

OECD Work on Patient Safety



Overview

While health care quality is improving across many OECD member countries, patient safety remains a central policy concern.

When people receive health care, they should be able to expect the care to be clinically effective, safe and responsive to their needs. But all too often patients are unintentionally harmed through the provision of care and while much effort is taken to help prevent safety failures in the care provided by the many devoted professionals involved, more can be done.

Health care is a high-risk endeavour. However, many safety failures can be prevented through a better safety culture to create an environment capable and motivated for improvement; better incentives for reporting; better education of staff involved in the care of patients and better ways to empower patients as partners in improving care. These

are the key health system building blocks for improved patient safety.

Failing to provide safe care to patients is a system failure. To strengthen health systems' ability to deliver safer care to patients, all the key actors need to be mobilised, educated and equipped to play an active role in preventing unintentional patient harm from health care. System-wide efforts putting safety at the centre of all health care activities combined with allocating sufficient resources to ensure safe care are essential to achieve patient safety.

The OECD has worked for several years with countries to identify and promote strategies to support cross-national sharing and learning of patient safety. We collaborate with the World Health Organization and other key international bodies concerned with improving patient safety globally. This brochure highlights key areas of OECD work on patient safety.

Key Health System Building Blocks for Improved Patient Safety

Patients: empowerment and reporting

Governance: regulation and incentives

Information infrastructure: data interoperability and EHR

Human capital: education and investment

Leadership and safety culture

Did you know?

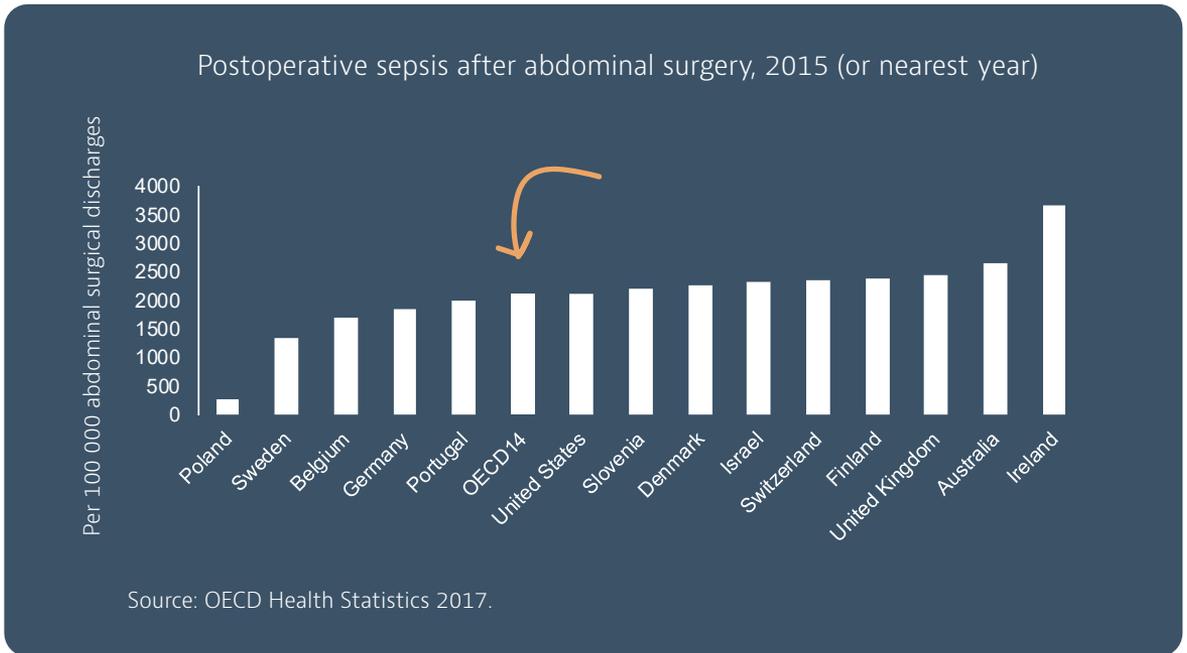
An average of 1 in 10 hospitalisations in high income countries result in a safety failure or adverse event.

International measurement of patient safety

The OECD has been leading efforts to develop and establish internationally comparable patient safety indicators for over ten years.

The OECD now routinely collects and publishes data from member countries on a suite of international indicators covering hospital, primary and long-term care. For example, routine hospital administrative data are used

to capture the rate of postoperative complications like sepsis across countries, national prescribing databases are used to generate international indicators of polypharmacy and antibiotic use, and international periodic inspection programmes enable the measurement of care-acquired infection and pressure ulcer prevalence in nursing homes.



Click here to download the report:
[Measuring the Patient Safety - Opening the Black Box](#)



Or scan with your smartphone to view it.

OECD is currently expanding patient safety indicators to help confidently assess international variations in patient safety and drive improvements at the service level within national health systems. Research and development work is now underway in key areas:

1. Measurement of patient reported experiences of safety;
2. Measurement of patient safety culture;
3. Measurement of care process indicators to support existing outcome indicators.



Did you know?

80% of the safety burden of care is due to a few common causes and events.

Safety in hospital settings

The cost of care related patient harm in hospitals is considerable, with 15% of hospital activity and expenditure estimated to be directly attributed to patient harm.

Because many adverse events can be avoided, this represents a waste for health systems. While efforts to reduce harm are not free, the cost of prevention is often dwarfed by the cost of failure.

An OECD report drew global attention to the economic implications of patient safety and identified potentially fruitful system-wide approaches to reducing harm and improve patient safety. The report was presented at the Global Ministerial Summit on Patient Safety in Bonn in 2017.

National policy experts and academics point to a hierarchy of interventions that are available and together can address patient safety

issues effectively. System-wide investment in long-term programmes such as professional education, safety standards linked to accreditation and a sound information infrastructure are key. At the organisation level, clinical governance and patient-engagement are important aspects of a systemic safety strategy. The fundamental importance of building an overarching safety culture is also clear.

Click here to download the report: [Economics of patient safety: Strengthening a value-based approach to reducing patient harm at national level](#)



Or scan with your smartphone to view it.

Safety outside hospitals

While much attention is given to patient safety in hospitals, about 50% of the global burden arising from patient harm originates in primary and ambulatory care.

The consideration of unintended patient harm in out of hospital care setting, including primary and ambulatory care and long-term care is becoming increasingly important as societies are ageing and chronic conditions are more comprehensively managed in the community.

Safety lapses in primary and ambulatory care settings continue to happen. In 2017, there were over 8 billion patient consultations with primary care providers in OECD countries alone. However, as many as four in ten patients experience a safety issue in their contact with primary care providers. Nearly half of the global burden of disease arising from patient harm originates in this sector, accounting for more than 7 million hospital admissions every year, or at least 6% of all hospital beds.

The key challenges to improving patient safety in primary care settings relate to the fragmentation of the sector, the lack of integration of information and measurement systems and under-resourcing. A reflection of this is the evident lack of consistent and robust safety data.

The OECD prepared a report on the economics of patient safety in primary care for consideration at the Global Ministerial Summit on Patient Safety in Tokyo in 2018, highlighting that combined with stronger governance, investing in integrated information infrastructure is the most important and pressing policy imperative for this care sector.

For more information visit:

www.oecd.org/health/patient-safety.htm
<https://stats.oecd.org/>

Contact:

hcqo.contact@oecd.org

Did you know?

As many as four in ten patients experience a safety issue in their contact with primary care providers.

Future of the OECD work on patient safety

The OECD recognises that improvements to patient safety are central to improving quality in health care and for achieving high performing health systems.

Building on its existing body of work of patient safety, the OECD is now focussing its attention on:

- Building further capacity to measure patient safety within and across care settings;
- Economics of patient safety in other out of hospital care settings, including long term;
- How governance of patient safety can be strengthened to improve care.

Click here to download the report:
[Economics of patient safety in Primary and Ambulatory Care – Flying Blind](#)

Or scan with your smartphone to view it.

