Yes/No	[Checkbox] Yes/No	[Dropdown Response rate] 0%-5% 6%-25% 26%-50% 51%-75% More than 75%	[Dropdown Response rate] No follow-up conducted after initiating treatment At discharge Within 30 days after	

	<p>PROMIS Men- tal Health Scales</p> <p>PCL-5</p> <p>Audit/Audit-C</p> <p>DAST-1</p>					<p>treat- ment</p> <p>3 months after initi- ating treat- ment</p> <p>6 months after initi- ating treat- ment</p> <p>12 months after initi- ating treat- ment/an- nual</p> <p>24 months or longer after initi- ating treat- ment</p> <p>Other (Please state the follow-up interval in the com- ment sec- tion)</p>	
--	--	--	--	--	--	---	--

PROM 2							
PROM 3							
PROM 4							
PROM 5							
PROM 6							
PROM 7							
PROM 8							
PROM 9							
...	Further text boxes will appear automatically.						

Please upload a PDF sample of the PROMs instrument(s) currently used in your hospital, such as a blank copy of the questionnaire (e.g., EQ-5D, PROMIS, KOOS)-

[IF Follow-up interval] To validate that your hospital conducts follow-up PROMs, please provide supporting documentation. Acceptable forms of proof include

SOPs or policy documents, blank follow-up questionnaires, an official confirmation letter from a department lead, or other equivalent documentation demonstrating follow-up practices.

5. PROMs Section 3

5.1 Are you reporting PROMs data internally within your hospital?

- Yes
- No

5.1.1 [If 5.1 is yes] Are you reporting PROMs data internally to clinicians?

Note: If you select "No", your hospital will not receive points for question 5.1.1. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.1.1.

- Yes
- No

Please provide proof via link or pdf

5.1.2. [If 5.1 is yes] Are you reporting PROMs to hospital management (e.g. board of directors)?

Note: If you select "No", your hospital will not receive points for question 5.1.2. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.1.2.

- Yes
- No

Please provide a pdf sample of the report

5.1.3. [If 5.1 is yes] Are you reporting PROMs data internally to patients?

Note: If you select "No", your hospital will not receive points for question 5.1.3. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.1.3.

- Yes
- No

Please provide proof via link or pdf

5.1.4. [If 5.1 is yes] Do you provide your patients individual reports of the PROMs data?

Note: If you select "No", your hospital will not receive points for this question 5.1.4. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.1.4.

- Yes
- No

Please provide a pdf sample of the report

5.2 Are you reporting your PROMs results to the public?

- Yes
- No

5.2.1. [If 5.2 is yes] Are you reporting PROMs on the internet? (please provide the link)

Note: If you select "No", your hospital will not receive points for question 5.2.1. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.2.1.

- Yes
- No

Please provide proof via link or pdf

5.2.2. [If 5.2 is yes] Are you reporting PROMs in a scientific publication?

Note: If you select "No", your hospital will not receive points for question 5.2.2. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.2.2.

- Yes
- No

Please provide proof via link or pdf

5.2.3. [If 5.2 is yes] Are you reporting PROMs with annual report? (Please state the year you started reporting and provide an example)

Note: If you select "No", your hospital will not receive points for question 5.2.3. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.2.3.

- Yes
- No

Please provide proof via link or pdf

5.2.4. [If 5.2 is yes] Are you reporting PROMs as part of a national PROMs project?

Note: If you select "No", your hospital will not receive points for question 5.2.4. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.2.4.

- Yes
- No

Please provide proof via link or pdf

5.2.5 [If 5.2 is yes] Are you reporting PROMs as part of a grant funded project?

Note: If you select "No", your hospital will not receive points for question 5.2.5. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 5.2.5.

- Yes
- No

Please provide proof via link or pdf

5.2.6. [If 5.2 is yes] Are you reporting PROMs in any other way?

- Yes
- No

Please specify and provide proof via link or pdf

5.3 Is there any PROMs data audit?

Note: If you select "No", your hospital will not receive points for the following questions in section 5.3. If you select "Yes" but do not provide proof links or documents, you will also not receive points for questions in section 5.3.

(PROMs data audit mouseover: a formal review process that assesses the accuracy, completeness, and reliability of PROMs data. This ensures the data accurately reflects patients' health outcomes and is collected and utilized in compliance with clinical and regulatory standards to enhance the quality of care.)

- Yes
- No

5.3.1 [if 5.3. yes] Is the audit performed internally or externally?

- Yes, internally
- Yes, externally
- Yes, both internally and externally

[If internally] To demonstrate that PROMs data at your hospital are reviewed for quality, please provide any supporting documentation of audit or review processes. This could include internal audit reports or any other evidence showing how data quality is ensured. Please select which type of proof you would like to upload:

5.3.2 [If externally] Is the external audit required by legislation or on a voluntary basis?

- Legislation
- Voluntary

Please provide the name and website of the auditor and upload proof.

Name of the auditor: [Textfield]

Website of the auditor: [Textfield]

To demonstrate that PROMs data at your hospital are reviewed for quality, please provide any supporting documentation of audit or review processes. This could include external audit reports or any other evidence showing how data quality is ensured. Please select which type of proof you would like to upload:

6. PROMs 4

6.1.1 Do you use PROMs data to optimize care processes?

- Yes
- No

If yes, please provide a recent example of how you use PROMs data to optimize care processes in your hospital:

Please write your answer here:

6.1.2 Are your PROMs data implemented into clinical programs (e.g. mental health programs)?

Information: *Clinical programs* are organized healthcare services designed to address specific health conditions or patient needs, following evidence-based guidelines. They may focus on prevention, treatment, rehabilitation, or long-term management. Examples include mental health programs, diabetes management programs, cardiac rehabilitation programs, cancer survivorship programs, and chronic pain management programs

Note: If you select "No", your hospital will not receive points for this question 6.1.2. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.1.2.

- Yes
- No

Please provide proof via link or pdf

6.1.3 Are your PROMs data used for research purposes?

Information: *Research purposes* can include any kind of research including internal studies, quality improvement projects, collaborations, academic research, even market or policy research. It does not require that the research leads to a publication; the data might be analyzed internally or shared in a research partnership without ever appearing in a paper.

Note: If you select "No", your hospital will not receive points for question 6.1.3. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.1.3.

- Yes
- No

Please provide proof via link or pdf

6.1.4 Are your PROMs data used to contribute to value-based healthcare projects (e.g. internal continuous quality improvement)?

Information: *Value based healthcare projects* aim to improve patient outcomes while optimizing the use of healthcare resources. They focus on measuring results that matter to patients and linking them to the cost of delivering care. Examples include internal continuous quality improvement initiatives, outcome-based payment models, and performance benchmarking programs. If your PROMs data are used to support such projects select 'Yes'.

Note: If you select "No", your hospital will not receive points for this question 6.1.4. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.1.4.

- Yes
- No

Please provide proof via link or pdf

6.1.5 Are your PROMs data used to contribute to outcome-based payment strategies?

Information: *Outcome based payment strategies* link provider payment to patient health results rather than service volume. PROMs data help demonstrate improvements, for example in mobility after surgery or symptom reduction in chronic disease programs. This question asks if your PROMs data are used in such models.

Note: If you select "No", your hospital will not receive points for this question 6.1.5. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.1.5.

- Yes
- No

Please provide proof via link or pdf

6.1.6 Are your PROMs data used for internal comparison between departments or locations within the hospital?

Note: If you select "No", your hospital will not receive points for this question 6.1.6. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.1.6.

- Yes
- No

Please provide proof via link or pdf

6.1.7 Are your PROMs data used for external benchmarking between providers and regions?

Information: *External benchmarking between providers* compares performance and patient outcomes across different healthcare organizations or regions. PROMs data can be used to identify best practices, highlight variations in care, and drive quality improvements. This question asks if your data are used for such comparisons.

Note: If you select "No", your hospital will not receive points for this question 6.1.7. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.1.7.

- Yes
- No

Please provide proof via link or pdf

6.2 Are you using PROMs data to support therapeutic decisions in real-time?

Note: If you select "No", your hospital will not receive points for this question 6.2. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.2.

- Yes
- No

Please provide a recent example of how you use PROMs data to support real-time decisions:

6.3 Are you using PROMs data for shared decision-making?

Note: If you select "No", your hospital will not receive points for this question 6.3. If you select "Yes" but do not provide proof links or documents, you will also not receive points for questions in section 6.3.

- Yes
- No

6.3.1. If PROMs data are used for shared decision-making, please provide an example and (if applicable) name the tool you are using for shared decision making (e.g. Clinical Decision Support Decision, quality improvement dashboards, etc.)

Please provide a recent example of how you use PROMs data for shared decision making and the tool you are using

Please upload a sample link or pdf of the shared decision-making strategies in place

6.4. Is PROMs data transferred to an existing registry?

Information: An *existing registry* is an established database or system that collects, stores, and manages healthcare data, often at a national or regional level for monitoring patient outcomes, quality of care, or research. Examples (including but are not limited to) the Swedish Hip Arthroplasty Register (Sweden), National Cancer Registration and Analysis Service (UK), National Cardiovascular Data Registry (USA), and the Australian Orthopaedic Association National Joint Replacement Registry (Australia).

Note: If you select "No", your hospital will not receive points for this question 6.4. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.4.

- Yes
- No

Please specify and provide proof via link or pdf

6.5 Are PROMs results reported back to the public authority (e.g. ministry of health)?

Note: If you select "No", your hospital will not receive points for this question 6.5. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.5.

- Yes
- No

Please specify and provide proof via link or pdf

6.6 Are your PROMs data contributing to international registries (e.g., OECD)?

Information: *International registries* are cross-country databases or collaborative systems that collect and analyze standardized health data from multiple nations. They enable comparison of patient outcomes, benchmarking of healthcare performance, and identification of best practices globally. Examples include the OECD Health Statistics, International Cancer Benchmarking Partnership (ICBP), and International Consortium for Health Outcomes Measurement (ICHOM) registries.

Note: If you select "No", your hospital will not receive points for this question 6.6. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.6.

- Yes
- No

Please specify and provide proof via link or pdf

6.7 Are your PROMs data contributing to MedTech, pharma, or innovation initiatives?

Information: *MedTech, pharma, or innovation initiatives* refer to projects, partnerships, or research efforts that are often led by medical technology companies, pharmaceutical firms, or health innovation organizations. They use health data to develop new treatments, devices, diagnostics, or care models. This question asks if your PROMs data are shared to support such initiatives, for example in clinical trials, product development, or real-world evidence studies.

Note: If you select "No", your hospital will not receive points for this question 6.7. If you select "Yes" but do not provide proof links or documents, you will also not receive points for question 6.7.

- Yes
- No

Please specify and provide proof via link or pdf

Please provide a recent example of when you shared your PROMs data:

7 Contact Person

7.1 Are you the contact person within the hospital which Statista can reach out to for validation purposes (if needed)?

- Yes
- No

7.1 [If "No" in Question 7.1]

Please name a contact person within the hospital which Statista can reach out to for questions regarding the data provided (if needed).

Title: [Textfield]

First name: [Textfield]

Middle name: [Textfield] **[optional]**

Last name: [Textfield]

Position: [Textfield]

Email: [Textfield]

Phone: [Textfield] **[optional]**

7.1.2 Do you consent to being contacted for surveys pertaining to Statista hospital rankings published in 2026?

- Yes
- No

Data confirmation and Senior Management validation

To include your survey responses in the evaluation, we require the following:

Confirmation of survey submission with an official work email address

The validation of survey from a senior management member of the hospital (e.g. CEO, Medical director, Director of quality department).

The validation of the survey by a senior management member of the hospital is to ensure that the hospitals' responses accurately reflect the extent of PROMs implementation.

Please note, the validating senior management member must have a leadership role and strategic decision-making responsibility within the hospital.

Rest assured, no personally identifiable data will be shared, and all data will be collected and evaluated anonymously, within the scope of relevant regulations. This verification serves to prevent fraud.

Statista reserves the right to verify the accuracy of the data provided in the survey.

Data Confirmation

Statista will periodically validate PROMs submissions and retains the right to conduct audits, including validation calls, to verify the accuracy of reported data. If any information submitted by your hospital is found to be false, your hospital could be ineligible for the PROMs score and severe cases could lead to exclusion from future rankings.

Please choose **only one** of the following:

- I confirm the use of the data provided for hospital rankings 2026 and in an anonymized and aggregated way for research purposes.
- I don't want to give an e-mail address, so my answers cannot be used for the evaluation.

If yes, please enter your contact details as the person completing the survey for the confirmation of submission here:

Name	
Email address	
Position	

Senior Management Validation

Please enter the information of the Senior Management member who will validate the responses and select the validation format.

Please note that validation can only be provided by a member of the hospital's senior management(C-Level).

Name	
Email address	
Position	Dropdown: Chief Executive Officer (CEO) Chief Medical Officer (CMO) Chief Nursing Officer (CNO) Chief Operating Officer (COO) Other C-level Executive (please specify)

[Mouseover for Other: validation is only accepted by a senior/executive leader with strategic responsibility in the organization]

Validation Format:

The Senior Management member will validate the survey responses online via email *[link to example validation text]* to hospitals@statista.com by November 26th, 2025.

or

The Senior Management member will validate the survey responses by downloading, and filling out the Validation form *[link to validation form]*. The signed validation form must then be uploaded here as pdf to complete the validation process.

[If pdf form]

Please upload the Senior Management Validation pdf here:

Please note, the information submitted in this survey will not be processed until the Senior Management member has validated the submission.

Once the validation process has been completed (via email or uploaded pdf form), you will receive an email confirming that your survey responses have been successfully submitted.

[Note text: in the case that you have not received a confirmation email within 7 business days of submission, please contact hospitals@statista.com. Please ensure you have whitelisted the address hospitals@statista.com]

Thank you for completing this survey.

Appendix C

The AHA indicators below, grouped by categories (General, Health Equity, Technologies and Innovation, Staffing), are used to calculate the AHA sub-pillar score for each hospital.

General	
1. Adjusted admissions	2. Adjusted patient days
3. Adult cardiac electrophysiology - hospital	4. Adult cardiac surgery - hospital
5. Adult cardiology services - hospital	6. Adult diagnostic catheterization - hospital
7. Adult interventional cardiac catheterization - hospital	8. Air ambulance services - hospital
9. Alzheimer Center - hospital	10. Ambulance services - hospital
11. Ambulatory surgical centers	12. Ambulatory surgery center - hospital
13. Arthritis treatment center - hospital	14. Assistive technology center - hospital
15. Bariatric/weight control services - hospital	16. Birthing room/LDR room/LDRP room - hospital
17. Blood donor center - hospital	18. Bone marrow transplant - hospital
19. Breast cancer screening/mammograms - hospital	20. Burn care - hospital
21. Cardiac - Limited service hospital	22. Cardiac intensive care - hospital
23. Cardiac rehabilitation - hospital	24. Certified trauma center - hospital
25. Chemotherapy - hospital	26. Community outreach - hospital
27. Community health education - hospital	28. Diabetes prevention program - hospital
29. Computer assisted orthopedic surgery (CAOS) - hospital	30. Endoscopic ultrasound - hospital
31. Electrodiagnostic services - hospital	32. General medical and surgical care (adult) - hospital

33. Fertility clinic - hospital	34. General medical and surgical care (pediatric) - hospital
35. General medical and surgical care (pediatric) - health system	36. Health research - hospital
37. Health fair - hospital	38. Heart transplant - hospital
39. Health screenings - hospital	40. Hospital owns trauma certification
41. Hospice program - hospital	42. Imaging centers
43. Hospital unit inpatient days	44. Inpatient palliative care unit - hospital
45. Immunization program - hospital	46. Intensivist FTE Pediatric intensive care
47. Inpatient surgical operations	48. Limited service hospital
49. Linguistic/translation services - hospital	50. Medical/surgical intensive care - hospital
51. Lung transplant - hospital	52. Neonatal intermediate care - hospital
53. Neonatal intensive care - hospital	54. Number of operating rooms
55. Neurological services - hospital	56. Nutrition program - hospital
57. Nursing assistive personnel - vacancies	58. Off-campus emergency department - hospital
59. Obstetrics care - hospital	60. Oncology services - hospital
61. On-campus emergency department - hospital	62. Orthopedic services - hospital
63. Orthopedic - Limited service hospital	64. Pain management program - hospital
65. Other intensive care - hospital	66. Patient education center - hospital
67. Palliative care program - hospital	68. Patient representative services - hospital
69. Patient education, advanced practice nurses/physician assistants	70. Physical rehabilitation outpatient services - hospital
71. Pediatric intensive care - hospital	72. Prosthetic and orthotic services - hospital

73. Primary care department - hospital	74. Rural health clinic - hospital
75. Respiratory therapists - vacancies	76. Social work services - hospital
77. Sleep center - hospital	78. Support groups - hospital
79. Sports medicine - hospital	80. Total births (excluding fetal deaths)
81. Tobacco treatment services - hospital	82. Total outpatient visits
83. Total hospital beds (calculated) ⁶	84. Urgent care center - hospital
85. Total surgical operations	86. Wound management services - hospital
87. Women's health center/services - hospital	

Health Equity	
1. Accountable for meeting health equity goals - CEO	2. Accountable for meeting health equity goals - designated senior executive
3. Accountable for meeting health equity goals - committee or task force	4. Accountable for meeting health equity goals - division/department leaders
5. Accountable for meeting health equity goals - employee resource group	6. Accountable for implementing strategies for health equity goals - CEO
7. Accountable for implementing strategies for health equity goals - designated senior executive	8. Accountable for implementing strategies for health equity goals - middle management
9. Accountable for implementing strategies for health equity goals - committee or task force	10. Accountable for implementing strategies for health equity goals - division/department leaders
11. Accountable for implementing strategies for health equity goals - employee resource group	12. DEI disaggregated data to inform decisions - patient outcomes

⁶ The number of beds was used as a feasibility check and had no impact on the scoring model

13. DEI disaggregated data to inform decisions - training	14. DEI disaggregated data to inform decisions - professional development
15. Health equity strategic planning - equitable and inclusive organizational policies	16. Health equity strategic planning - systematic and shared accountability for health equity
17. Health equity strategic planning - diverse representation in hospital and health care system leadership	18. Health equity strategic planning - diverse representation in hospital and health care system governance
19. Health equity strategic planning - culturally appropriate patient care	

Technologies and Innovation	
1. Computed Tomography (CT) scanner - hospital	2. Diagnostic radioisotope facility - hospital
3. Electron Beam Computed Tomography (EBCT) - hospital	4. Full-field digital mammography (FFDM) - hospital
5. Magnetic resonance imaging (MRI) - hospital	6. Intraoperative magnetic resonance imaging - hospital
7. Magnetoencephalography (MEG) - hospital	8. Multi-slice spiral computed tomography < 64 slice - hospital
9. Multi-slice spiral computed tomography 64 + slice - hospital	10. Positron emission tomography (PET) - hospital
11. Positron emission tomography/CT (PET/CT) - hospital	12. Single photon emission computerized tomography (SPECT) - hospital
13. Ultrasound - hospital	14. Image-guided radiation therapy - hospital
15. Intensity-modulated radiation therapy (IMRT) - hospital	16. Proton beam therapy - hospital
17. Shaped beam radiation system - hospital	18. Stereotactic radiosurgery - hospital
19. Basic interventional radiology - hospital	20. Robotic surgery - hospital

21. Telehealth consultation and office visits - hospital	22. Telehealth eICU - hospital
23. Telehealth stroke care - hospital	24. Telehealth remote patient monitoring: post-discharge - hospital
25. Telehealth remote patient monitoring: ongoing chronic care management - hospital	26. Other telehealth - hospital
27. AI or machine learning - predicting staffing needs	28. AI or machine learning - predicting patient demand
29. AI or machine learning - staff scheduling	30. AI or machine learning - automating routine tasks
31. AI or machine learning - optimizing administrative and clinical workflows	32. AI or machine learning - does not apply
33. Telehealth/virtual care - number of video visits	34. Telehealth/virtual care - number of audio visits
35. Telehealth/virtual care - number of patients monitored through remote patient monitoring	36. Telehealth/virtual care - number of patients receiving other virtual services

Staffing	
1. Full-time and Part-time physicians and dentists	2. Full-time and Part-time medical and dental residents and interns
3. Full-time and Part-time other trainees	4. Full-time and Part-time registered nurses
5. Full-time and Part-time licensed practical (vocational) nurses	6. Full-time and Part-time nursing assistive personnel
7. Full-time and Part-time radiology technicians	8. Full-time and Part-time laboratory technicians
9. Full-time and Part-time pharmacists, licensed	10. Full-time and Part-time pharmacy technicians
11. Full-time and Part-time respiratory therapists	12. Full-time and Part-time all other personnel

13. Full-time and Part-time total facility personnel	14. Total Full-time and Part-time hospital unit personnel
15. Total Full-time and Part-time nursing home type unit/facility registered nurses	16. Total Full-time and Part-time nursing home personnel
17. Full-time and Part-time advanced practice nurses	18. Full-time and Part-time physician assistants

