

Comparative Health Policy Analysis between Patient and Client Safety Strategy (PCSS) of Finland, 2017 and National Patient Safety Implementation Framework (NPSIF) of India, 2018

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Abstract

In health care setting, damage can be triggered by series of faults or adverse events. The health organizations and social welfare services, are absolutely liable for quality health care and patient safety. The objective of patient care should complete abstinence of patients from any unessential or potential harm. The aim of the essay is to critically compare the national policies of two countries, Finland and India on ‘‘Patient safety’’. Also, to examine and compare the relevant actors and stakeholders, including their interests and power; the pertinent factors that lead to the policy formation and the process by which the policy was implemented and monitored in both countries which are so diverse from each other; India being developing and Finland, developed. This paper also discusses the individual analysis of both countries, following a brief comparison of similarities and dissimilarities between policies of a developing and a developed country. After critically analyzing policies of the countries stark different from each other, the major dissimilarity noticed was the gap between the developed and the developing country and the sensitivity of the problem perceived which is described in detail further in the paper.

Keywords: *policy analysis, health policy triangle, Indian policy system*

Introduction

Patient safety is a fundamental element of health care. It is being increasingly recognized as an issue of global importance, and a critical dimension of Universal Health Coverage (UHC). The objective of patient care should complete abstinence of patients from any unessential or potential harm.¹ According to WHO, of every 100 hospitalized patients at any given time, 7 in developed and 10 in developing countries will acquire healthcare-associated infections(HAI). According to

the statistics, in developed countries as many as 1 in 10 patients is harmed while receiving hospital care. It is also estimated that globally of the 421 million patients hospitalized annually, 42.7 million patients suffer from adverse events cause of lack of patient safety.² To overcome this situation, India launched its National Patient Safety Implementation Framework(NPSIF) in the year 2018. Similarly, Finland Patient and Client Safety Strategy(PCSS) was launched by the Finnish government in the year 2017.

The comparative essay begins, giving a brief idea of the framework used for the comparison of two national policies, followed by individual analysis of the developed and then the developing countries, ending with a comparative study of the both. India and Finland were decided to be discussed upon since the basic idea was to highlight the differences of the same health issue between a developed and a developing country and ponder on how problems for one country goes unnoticed

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or is not even of relevance to another country.

Theory

Policy analysis is a set of complex, intertwining procedures. From the different frameworks for analyzing policies, the one used in this essay is ‘‘The Health Policy Triangle’’³ which allows the retrospective analysis of the contextual factors, the process by which the policy was formulated, implemented and evaluated, the objectives of the policy and the actors. It presents a simplified approach to a complex set of interrelationships.⁴

Actors are individuals, groups or organizations involved in policy-making or who get affected once the policy is implemented. Context refers to universal factors which may have an effect on health policy. These include situational, structural, cultural factors. Content and process form the base of the triangle of health policy analysis. Content details the issues addressed in the policy. It comprises of the normative and cognitive assumptions of the society. The process is a crucial step in policy analysis.

Problem identification explains the agenda setting. The second step is formulation, followed by implementation, which is often the most neglected. However, it is the most important step of policy making because if policies are diverted at the implementation, the policy outcomes will be distorted. Policy evaluation and monitoring is the ending procedure of the policy process that deals with the post effects of policy implementation.³

Patient and Client Safety Strategy (PCSS), (2017-2021)

Finland belongs to countries that enjoy an highly developed coordination for the furnishing of healthcare services. However, patient safety was unsuccessful to gather ample awareness until recently.⁵ Patient safety was first introduced in Finnish legislation in the year 2010 by the Ministry of Social Affairs and Health. The current theme of client safety emerged when the criteria for long-term inpatient care were made specifically so that the older population avails inpatient care with patient safety justifications. Unfortunately, the policy was open to various interpretations and amendments. Later, The Ministry of Social Affairs and Health

updated the Patient Safety Strategy into the Patient and Client Safety Strategy (PCSS) in the year 2017, to ensure services provided to the patients are safe and to encourage maximum participation from patient/clients, and their family members. The aim of the policy is to contribute to the development of Finnish health care and social welfare services towards a harmonized safety culture and to promote it in practice.⁶

Actors

Ministry of Social Affairs and Health implemented the PCSS in collaboration with various establishments in the governmental units like the regional government officials, Patient Safety Association and many other ‘‘actors’’ in the field which includes, health service providers like the doctors, nurses, etc; and most importantly patients/clients and their family members. All key stakeholders use considerable influence on the policy process. Ministry of Social Affairs and Health, Finnish health care and social welfare and the regional government form the intangible resources possessing the maximum power and legitimacy in the policy issue which play a pivotal and supportive role in articulating the policy process.⁶

Agenda setting/Problem Identification

The increasing tendency towards outpatient hospital care with a shortage of manpower and rapid employee turnover leads to the overburdening of the work resulting in professional misconducts and assault.⁷ Patient and client safety is a part of public service promise. The regional government, social welfare, and health care reforms provide new opportunities for strengthening safety culture that promotes patient and client safety, that forms the Leichter’s (1979) structural and cultural context of the policy.³ These were the unique focusing events that lead to the agenda setting and the problem identification of the policy. Again, according to The Hall legitimacy, feasibility and support model; the issue was highly legitimate since promoting patient and client safety is part of the responsibility for providing social welfare and health care, less feasible accounting the constraints among the service providers^{3,6} and the policy gathered complete support from all important agencies and stakeholders to successfully set in the agenda.

Policy Formulation.

The Ministry of Social Affairs and Health is the crucial governmental department involved in formulating the policy. It involved other stakeholders such as regional government officials and health care service providers in the formulation aiming towards the cohesive safety culture of patients. The essential contents of the policy are management, responsibilities, safety culture and legal provisions. Patients and their relatives are dynamically integrated in increasing excellence and wellbeing. The political context being the ministry and the governmental agencies included in the actors, help in the communication of the policy to the lower strata.

Policy Implementation

Implementation of this policy essentially follows the ‘‘Bottom-up approach’’ (Lipsky, 1980)³ that is the implementers or the beneficiaries of the policy play an important role in the implementation procedure. They are not mere managers of policy who follow higher authorities rather participate actively. Patients recommend developmental needs and deficiencies to work for the future.

In case of any adverse situation, the health care providers inform the patient and their family members and discuss the consequences. Patients’ roles have emerged from passive recipients of care to more active and informed co-producers of health.²

Analyzing the adverse situation and publishing it promotes transparency and helps in future reference for doctors.⁶ Appropriately educated and oriented personnel are given the responsibility of maintaining client safety and their duties have been noticeably conditioned. Latest technologies are accepted and organizations follow special guidelines on the practices and defenses, which ensures high-quality and safe care. Many of the implementation procedures are still under progression since the policy accepts a nine-year action plan.

Policy Evaluation & Monitoring

The organization has observational units and personnel in charge of proper functioning of the equipments. Specific executives have been assigned obligations to ensure the safe practice and availability of resources for the same. The followed action plans

are implemented according to the statistics gathered on patient safety incidents. The organization has specific regulations on reporting and dealing with feedback. Open discussions are organized by supervisors to discuss without blaming and are used for risk assessment promoting learning. The principle of no-blame and transparency is an essential part of the promotion of patient and client safety, but immediate interventions are taken for service providers that put patient safety at stake.⁶

National Patient Safety Implementation Framework (NPSIF), (2018-2025)

Introduction

A multitude of initiatives addresses patient safety aspect independently in India. But they are regarded as standalone exercises and not under one umbrella. In 2015 during the 68th WHO Regional Committee for South-East Asia, all Member States of the Region, including India, endorsed the ‘‘Regional Strategy for Patient Safety in the WHO (2016-2025)’’ aiming to support the development of national quality of care and patient safety strategies and committed to translate objectives actionable at country level. The main aim of the National Patient Safety Implementation Framework (NPSIF) is to synergize a multitude of initiatives and to attain patient safety goals, largely focused on improved caliber of care and making headway towards UHC¹.

Agenda setting/Problem identification

There are a huge number of people who are deprived of secure and suitable medical support and lack a proper national health policy which ensures the proper assessment. Discussing the structural context, India lacks proper technology leading to unsafe patient care. Though there are a number of incident surveillance institutes for infection control in India, they lack regulatory mechanisms and integrated national level guidelines. There is a lack of system reporting HAI and there is no authority in place to collect, analyze HAI at the a national level.¹ India faces a lot of challenges regarding patient safety ranging from unsafe injections, biological waste management, high rates of medicines, healthcare-associated infections, forming the situational context for the policy. In 2004, a study in an urban slum in Delhi showed that only 22% of injections used were sterile

and safe⁸. According to WHO, there is 1 doctor for 1000 population in India.² The strain in the doctor-patient ratio leads to unsafe health practices. While managing the medical errors, “personal approach” or “incident blaming” also leads practitioners trying to conceal their fault which describes the cultural context. Fragmented laws on policies like consumer protection have been unsuccessful to classify the rights and privileges of the patients. Safety studies show additional hospitalization cause of unsafe health practices, infections acquired in hospitals, DALY cost around US\$ 19 billion annually; which hampers the national economy. This economic loss boosts the interest of stakeholders in patient safety. Multiple stakeholders and actors were involved in various stages of policy.

Actors

The major actors in the policy are Directorate General of Health Services, Ministry Of Health & Family Welfare (MoHFW), who with the assistance from the WHO Country Office India, National Health System Resource Centre (NHSRC), made the final draft and incorporated the policies at various levels. Various other stakeholders were involved in the policy like National Accreditation Board for Hospitals and Healthcare Providers, National Quality Assurance Standards, The Central Pollution Control Board, etc. and other relevant ministries like defense, railways, and environment, etc were key government departments and bodies responsible for formulation and execution.¹

Policy Formulation

NPSIF, developed following a series of legal procedures starting from constituting an expert group including all major stakeholders and actors, preparing and approving draft by the ministry to seeking comments of the partners and designing final draft. The content of the policy covers quality assessment, the intensity of adverse events prevention and control of HAI, etc. It also focuses on forming a patient safety campaign and research.

MoHFW formulated the entire policy along with other ministerial stakeholders. It constituted a multi-stakeholder Patient Safety Expert Group in August 2016. The group was given the task to operationalize the patient safety agenda at the country level. The plan is to

implement the program over 2018-2025.¹

Policy Implementation

NPSIF focuses to implement in national and sub-national levels as well as to public and private sectors. The MoHFW aims to perform implement NPSIF efficiently through institutionalization within the existing policy, regulatory and program management framework. The policy follows the “Top-down approach”³. At the national level, MoHFW constituted National Patient Safety Steering Committee, will have representation from all relevant governmental and non-governmental stakeholders. At the state level, there is a designated nodal officer appointed. Separate committees are constituted chaired by the principal secretary in all the states. Similar implementation procedures are carried out in district and village levels. The policy mentions about involving patients, families, media personnel, etc but gives the least information about it. Specific budget lines for patient safety like capacity building, surveillance systems, inflectional prevention, and control, etc are included in all vertical national programs. The central and state budget establishes national programs.¹

Policy Evaluation/Monitoring

Evaluation reveals strategies like baseline assessment of estimating the burden of unsafe care, funding for patient safety research were achieved in 100%. Whereas, biomedical engineers and a surveillance system are still under assembly. The policy also highlights various other priority areas like adverse drug reaction reporting, establishing hospital transfusion committee, etc. Various priority levels are divided and proper intervention and monitoring teams are engaged.¹

Comparative analysis

Albeit both policies describe the same issue, it is clear that both the countries addressed the problem very differently. While Finland aims to target the intricate needs of the patients, India still is on the run for the fulfillment of basics like safe injection practice, lack of proper technology and regulatory mechanism, etc. The aim of the Finnish policy was to include maximum participation from patients/clients, whereas India deals with issues like attaining patient safety goals and progressing towards UHC. In the former policy,

the actors were the beneficiaries whereas ministerial personnel were the lead actors in the later. Discussing the problem identification, Finland has problems with a rapid patient turnover leading to overburdening of work, professional assault, etc. Similarly, India also faces problems like lack of proper technology, no regulatory mechanism, etc. Analyzing the implementation of the policies, Finland follows the Bottoms-Up approach, while India follows the Top Down approach. PCSS appointed specific personnel for monitoring, manage resources, equipment safety. NPSIF established patient safety cells at central and district levels, also patient safety surveillance system.

Conclusion

To summarize, the paper briefly describes the comparative policy analysis of a developing with a developed country, with regard to patient safety measures. Maximizing involvement of people in policy making, results in better implementation, incorporating the grass-root level needs. Although, working towards a common health goal both countries shared a different perspective of problematization, as the needs for a developing country are unlike, those of developed. The demands of health and health care identified in Finland still goes unrecognized in India furthermore the latter still has a long way to attain UHC.

Relevance and Recommendation

This research helps us understand the disparity of health systems in a developed and a developing country giving room for the research to be taken ahead as to how this disparity can be minimized.

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References

1. MoHFW. *National Patient Safety Implementation Framework (2018-2025)*. 2018, September. [Cited January 14 2019]. Available from: https://main.mohfw.gov.in/sites/default/files/national%20patient%20safety%20implimentation_for%20web.pdf
2. WHO. *Patient safety*. 2018, August 28. [Cited January 26 2019]. Available from: <https://www.who.int/patientsafety/en/>
3. Buse K, Mays N, & Walt G. *Making health policy*. McGraw-Hill Education (UK). 2007. Available from: <https://www.semanticscholar.org/paper/Making-Health-Policy-Buse-Mays/047b12ff3abb511b41798c2f0b7d7dfb4c2c1be4>
4. El-Jardali F, Bou-Karroum L, Ataya N, El-Ghali H A, & Hammoud R. *A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: Learning from failure*. *Social Science & Medicine*. 2014;123: 45-54. Available from: <https://pubmed.ncbi.nlm.nih.gov/25462604/>
5. Doupi P. *National reporting systems for patient safety incidents: a review of the situation in Europe*. Raportti/Terveysten ja hyvinvoinnin laitos (THL)= Report/National Institute for Health and Welfare. 2009;13/2009. Available from: <https://www.julkari.fi/handle/10024/80105>
6. Ministry of Social affairs and Health. *Patient and Client Safety Strategy 2017–2021*. 2017. [Cited January 14 2019], Available from: https://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/80354/11_2017_Patient_and_client_safety_strategy_2017-2021.pdf?sequence=1
7. *Nurse fined 560 euros for assaulting elderly patient at a Turku hospital*. Uutiset. 2017, May 23. [Cited January 14 2019], Available from: https://yle.fi/uutiset/osasto/news/nurse_fined_560_euros_for_assaulting_elderly_patient_at_a_turku_hospital/9628676
8. WHO. *India Injection Safety Implementation Project (2016-2018)*. [Cited 26 January 2019]. Available from: http://www.searo.who.int/india/publications/publicatoins_india_injection_safety_implementation_book.pdf
9. *Less than one doctor for 1000 population in India: Government to Lok Sabha*. The Economic Times. 2017, July 21. [Cited January 26 2019], Available from: <https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/less-than-one-doctor-for-1000-population-in-india-government-to-lok-sabha/articleshow/59697608.cms>