The most important causes include human failure, organizational causes and problems with medical devices.

2. Errors and Accidents in mental care in 1999:

category of care for the mental care for total			
error/accident handicapped health car the elderly			
contact	175	112	43 330
organizational	70	100	52 222
content of care	68	116	106 290
others	54	72	92 218
total	367	400	293 1060
suicide attempt	15	74	1 90
suicide	5	473	6 479

3. Accidents involving drugs

For the year 1999 (most recent year for which data are available) 34 adverse incidents involving drugs have been reported.

2

There has not been a nationwide evaluation of data concerning errors and near-accidents collected by the hospitals yet (Inspectie voor de Volksgezondheid, 1997). See "Action by other stakeholders" for more details.

Problem: Is it known wether the number of medical accidents is increasing or decreasing?

See answer to first problem for details.

Problem: How much is allocated in the national health budget for research activities on medical error?

The Ministry of Health, Welfare and Sport contributes to the quality of care by legislation as well as by supporting and giving financial assistance to research and quality control projects. Funds have been earmarked for research into quality systems in care institutions, for developing standards and protocols, for certifying institutions and improving training programs.

1. patient/consumer organizations: Patient organizations spend their financial resources on the development of quality criteria from the patient's perspective and on the development of quality measurements.

They spend about 40 to 50 million (mio) guilders (f) on di_erent programs and projects.

2. health care providers: The government subsidizes the development and implementation of quality systems and instruments by health care providers.

• specialists

– local initiatives: f 216 mio

– infrastructure for the facilitation of the implementation of quality management: f 9,5 mio per year

– product characterization: f 0,3 mio

– transformation of existing protocols in cost e_ective protocols: f 6 mio per year

– and others

• emergency care

– quality management in emergency care: f 10 mio

– intensive care: f 14 mio

– and others

3

• care for the elderly: about f 20 mio for di_erent projects on quality

care
• several million guilders are spend on the development of quality systems in the mental health care, for general practitioners, in the pharmaceutical care, in the paramedical care and others;
(Ministerie van Volksgezondheid, Welzijn en Sport, 2000a)
Problem: Is the status of medical error understood well in your country?
After a period of growth in the health care sector the Dutch government made an attempt to control the costs in health care. The appropriateness and cost e_ectiveness of various clinical procedures and medical treatments was questioned. The variation in the treatment procedures utilized and the outcomes achieved caused an increasing concern about the quality of the care provided. The demand for proof of transparent quality was increasing due to problems in the continuity of care that was caused by poor coordination among professionals, the health care organizations and the various fields of health care as more and more new disciplines and treatment methods occurred. The increasing scarcity of financial resources, too, is a reason why pressure is put on professionals to make care more transparent and to account for their actions. Finally, patients have become more active participants in the care process. They want to choose by whom they are treated and where. They also want to be involved in the decision making process on clinical and political level. The di_erent forces might have influenced the development of quality systems in health care organizations.
In the Care Institutions Quality Act appropriate care is defined as care that is e_cient, e_ective and client-oriented. The top management of an organization is responsible for the quality of care that is provided by the entire organization. The responsibility for the quality of care provided for individual clients rests with the professionals (Wagner, 1999).

1.2 Public concern about medical accidents/errors

Problem: Is the number of law suits concerning medical accident increasing? Please provide recent statistics if available.
There are no statistics concerning the number of law suits against medical accidents in the Netherlands. A jurist stated that the number of lawsuits has been stable throughout the last five years, that is around 30 lawsuits per hospital.
4
Problem: Is the industry interested in patient safety?
In the industrial sector emphasis is laid on continuous improvement of processes. Quality assurance is part of every worker's task. Quality also becomes a competitive factor. Companies implement a quality system in order to prove to the client that their products are of good quality (Wagner, 1999).
There is collaboration between industry and hospitals to foster the quality and safety of goods. A growing number of non-specialists take part in peer review committees. This accounts especially for pharmacists an clinical chemists. By their participation in the committees these professions wish to foster the integration of their work into the activities of the specialists (Klazinga, 1996).

1.3 Impact of IOM report

Problem: Please assess the influence in your country of the report from the Institute of Medicine in the US, "To Err is Human".

An interviewed quality manager stated that the report had not have a great impact yet. People are slowly beginning to pay attention to it and to the consecutive report "The Quality Chasm", also published by the IOM. The second report is believed to have a greater impact in the long run than "To Err is Human".

2 Action by stakeholders

2.1 Government action toward medical accidents/errors and patient safety

Problem: Has the government instituted policies especially for medical accidents?

Before 1988, centralized formulation of regulations was emphasized. In 1987, the report of the "Commissie Dekker" appeared. On the basis of this report the government opted for another role. It no longer sought to regulate down to the finest details exactly how parties involved in health care should behave. Emphasis was laid on self-regulation of health care providers and insurance companies. The government stepped back. The changes led to more competition between health insurance companies, to more freedom of consumers to choose a health insurance company and to the development of quality criteria by health care providers. Because new global legislation

5

was required to support these changes the Dutch government introduced five general acts in order to assure the quality of care and to increase the rights of the patient.(Inspectorate of Health Care, 1999; Wagner, 1999).

1. The Care Institutions Quality Act (in Dutch: Kwaliteitswet Zorginstellingen) came into e_ect in 1996. It is based on the principle of self-regulation and contains a limited number of general quality requirements instead of detailed norms. The aim is to create optimal conditions for the achievement of quality. To reach a good standard institutions must meet certain quality requirements. Central to the Quality Act is the concept of responsible care. It is left up to the institutions to work out what responsible care means in their particular case. The Quality Act requires care institutions to set up a quality system, that regularly assesses the quality of care.
2. The Individual Health Care Professions Act (1993; in Dutch: Wet op de beroepen in de individuele gezondheidszorg) focuses directly on the quality of professional practice of the individual care provider. It requires health professionals to provide appropriate care and to continuously monitor and improve the quality of the care they provide. The act does not place any control on medical treatment though. However, it does contain several provisions in order to protect patients from incompetent treatment: Various procedures, such as giving an injection are restricted to certain groups of professionals. For a number of professional practitioners a system of statutory title protection and registration has been introduced. Disciplinary procedures are public.
3. The Medical Treatment Contracts Act (1995; in Dutch: Wet op geneeskundige behandelingsovereenkomst): This act lays down several rights as well as obligations for patients and care providers, such as informed consent.
4. The Clients' Right of Complaint (Care Sector) Act (1995; in Dutch: Wet Klachtrecht): The act requires health care organizations to set up an accessible complaints system.

5. The Client Participation Act (1996; in Dutch: Wet Medezeggenschap): Care organizations are required to set up a Patients' Council which has the power to make recommendations in many areas, such as the budget, the food and the quality policy.
6

2.2 Action by other stakeholders

Problem: Is there a policy by provider association, medical doctor, nurse, or hospital?

Quality control is forming an increasingly essential part of the policy pursued by care providing trusts. Those trusts must meet certain quality requirements. The Care Institutions Quality Act (1996) o_ers the institutions the possibility to develop their own quality control policy together with insurance companies and patient and consumer organizations. The public sector does not wish to set the requirements itself regarding the variety of care that is provided by di_erent institutions. The institutions are thought of as being the most familiar with their own questions regarding quality.
In order to develop the quality requirements that apply to their particular case institutions can use standards, protocols and guidelines that have evolved over the years. In order to achieve responsible care there are continuous sta_ training, quality manuals, quality control o_cers and surveys among patients.
Institutions prepare quality control reports annually which provide details on the quality control policy pursued by them (Ministry of Health, Welfare and Sport, 2000b; Sluijs et al., 2001).
The degree to which an institution pays attention to quality management is expressed in its quality policy. This means that the institution has a mission statement, the products it supplies are being described, a quality policy has been documented and developed in regularly assessed working plans and is subject to an annual audit included in an annual report.
A number of models that have been applied in the business world are made use of in establishing systematic quality assurance. Many quality assurance systems are based on the ISO (International Organizations of Standards) systems. The European Foundation Quality Management's (EFQM) Total Quality Management-model and the derivative model of the Netherlands Quality Institute have been applied as well.
The ISO approach is concerned with the development of broad norms for the quality of products, processes, and services and the attention to quality in and of itself. An important characteristic of the ISO norms is the emphasis on process control through the documentation of procedures. In the EFQM approach organizational culture and the judgement of end-users also play a role. The awareness of quality on the part of the sta_ is being emphasized (Inspectorate of Health Care, 1999).
Hospitals are required to set up a committee that investigates and collects data on errors and near-accidents. Results have to be published in the
7
annual report of the hospital. Those committees are called MIP- or FONAcommittees (MIP = Report of incidents in patient care, in Dutch: Meldingen Incidenten Patientenzorg; FONA = Errors and near-accidents, in Dutch: Fouten en near-accidents). The focus of their work is the improvement of quality by taking preventive actions based on the results of the investigations

(Casparie, 1988).

2.3 Action by patients, patients' groups or representatives

Problem: Do patients, patients' groups or representatives have a strong influence on governmental or health care professionals' activities for medical error prevention?

Patients in the Netherlands do have a strong influence on quality policy. At a national level, trusts have agreed on a quality control policy jointly with insurance companies, patient and consumer organizations and the public sector. The various stakeholders met at the so called Leidschendam Quality Conferences in 1989, 1990, 1995 and 2000 in order to ensure the access to appropriate care.

The position of the patient has improved in recent years. Because in the health care system the client is directly involved and is an object of the care provided, the participation of clients is of special interest in the quality systems used in the care sector. This development is supported by way of legislation by the public sector. Following the introduction of the Client participation Act in 1996 client councils have been set up at all care institutions. These councils ensure that patients have a say in the policy of the institution. They make recommendations regarding quality control policy a.o. (Ministry of Health, Welfare and Sport, 2000b; Wagner, 1999).

The government ensures that patient/consumer organizations are provided with enough financial resources in order to play a meaningful role in quality management (Ministerie van Volksgezondheid, Welzijn en Sport, 2000a).

2.4 Third Party Accreditation

Problem: With regard to quality a third party organization evaluates hospital performance and accredits hospitals in many countries. In some cases, the organization rates/benchmarks hospitals or health care institutions. Is there such an organization in your country? If so, please describe its responsibilities an activities briefly. Also, what results (if any) are made publicly

available?

1. The Health Care Inspectorate monitors the quality of care in the Netherlands. Inspectors visit institutions and practitioners' consulting rooms to carry out an inspection or reacting on complaints and reports. The Inspectorate can also instigate a formal investigation and take action. An inspector can demand the discontinuation of care if the patient's health is at risk.

Once a year the Inspectorate classifies the Dutch hospitals according to di_erent aspects. The results are made public in a news magazine. (Inspectorate of Health Care, 1999)

2. One central and five regional disciplinary tribunals are monitoring the quality of individual professional conduct. The Medical Disciplinary Act oversees the performance of professional practice. Legal conclusions have three purposes:

- the development of norms for the professionals as a group
- the punishment of the accused
- the restitution of the patient (to a lesser extent)

Legal conclusions are made public. (Inspectorate of Health Care, 1999)

3. Patient/client organizations: Some patient organizations in the Netherlands

are occupied with projects aimed at assessing, guaranteeing and improving health care (Inspectorate of Health Care, 1999). The Netherlands Institute for Health Services Research (NIVEL) states that patient/ client organizations assess 14% of the hospitals (Sluijs and Wagner, 2000).
4. Insurers: The most important activities of health care insurers lie in the assessment of the quality systems of health care providers. They check the existence of appropriate o_cial documents and annual reports on quality (Inspectorate of Health Care, 1999).
5. NIAZ: NIAZ is the Netherlands Institute for Accreditation of Hospitals. It has been established in 1998 and is the only institute of this kind in the Netherlands. Hospitals can make a request for a survey of their organization by peer review. The accreditation system uses the Canadian accreditation system as a model. The standards have been
9
adapted to fit the Dutch situation. The objective is to enhance quality improvement and quality assurance in hospitals.
A relevant website: www.niaz.nl.
6. CCKL: CCKL is the Dutch Accreditation Board for Medical Laboratories (in Dutch: Coordinatie Commissie voor Kwaliteitsbewaking in de Gezondheidszorg). There is an increasing request for an o_cial accreditation of the quality management system and the competence of the professionals through CCKL. The following article gives an overview of the applied standards, the rules for accreditation etc.:
Slagter, S. & Loeber, J.G. (2001): "Accreditation of medical laboratories in the Netherlands", Clinica Chimica Acta, 309(2):155-61

3 Information Systems

3.1 Reporting system/information system

Problem: Is there any nationwide reporting system for medical accidents, analogous to a reporting system in the aviation industry, or the adverse event reporting system in Australia?
Institutions and recipients of care report to the Inspectorate of Health Care problems or calamities. The inspectorate gives the following definition for calamity: A calamity is every unintended or unexpected incident that leads to death or serious damage. Reporting is voluntary since the Care Institutions Quality Act came into e_ect in 1996 that required hospitals to register and investigate in medical errors and accidents themselves. The number of calamities reported to the inspectorate are therefore believed to be just the tip of the iceberg.
Mostly the institutions themselves investigate in the event of a calamity and report to the inspectorate. However, if it is considered to be necessary the inspectorate takes up the investigation itself. The results of the investigations in the calamities are collected in a nationwide anonymous registration system. As soon as the results are known the inspectorate decides on the nature of the calamity: calculated risk, unforeseen complication or medical error.
The registration of calamities enables the inspectorate to identify high risk areas and to warn and give advice to the government, the industry or the institutions (Inspectie voor de Volksgezondheid, 1997; Inspectie voor de Gezondheidszorg, 2000).
10

3.2 Complaints from patients or their families

Problem: Is complaint data collected and analyzed?

In 1995 the Clients' Right of Complaint (Care Sector) Act came into e_ect. It requires care providers and care institutions to have an accessible complaints procedure. About three quarters of the care institutions currently have a complaints committee to which patients can submit complaints about things that have gone wrong.

Most complaints concern an incorrect approach, a lack of privacy, deficiencies in organization and the quality of food (Ministry of Health, Welfare and Sport, 2000b).

3.3 Public availability of medical outcome information

Problem: Please describe the extent to which medical outcome information and other information on medical quality is available to the public. In particular is such information available on a provider-by-provider basis?

The Care Institutions Quality Act requires all care institutions to provide clarity on the quality of care. Institutions have to publish an annual quality report which is sent to the Ministry of Health, Welfare and Sport, the Health Inspectorate and the regional patient/consumer organizations (Sluijs et al., 2001).

4 Legislation and Juridical Involvement

Problem: With regard to the legal system, if someone reports a case and the error is not caused by her/his negligence or system error, in some countries the reporter is protected from legal liability. Do you have the same system in your country as well?

Based on the results of the investigation the Inspectorate of Health Care decides on the nature of a calamity (see also "Reporting system/information system"). Calculated risk means that the physician opted for treatment although he/she knew that a certain risk was inherent to the procedure. Unforeseen complications are complications known from the literature but that had not been expected. Neither in the case of calculated risk nor in the case of unforeseen complications a calamity is interpreted as being caused by medical error (Inspectie voor de Volksgezondheid, 1997). Indemnity is mostly provided by the trusts.

11

Problem: Is there any no fault compensation scheme for medical errors similar to the no fault compensation scheme in some countries for side e_ects of drugs?

The representative of a Dutch hospital stated the following: There is no no-fault compensation scheme in the Netherlands. There has been a discussion about this topic a few years ago because it was perceived unfair that victims of medical error would not receive a compensation under specific circumstances although they deserved it. However, a no-fault compensation was not introduced because the social insurance system takes care of most of the victims. As long as this system stays a_ordable the idea of a no-fault compensation scheme is being abandoned.

5 Concept of quality and safety

5.1 Health care quality and medical error/accident

Problem: In the IOM report "To Err is Human", there is a discussion that we have to take a measure against both health care quality and medical

errors because they have the same root cause. Is this concept prevailing in your country?
In the Netherlands risk management and quality management are perceived as being two sides of the same medal. Health care policy, especially quality control policy, is strongly linked with medical error prevention. Central to quality control policy are a number of legislation acts that aim at protecting the patient from incompetent treatment, for example the Individual Health Care Professions Act known as "BIG" (Ministry of Health, Welfare and Sport, 2000b).

5.2 "Risk management" and patient safety

Problem: The practice of "risk management" in some settings has come to signify the protection of hospitals against the risk of litigation by patients. The IOM report stressed, by contrast, the importance of patient safety as the proper goal of risk management. How would you assess the actual practice of "risk management" as it exists in your country, as between these two models?
The patient is the focal point of medical quality policy in the Netherlands. Patient orientation is an important aim of this policy. Improving the position of patients and protecting their rights is an major issue. The

Netherlands signed "The Declaration on the Promotion of Patient's Rights in Europe" under the auspices of the WHO in 1994. The most essential rights of patients were adopted as part of the Netherlands Civil Code in 1995 by way of the Medical Treatment Agreements Act (Dutch initials: "WGBO"). This is a legal framework that regulates the right of the patient of being informed about not only the nature and seriousness of a disorder but also about the proposed treatment, the consequences and alternatives, and the right of consent (Ministry of Health, Welfare and Sport, 2000b).
Other acts that have been introduced in order to improve the position of the patient are (see also "Government action toward medical accidents/errors and patient safety"):

- the Clients' Right of Complaint Act, 1995
- the Participation by Clients of Care Institutions Act, 1996

6 Risk Management at Hospital or Clinic Level

6.1 Risk Managers

Problem: Are there any organizations to train risk managers in your country?
No, there are no such organizations in the Netherlands.
Problem: Do hospitals in your country have a specific post for a person charged with the responsibility of medical error prevention?
Trusts are not required to have a risk manager on their sta_. There is only one hospital in the Netherlands that has a risk manager. This is the university hospital in Maastricht (in Dutch: Academisch Ziekenhuis Maastricht).

6.2 CQI (Continuous Quality Improvement)

Problem: Do you have integrated managing units in hospitals for continuous feedback loops to improve quality and prevent error?
Of the Dutch hospitals 5% have integrated quality management units, that means that they have established a coherent quality system that embraces the whole organization. Two third of the trusts are working on projects concerning quality care, one third is preparing for quality care (Sluijs and Wagner, 2000).

13
Problem: Is there any package of systems to improve patient safety in each high risk area in a hospital, such as anaesthesia, surgery, ICU, delivery and emergency room? If so please describe.
Over the past ten years, a great deal of e_ort has been put in producing guidelines, protocols and standards in the medical profession. A high percentage of hospitals makes use of protocols for specific treatments or procedures. Additional measures include protocols for routing of the client from intake to discharge, for unforeseen procedures, for information to the client, for critical aspects of the care provision process, for medical aids and for specific target groups or diagnostic groups. There are also standards for collaboration with other institutions (Wagner, 1999).
Problem: Have specific measures been developped and widely instituted to prevent common accidents such as medication errors, transfusion errors and falls? Please describe.
The following tabel illustrates the proportion of hospitals (n = 101) that make use of specific protocols (Sluijs and Wagner, 2000).

kind of protocol	hospitals applying protocol (%)
order of bloodproducts	75
blood transfusion	75
medication	65
prophylactic use of antibiotics	66
preoperative screening	64
completion of patient records	53
prevention of infections	86
prevention of decubitus	79
prevention of medication errors	47
prevention of falls	42

6.3 Risk Analysis Methods

Problem: What methods are generally employed to analyze risks associated with medical errors at health care institutions?
Quality improvement procedures involve the systematic monitoring and improvement of the process of care via the quality cycle. In order to determine wether the care delivered meets the requirements systematic measurements are performed and adjustments are made where necessary. The
14
quality cycle is part of the institution's quality system, i.e. the outcome of the quality improvement procedures is fed back to the providers of care and to the management.
In the field of provision of care care plans are used to monitor individual care. In these plans care targets and the actual care provided are formulated and an assessment is made to determine the extent to which the targets have been achieved. Also special committees are appointed to monitor hygiene, infections, accidents etc. (Wagner, 1999).

6.4 Education and Training for Employees

Problem: What special training courses oriented towards patient safety, if any, are o_ered or required for specific groups or hospital employees?
In two third of the institutions employees are trained in quality care, e.g. quality management, procesanalysis, and development of protocols. Sta_

have the opportunity to pursue quality activities during working hours in most of the institutions. Most trusts enable their sta_ and professionals to attend special training on quality management (Sluijs and Wagner, 2000). Training in quality management includes teaching various methods to the assurance of quality and its improvement and encouraging professionals to critically review their own work. Training in the priorities of quality management occurs less frequently.
Relatively few institutions train new sta_ systematically: 11% in primary health care and 21% in care for the disabled in 1995 (Wagner, 1999).

7 Peer Review

Problem: Please describe briefly the peer review systems prevailing in your country, or provide descriptive references.
There are two di_erent peer review systems in the Netherlands. On the one hand peer review activities are carried out by scientific societies as part of their quality management activities. They include the visitation of teaching and non-teaching hospitals. A technical focus on quality aspects is still predominant. However, recently a broadening of the scope is noticeable. Emphasis is more and more laid on specialists' attitude. Since specialists consider themselves first of all a member of a partnership (i.e. the form the organization of economic entrepreneurship of medical specialists takes in the Netherlands) and only in second place a member of the medical sta_, visitation of partnerships set up by the respective scientific society is more easily
15
accepted than visitation by the whole medical sta_ described hereafter.
On the other hand a national program for peer review (in Dutch: intercollegiale toetsing) among medical specialists in hospital exists which had been initiated by the Dutch Organization of Medical Specialists (LSV = Landelijke Specialisten Vereniging) and which is supported by the Dutch Institute for Healthcare Improvement (CBO = Centraal Beleidsorgaan voor de intercollegiale toetsing; literally: "the central support organization for peer review"; founded in 1979). This program is rooted in the discussions about medical sta_ development that took place in the 1950s. In 1976 a policy report on peer review (LSV, 1976) was published that describes a methodology for peer review that is based on the following features:

- problem based: a problem based approach is chosen based on the notion that physicians will only be willing to learn on issues they consider to be relevant;
- cyclic activity (i.e. systematic and using explicit criteria): this approach is consistent with methodologies of quality management such as the PDCA method (Plan-Do-Check Act); this methodology has been adapted for the Dutch peer review program for medical specialists, however, it has in essence stayed the same;
- establishing a peer-review committee within the context of the medical sta_: Peer review is perceived as a professional obligation that is linked to the drive to control the knowledge domain of medicine and to the maintaining of professional autonomy. Since the specialist is part of a team and together with others produces a common product it is perceived logical to locate peer review in medical sta_s.
- voluntary participation.

Over the years peer review has developed into an integral part of quality

management activities in medical sta_s in the Netherlands. In the 1990s around 80% of Dutch hospitals engaged in peer review activities and have set up peer review committees. These committees select topics for audit and assesses these topics according to the PDCA cycle. The methodology for selecting an appropriate topic promoted by the CBO is the priority meeting. The focus lies on the system not on the individual.
A very good and useful descriptive reference is Klazinga (1996) which can be found in the reference list. It is written in English. A relevant website is found at: www.cbo.nl.
16

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17

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18

A response to the international comparative survey of medical Accident prevention and patient safety policy
The Singapore situation

Respondent: Lim Meng Kin

Singapore Answers

A. Situation on Medical Error

1. Studies and research activities on medial accidents/errors

a. Is there any study on facts and occurrences of medical accidents/error s?

No, there has been no study in Singapore into medical errors. However, the Ministry of Health is aware of the need for such a study and is currently looking into the feasibility of carrying out a comprehensive national study on medical error incidence.

b. Is the number of medical accidents increasing?

There is currently no data to show a rising trend in the incidence of medical errors.

c. How much is the budget for those studies and research activities?

We do not know now. If and when a decision is made to undertake a national study on medical errors, a determination of the costs involved will be made and it will be budgeted accordingly.

d. Is the status of medical errors understood well in your country?

The epidemiology of medical errors has not been researched before in Singapore. But ongoing efforts are being made, in consultation with international experts, to develop a system to detect and ameliorate potential sources of medical errors at the national level.

2. Public concern for medical accidents/errors

a. To what extent are medical accidents/errors getting public concern in your country?

The public receives its information on medical errors mainly from the print and television media, whenever the latter report on research data and human-interest stories from other countries such as the US and Europe, and on specific local incidents that have occurred and have reached the media's attention. Other than this, the public – in general – has not been vociferous about the issue of medical errors in Singapore.

b. Is the number of lawsuit against medical accident increasing?

The numbers of civil litigation cases involving medical negligence showed a modest increase over the past few years.

c. Is the industry interested in patient safety?

Yes, both the public and private medical sectors are actively involved in implementing various healthcare quality and patient safety initiatives, partly in response to the Government's directions, but also because there is a desire among healthcare providers to ensure that patients have the best outcomes possible for their conditions.

3. Impact of IOM report

Is a report from the Institute of Medicine in the U.S., "To Err is Human", published in November 2000 known in your country? And if so, did it have influence?

Yes, the report is known amongst both the healthcare regulators and healthcare providers. The recommendations of the Institute of Medicine report are currently being reviewed by the Ministry of Health to determine what is applicable or relevant to the local context.

B. Action by Stakeholders

1. Government action toward medical accidents/errors and patient safety

Is there a governmental policy especially for medical accidents?

If there is, please describe the policy including the historical development of the policy.

Medical errors that result in death would be reviewed by the State Coroner system. For serious adverse events, the Ministry of Health requires that hospitals report and review them through the convening of a Committee of Inquiry. Complaints related to standard of medical care are also reviewed for possible systemic problems that would require remedial action by the institution.

2. Action by other stakeholders

Is there a policy by provider association, medical doctor, nurse, or hospital?

Public hospitals are currently developing systems of voluntary self-reporting of adverse events and "near misses". Physicians' Medical Protection insurance societies regularly disseminate cautionary tales as learning points for the benefit of their participating members. The local professional organizations do not as yet have a policy on medical errors.

3. Action by patients, patient groups or representatives

Do patients, patient groups or representatives have a strong influence on governmental or health care professionals' activities for medical error prevention?

Patient complaints on medical care and feedback through various channels help inform the Ministry of Health and hospitals on the areas of health care that need review to prevent future medical error occurrences.

4. Third Party Accreditation

With regard to quality, third party organization accredits and evaluates hospital performance in many countries. And in some cases, the organization rates/ benchmarks hospitals or health care institutions. Is there any such an organization in your country?

There is no third party accreditation of healthcare institutions in Singapore at the present moment. The Ministry of Health licenses hospitals, evaluates their clinical performance in various areas, and benchmarks them against comparable institutions abroad through participation in benchmarking projects such as the Maryland QIP.

C. Information System

1. Reporting system/ information system

Is there any nation wide reporting system for medical accidents, e.g. a reporting system in aviation industry or adverse event reporting system in Australia?

Individual hospitals have different systems in place for the monitoring of medical errors. For public hospitals in particular, the Ministry requires that they report serious adverse events and review them through the convening of a Committee of Inquiry. The Ministry is also in the process of standardizing the hospital-level reporting systems in public hospitals for less serious errors and near-misses so that the data collected can be analyzed and used at the national level, rather than just at the individual hospital level, as is presently the case.

If there is,

a. Is it obligatory or voluntary?
b. Who collect data?
c. Who analyze the data?
d. Is there any legal protection for reported cases against lawsuit?

2. Complaints from patients or their family

Is complaint data collected and analyzed? If so, how?

Presently, complaints on medical care can be channeled to:

(a) the hospitals directly
(b) the Singapore Medical Council (where the complaint is against a medical professional)
(c) the Ministry of Health.

Complaint data is collected, tracked and used by each of the three bodies individually.

D. Legislation

a. With regard to a legal system, if someone reports a case and the error is not caused by her/his negligence or system error, we heard that there is indemnification system in indemnity some countries. Do you have the same system in your country as well?

In order for a complainant to receive compensation for damages caused by medical error or negligence, he/ she will usually have to pursue the matter as a civil litigation case in the courts. All practising doctors have to be covered by medical protection schemes.

b. Is there any no fault compensation scheme for medical errors similar to a no fault compensation scheme for side effects of drug?
There is no "no fault compensation scheme" in operation. However, disputants in medical negligence cases are increasingly encouraged by the Government to have their disputes settled through state-run mediation or arbitration centres, rather than in court.

E. Concept of Quality and Safety

1. Health care quality and medical error/accident
In the IOM report, "To Err is Human", there is a discussion that we have to take a measure against both health care quality and medical errors because they have the same root cause. Is this concept prevailing in your country?
Yes. The Ministry already monitors the quality of healthcare through a set of clinical performance indicators, and will be looking to complement this with the measurement of medical errors.

2. Concept of patient safety
In the same report from IOM, the importance of a concept of patient safety is proposed against risk management to hospitals for litigation. Does a concept of patient safety prevail in your country?
Yes. This concept prevails in the country, which is why the Ministry of Health has decided that the issue of addressing medical errors is one of its priorities in its continuing efforts to improve the quality of healthcare. It is recognized that risk management at the hospital-level for reducing the risk of litigation alone is not sufficient to ensure patient safety.

F. Risk Management at Hospital or Clinic level

1. Risk Manager
a. Is there an organization to train a risk manager in your country?
Most of the risk managers receive their training on-the-job and as they work closely with quality managers, hospital lawyers and malpractice insurance carriers. There is no formal organization that trains them.

b. Is there any post taking charge of medical error prevention such as risk manager in a hospital?
Yes - depending on the hospital, the medical error prevention efforts can be led by the quality manager, risk manager, nurse manager or other dedicated healthcare professionals relevant to the activity.

2. CQI (Continuous Quality Improvement) / Patient Safety
Do you have integrated managing unit in hospital for quality and error?
Yes, most hospitals would have in place CQI, TQM or other quality systems to integrate the various components of clinical quality.

3. Fail Safe and Fail Fault System
Is there any pattern of system to improve patient safety in each high risk area such as anesthesia, surgery, ICU, delivery and emergency room in a hospital?
Each hospital would have in place its own measures (e.g. colour coding, simplifying complex procedures, standardizing drug dosages and timing of doses, etc) depending on the particular high-risk area identified.

4. Specific Measure for High Frequency Risk Procedure

Has specific measure been developed to prevent medical errors such as medication error, transfusion error and falls?
Yes. These measures would be hospital-specific e.g. the introduction of the online prescription, fall prevention guidelines, etc.

5. Risk Analysis Method
What methods are generally employed to analyze risks associated with medical errors at health care institutions?
Each hospital would be using different methods; the Ministry does not monitor the specific methods employed.

6. Education and Training for Employee
a. Is there any training course for employees in a hospital?
Yes, employees are given the necessary training by the hospital, with attention to error prevention where relevant.

b. Is there any hospital or clinic which develops educational tools and/or training materials designed to alter behaviors to prevent errors and increase safety?
Hospitals recognize the need to, and do develop educational / training materials to prevent errors, e.g. education materials for patients on anticoagulation.

A response to the international comparative survey of medical Accident prevention and patient safety policy
The Sweden situation

Respondent: Synnove Odegard

Sweden

A Survey of Medical Accident Prevention Policy

Questionnaire on international comparison of medical accident prevention policy

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Background: Japanese Situation

In January 1999, an unthinkable medical error occurred at one of the prestigious hospitals in Japan. Two patients were mixed up at surgery and a lung was taken out of the wrong patient. Since then several serious medical errors have been reported at prestigious medical centers. The Japanese people's trust in their health care system has been shaken. The government has to respond to the situation. A committee to investigate the root causes of those medical errors was formed in March 1999 and reported the need for integrated activity to prevent medical errors. Other professional associations, such as the Japan Medical Association, Japan Nursing Association, Japan Pharmaceutical Association, Japan Dental Association and Japan Hospital Association have also formed committees to develop preventative measures from their perspective. Particularly, 240 central government hospitals have developed a manual to deal with medical errors in October 1999. 2 million USD is allocated to research on patient safety in the 2001 fiscal year budget. A national committee on patient safety was formed in June 2001 to develop a comprehensive policy.

The main aim of this survey is to investigate medical accident prevention policy in the following countries: the U.S., the U.K., Germany, Sweden, the Netherlands, France, Australia, and New Zealand.

Questions

A. Information on Medical Error

1. Studies and research activities on medical accidents/errors

a. Are there any epidemiological studies in your country concerning medical accidents/errors?

Non-epidemiological analytical studies? Please give references if available.

No we have not done any epidemiological studies in Sweden. The first Nordic study came from Denmark (fall 2001). As far as I know there is only one analytical study that has been done. It is concerning the Swedish mandatory reporting system. We are aware that it is a great underreporting to this system in Sweden. The total population are around 9 miljon people. Last year only 900 cases (sentinal events) were reported. I will send the studies as an attachment to this file. One can compare the reported cases with cases reported to patient insurance company who received about 9500 cases last year.

b. Is it known whether the number of medical accidents is increasing or decreasing?

The cases reported to the Patient insurance company are increasing. Even to other more local system the complaints are increasing, whether this is a sign of a real increase or not of patient injuries is hard to say.

c. How much is allocated in the national health budget for research activities on medical error?
We don't have any official report to answer that question.

d. Is the status of medical errors understood well in your country?
It is hard too answer the question correctly because it depends on who you are asking. There is a growing awareness among people within the health care sector. But I will not say that people in general really know the problem and special not the underlying factors. At the Federation of the county council we are trying to put this question in focus. We have some interesting projects ongoing where we are collaborating with people from the nuclear power plants. We are trying to take a very broad grasp (?) to one hospital to see what we can learn.

2. Public concern about medical accidents/errors
a. To what extent are medical accidents/errors arousing public concern in your country?

b. Is the number of lawsuits concerning medical accident increasing? Please provide recent statistics if available.
We don't have that system in Sweden. We have a special authority called the Medical Responsible Board (MRB) where people can complain and where the healthcare providers can receive a reprimand.

c. Is the industry interested in patient safety?
There is a growing interest in different areas and we are going to make a survey to get a picture