Patient safety in the WHO European Region

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Proportion of inter-country variation in levels of mortality in 67 developing countries explained by indicators of care and context

Fuente: World Health Report 2005, pg 83,
Challenge for WHO European Region

- Variations in Health System development, its financing and resources
- Increasing health inequalities between countries and within the same country
- Mounting expectations, rising costs, multiple health crisis
- More freedom of choice in a constantly changing context:
  - reforms in the health sector
  - increased cross border movement
Hospitals for Europe working party:

‘Every 10\textsuperscript{th} patient suffers from preventable harm’
Strengthening health systems

WHO WHA and RC Resolutions

- Common values
- Partnership

Health gain intervention targets:
- individuals
- populations at large
- wider determinants of health

Focus

Health levels & Health distribution
Functions and Goals of Health System

**FUNCTIONS**
THE SYSTEM PERFORMS

- **Stewardship**
- **Creating resources**
  (investment and training)
- **Service delivery**
  (personal and population-based)
- **Financing**
  (collecting, pooling and purchasing)

**GOALS / OUTCOMES**
OF THE SYSTEM

- **Health**
  (level and equity)
- **Responsiveness**
  (to people's non-medical expectations)
- **Financial protection**
  (and fair distribution of burden of funding)
- **Efficiency**
Safety – a key to quality

- Safety challenges differ: countries, approaches, response capacities

Quality

Safe

Effective

Efficient

Equitable

Accessible

Acceptable

Evidence-based
Recognised improvement logics

What is the issue?

What are the root-causes?

Which interventions will address the issue?

Measure and report safety issues

Study the system of care

Implement changes within the health system

Monitor

Evaluate

Adjust
Change the System to Improve safety

**Exercise Stewardship**
- Evidence-based policies
- Non-punitive error reporting system
- Supportive supervision and control

**Generate Resources**
- Computerize medical records
- Medications with bar-codes
- Train staff in reporting errors
- Special certification in critical care

**Safety Issue: Accidental Death**

**Finance the System**
- Assess cost of errors
- Financial incentives for performance according to standards
- Invest in safer care interventions

**Organize Service Delivery**
- Computerized reminders and alert systems
- Team-based quality improvement projects
A European baseline survey on patient safety

Aims:

- Respond to identified need to fill the information gap
- Target: 52 members states
- Questionnaire based

- Raising awareness on patient safety
- Identifying national focal points
- Evaluating major problems at national and regional levels

Benchmarking and priority interventions
General overview

- Overall response rate: 76.9%
- The first to respond: new EU and accession countries
- The lowest response rate: NIS
- ‘Target’ interventions are present
- Reporting systems are seldom clearly regulated
- The system approach is in process
- Identifying national stakeholders is a challenge
High political commitment to quality & safety

Are safety and quality priorities on the national health agenda?
- 97% YES
- 3% NO

Can you indicate national laws, regulations or policies for patient safety and quality?
- 97% YES
- 3% NO
Regulatory framework

Costs of error practically overlooked at national scale, within the current regulatory context
Different approach and understanding of the issue

- Western European MS: homogenous attitude/approach towards quality and safety at national level

- Central and Eastern European MS: variation of practices/building the understanding of the issue
Slow implementation process

Most safety programmes operational in
- Infection control (85%)
- Pharmaceuticals (77.5%)

Lower reported rate for
- Safe clinical practice (56%)
- Safe environment (52.5%)

Reported gap between availability & use of standards and good working practices

Regular inspections are reported to be in place by 72% of respondents

Are there inspection activities of health care services performed on a regular basis?

- 72%
- 28%
Reporting systems

- Seldom regulated
- Responsibility of the physician (72.5%)

Mostly
- disease reporting (ICD)
- serious events
- (blood transfusion, drug administration)
Patient empowerment on its way

Reported data presents an over optimistic picture of patient empowerment.

Are patients encouraged to communicate expectations to health care professionals?

- Yes: 61%
- No: 39%

Is there a system in place for patient reporting of adverse events?

- Yes: 67%
- No: 33%
Common obstacles

- The lack of a safety culture, individual and institutional
- The lack of communication between professionals +/- patients
- The weak pro-active risk assessment
- The limitation of funds and sometimes subsequent access to technologies
Arising from the survey

- Need for consistent approach
- Need for efficient mechanisms to support implementation
- Guidelines for reporting systems
- Patient empowerment and information

Safety culture and multidisciplinary team work, with the patient as part of the team
The challenge is how to make Member States’ health systems as effective as possible in addressing Patient Safety in each particular context (national resources, values, political situation, etc…)
WHO/EURO vision…

- **Health system focus** to all health programmes for addressing system issues
- **Building more partnerships** for stronger impact
- **Emphasis on evidence based policy making** for appropriate prioritisation
- **Transparent monitoring, evaluation and feedback** for improved performance
The Health System Initiative launched in the Regional Committee 55 aims at helping Member States overcome such challenges.

Effective health systems can save more lives!