Executive Summary

Decision Making Process for Safety Issues in Health Services and Technologies

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This study has been performed to improve discussion and decision making on healthcare safety issues of Healthcare Safety Advisory Committee in NECA to support Korean Government safety policy making. For this purpose, we reviewed three countries patient safety policy making process including UK, Australia and the US.

The IOM report named 'To Err is Human' had facilitated patient safety policies and activities not only in the US but also globally. In the UK, government intiatives of Department of Health had facilitated patient safety culture throughout the NHS system. Department of Health published the reports including 'An organization with a memory'(2000), 'Building a safer NHS'(2001), 'Patient First'(2006) for supporting NHS staff patient safety activities. National Patient Safety Agency had been established as the key organization for patient safety incidents, including medication and prescribing error reporting.

In Australia, Australian Patient Safety Foundation, non-profit independent organization, had monitored the anesthetic incidents and provided leadership in the reduction of harm to patients since 1988. The foundation had developed Australian Incident Monitoring System fended by government and performed collaborative work with World Health Organization to develop an International Classification of Patient Safety. The foundation is collaborating with Royal Colleges of Radiologists and Emergency Medicine in Australia and New Zealand to provide specialty-specific incidents reporting system.

In the US, AHRQ, the government agency had become a key organization to facilitate patient safety activities since 2001. The US congress had allocated 50 million dollars to AHRQ for patient safety researches and related activities. AHRQ set priorities and strategies to achieve patient safety targets including patient safety reporting system. AHRQ developed the National Patient Safety Network and data structure to promote 90% of hospitals in the US perform patient safety reporting as their standard

activities until 2010. These patient safety activities are closely linked to quality and safety issues of hospital accreditation programs of Joint Commission.

ECRI Institute is a unique example of patient safety activity. The institute has been specialized in device-related safety issues and announced the top 10 health technology hazards selected by its own methodology every year. ECRI Institute has been listed on the federal patient safety organization focused on device problem reporting.

Three countries can be characterized by their patient safety initiatives. UK has strong government initiative patient safety programs leaded by Department of Health. Australia has nongovernmental initiative of APSF and the US have governmental agency, AHRQ initiative program.

We can have several implications for better patient safety issues decision making of Healthcare Safety Advisory Committee of NECA to facilitate patient safety activities in Korea. First, governmental initiative for patient safety policy need to be strengthened to make supportive environment including establishment of incidence reporting system and related regulations. Second, governmental agencies can have initiative for the patient safety researches and programs. They can be activated and facilitated with governmental funding and other supportive actions. Third, the voluntary efforts for patient safety of nongovernmental organizations especially medical societies need to be activated. It will be important to have close relationship among the governmental agencies including NECA, Healthcare Accreditation body and patient safety organization for efficient and stable safety issuing mechanism of Healthcare Safety Advisory Committee.

Key Words : safety in health care, patient safety, Healthcare Safety Advisory Committee