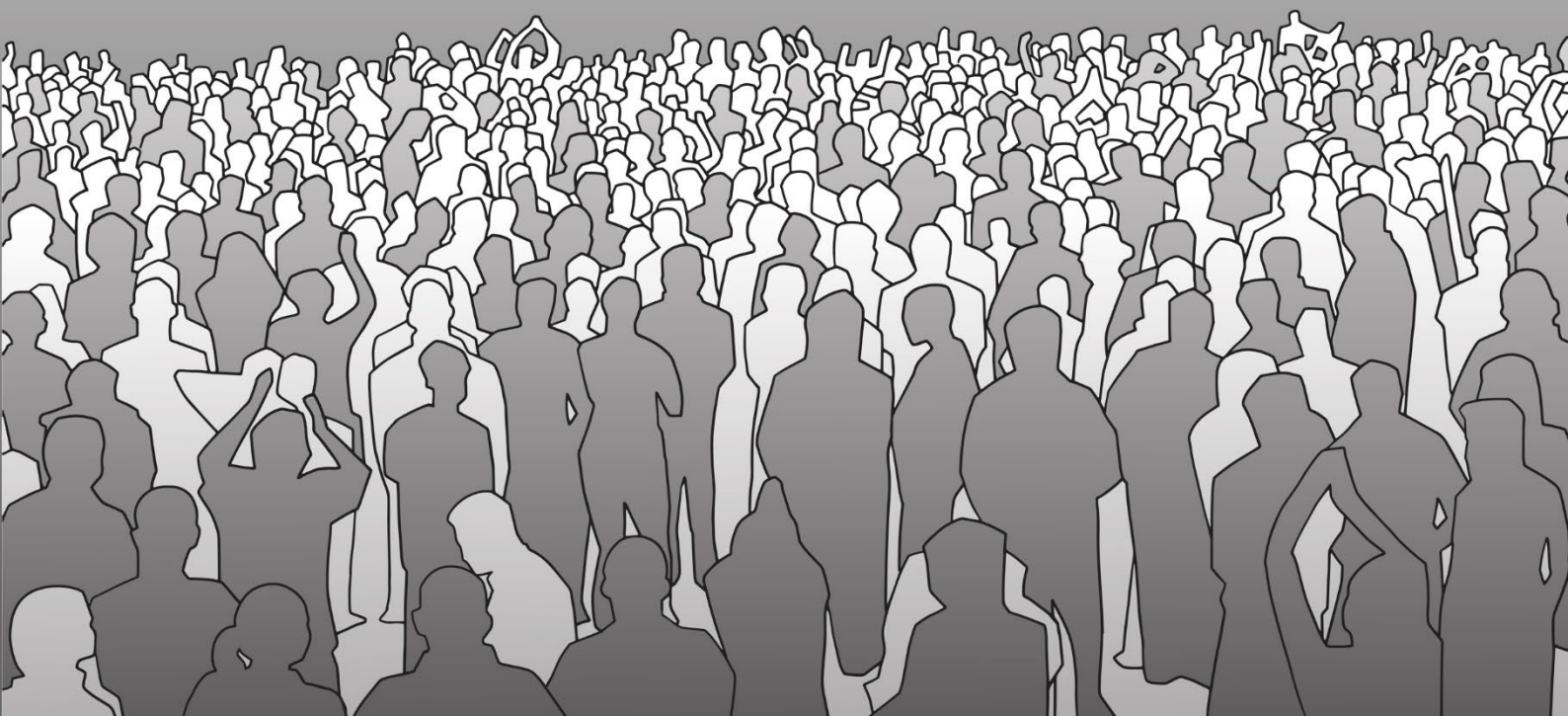
The Health Consumer Advocacy Alliance

Experts by Experience

Health Consumer Advocacy Alliance

Supplementary Submission B

31 October 2024



Petition request

That the House of Representatives establish a fully resourced, independent Patient Safety Commissioner (PSC) accountable to Parliament to take a proactive approach to preventing patient harm, with powers to take or require action.

Petition reason

We believe too many people have been harmed in NZ's health system because of system failures that have not been identified through existing processes. In our view, the HDC, HQSC, ACC and Medical Council lack independence. Existing processes primarily only respond after harm has already occurred, rather than being able to proactively assess and prevent systemic harm. We see a better model than the NZ status quo in the English and imminent Scottish independent Patient Safety Commissioners.

The Health Consumer Advocacy Alliance

Experts by Experience

The Health Consumer Advocacy Alliance is a collective of experienced health care advocates who share a common passion for creating positive, effective and lasting change. Our founders have a common standpoint; that health care as it is now, is not working, that the experience of New Zealanders in the health system is not what it should be. By working together and pooling our experience we identify areas and opportunities where we can facilitate change within the healthcare system and ensure that our voice, the consumer voice, is heard.

The Health Consumer Advocacy Alliance — founded by consumers for consumers. Experts by experience.

https://consumeradvocacyalliance.co.nz/

This Supplementary Submission provides additional information that quantifies the available harm data internationally and in Aotearoa, it offers greater insight into the statements made in our main submission.

We include recommendations for the overall structure of a Patient Safety Commissioner role, based on the set-up of England's Commissioner position however, we feel this should be a consultative, co-design process with our health sector, and consumers/patients to determine the role for the Aotearoa New Zealand context.

Please note: for clarity and readability there is some minor repetition of material from our main submission.

Avoidable Patient Harm and Medical Injury

Medical error, treatment injury and harm caused to consumers/patients in the course of receiving health care and medical treatment is a significant cause of morbidity and mortality.

The WHO *Global patient safety action plan 2021–2030* [1] states that "patient harm due to unsafe care is a large and growing global public health challenge and is one of the leading causes of death and disability worldwide. Most of this patient harm is avoidable."

It is the inadequately addressed avoidable, preventable harm to New Zealanders that occurs in the course of their health care and medical treatment that demands the establishment of a Patient Safety Commissioner.

Available Data for Aotearoa New Zealand

There is no comprehensive, publicly available review of the extent of avoidable patient harm and medical injury in Aotearoa New Zealand. However, from a review of the data that is available over the last 25 years, it is evident that there has been scant reduction in medical error, treatment injury and patient harm.

In 2001, Davis *et al.* found that adverse events were associated with 12.9% of hospital admissions, of which approximately 35% were classified as highly preventable.[2] The authors found that an average of over nine days per event was added to hospital stay; nearly a 20% of events originated from outside public hospitals, and 20% of those arose in another institutional context. Permanent disability or death was the outcome in 14.5% of events.

In 2006, Auckland University School of Population Health lecturers Mary Seddon and Alan Merry found more than 1500 people were killed or permanently disabled annually in this country through preventable medical error.[3]

An Aotearoa New Zealand study into incidence of harm within general practice, published in 2021, which involved 9076 study patients with 115,797 unique general practice visits, 212,963 prescriptions of 833 different pharmaceuticals and 2,578 hospital admissions, found 2,972 harms experienced by 1,505 patients.[4] The researchers found that, while most harm was considered minor, general practice records reveal the extent of severe harms, including preventable deaths.

We can gain some understanding of the extent of the burden of medical harm and treatment injury through those health entities that collect limited patient harm data. In 2021/22, the Health and Disability Commission (HDC) received 3,413 complaints — an unprecedented increase of 25% on the previous year. The Advocacy Service received 2,971 complaints.[5]

ACC treatment injury data is available from 1 July 2005, when treatment injury provisions came into law. The 2005 ACC Act legislation, when written, did not include complex injury, this results in inequitable access to claim cover and support via ACC for non-accident-related harm.

In 2019/20 ACC made a cover decision on 16,604 claims for treatment injuries and accepted 11,285 claims.[6] "Each of these claims represent a person who was harmed during treatment."[6] Of the accepted treatment injury

claims, 60.9% were from treatment in public hospitals, 13.7% from private hospitals and 12.7% from general practice.

However, relying on ACC data for treatment injury results in a gross under-estimation of the extent of medical injury and harm to patients in the health system. Not all people harmed in the course of their health care will make a claim with ACC, and for those that do, ACC declines a substantial number of claims (37% of medical/treatment injury claims compared with only 2% of personal injury claims) because of an arbitrary claim boundary test, and dysfunctional review process.[7]

Dr Katherine Wallis, a GP and Senior Lecturer at the University of Auckland, found in her 2017 paper that despite Aotearoa New Zealand's no-fault compensation for treatment injury creating an environment in which our health system could generate "novel patient safety data for learning", it has "yet to translate into improvement in patient safety".[8]

The total number of adverse events reported to the Health and Safety Commission (HQSC) in 2019/20 was 975 (916 in 2018/19).[9] The report *National summary of adverse events reported to the Health Quality & Safety Commission 1 July 2019 to 30 June 2020* reveals that the number of reported serious harm DHB adverse events (non-mental health), has climbed steadily from 181 in the 2006/07 year to 627 in the 2019/20 year.

While HQSC state that the increase in overall reporting demonstrates an open culture of reporting,[9] the reality is reporting of adverse events is largely not mandatory and we have no real idea if the increase in adverse events reflects an increase in reporting or an increase in incidents of harm or both.

The burden of medical and treatment injury is a global problem. A paucity of recent and comprehensive scientific research into the scale of medical harm in Aotearoa New Zealand must not be taken as evidence of absence, and it must be assumed that we have as significant a problem as those countries that we habitually compare ourselves with (US, UK, Canada and Australia).

Sir Liam Donaldson, Patient Safety Envoy, WHO, stated at the 5th Global Ministerial Summit on Patient Safety, "We need to acknowledge that no news is not necessarily good news, meaning that just because there aren't adverse effects/harm being reported does not mean it isn't occurring. In fact, we can go further by saying that not only is history repeating itself, but the same harm is happening to different people in different places."[10]

International Data

The World Health Organisation says that "On average, an estimated one in 10 patients is subject to an adverse event while receiving hospital care in high-income countries."[1]

A 2017 OECD report found that "adverse events are estimated to be the 14th leading cause of morbidity and mortality in the world. This puts patient harm in the same league as tuberculosis and malaria, and makes it a genuine global public health concern."[11] The report also found that "many adverse events are preventable".

In 2016, Makary and Daniel estimated that medical error is the third biggest cause of death in the US, and that medical error leading to patient death is under-recognised in many other countries including Canada and the UK.[12] Makary and Daniel call for better reporting, saying that problem of medical error should not be exempt from a scientific approach and that there should be more appropriate recognition of the role of medical error.

The World Health Organisation[1, 13] states that:

- Around one in every ten patients is harmed in health care and more than three million deaths occur annually due to unsafe care. In low-to-middle income countries, as many as four in 100 people die from unsafe care.
- Above 50% of harm is preventable; half of this harm is attributed to medications.
- Some estimates suggest that as many as four in 10 patients are harmed in primary and ambulatory settings, while up to 80% of this harm can be avoided.

- Common adverse events that may result in avoidable patient harm are medication errors, unsafe surgical procedures, health care-associated infections, diagnostic errors, patient falls, pressure ulcers, patient misidentification, unsafe blood transfusion and venous thromboembolism.

The Cost of Patient Harm

Harm caused to patients in our health system is a significant direct financial cost to our health system and to the patients themselves. There are also substantial wider and indirect costs, including to patient's whānau and communities, and productivity costs, a burden that the entire nation must bear. Additionally, there are costs to ACC to cover accepted claims (not to mention the administrative cost of assessing claims even those that are ultimately denied), and when complaints are lodged with the HDC, irrespective of the formal outcomes of such complaints.

A study published in 2002[14] found that in Aotearoa New Zealand "up to 30% of public hospital expenditure goes toward treating an adverse event", and that does not take into account the cost to individuals in both direct and indirect costs, loss of quality of life etc., and to the community in loss of productivity and participation. Brown *et al*. found that "adverse events are estimated to cost the medical system $NZ870 million, of which $NZ590 million went toward treating preventable adverse events."[14] Allowing for inflation, those figures would be expected to have almost doubled to NZ$1.6 billion and $1.1 billion respectively.

ACC figures can provide limited insight into the costs of treatment injury. In the ACC report *Supporting Treatment Safety 2021: Using information to improve the safety of treatment* [6] it was reported that actual costs and predicted future costs for all treatment injuries in the 2019/20 financial year was $484m. The total cost for the years 2009/10 to 2019/20 was $9.18 billion.

If we look at a single type of treatment injury, we can gain an understanding of how failures to address preventable patient harm can cost Aotearoa New Zealand just through ACC cover.

For example, "FACS [Foetal Anti-Convulsant Syndrome] has a life-long impact on affected children and their family/whānau. It can cause physical malformations such as heart defects, cleft palate, and spina bifida, as well as learning and behavioural difficulties. The average lifetime cost to ACC of a single FACS claim is estimated at $7 million. A single severe claim is estimated to cost ACC between $5 million and $25 million, which is an indication of the impact on the person."[6]

For surgical mesh the total cost of claims between 2015/16 and 2019/20 was $21.99 million with the annual cost of claims more than doubling in five years.[6] In other surgery related claims the total cost over the same period was $179.85 million with annual cost of claims increasing by 62% in five years.[6]

However, focusing on the ACC cost per individual, of harm from medical injury, grossly underestimates and understates the total financial burden of that harm, which must consider the financial burden on families/whānau, loss of productivity, loss of quality of life, disability-adjusted life years (DALYs), years lived with a disability (YLDs) and years of life lost due to premature mortality (YLLs). Nor does this include the cost within the health system, and to individuals, that is not covered by ACC cover.

In the past the total burden of ***personal injury*** in Aotearoa New Zealand has been calculated,[15] including treatment and rehabilitation costs, lost economic contribution and human costs (including the cost of pain and suffering). However, it appears that no such investigation of the total burden of ***medical harm*** and ***treatment injury*** has been carried out in this country.

It is important to remember that our population and the number of accepted ACC claims is increasing, so financially speaking, on that measure alone, the cost is significant.

The World Health Organisation says that patient harm potentially reduces global economic growth by 0.7% a year.[1] On a global scale, the indirect cost of harm amounts to trillions of US dollars each year.[1]

According to a 2022 OECD report, "In developed countries, the direct cost of treating patients who have been harmed during their care approaches 13% of health spending. Excluding safety lapses that may not be preventable puts this figure at 8.7% of health expenditure."[16]

Based on the health budget for Aotearoa New Zealand for the 2024/25 year of $29.6 6 billion[17], $2.5 billion is likely being spent on avoidable, preventable harm to patients in our health system. That is 1% of our GDP being spent to fix harm that should not have happened! That is 1.38% of the total annual Government expenditure in the 2024 budget to fix harm that should not have happened!

On top of direct costs to Aotearoa New Zealand, are the indirect costs that include "lost productivity (of patients as well as their families and informal carers), lost taxation revenue as well as higher welfare payments and perhaps also financial compensation. Indirect costs can also include the lost wages and decreased productivity of health workers and professionals involved in patient harm, who are often described as the 'second victims' of unsafe care."[11]

A significant proportion of patient harm can be prevented through better policy and practice, "with the cost of prevention typically much lower than the cost of harm."[18]

For example, the WHO Global Patient Safety Action Plan found that "Investment in reducing patient harm can lead to significant financial savings, and more importantly better patient outcomes. An example of a good return on investment is patient engagement, which, if done well, can reduce the burden of harm by up to 15%."[1]

"The costs of prevention are dwarfed by the costs of failure."[18]

A Model for a Safety Commissioner for Aotearoa New Zealand Patient

The Patient Safety Commissioner would:

- Be a Crown entity.
- Be entirely independent of any other health agency.
- Be fully funded and resourced.
- Be appropriately staffed with a full-time PSC, research and investigative staff and support staff.
- Be an independent champion of the voice of consumers' experience, informed by consumer experiences of harm within the health system.
- Seek to deliver systemic improvements in patient safety
- Have the legislative ability to actively seek data and information to inform and deliver their primary functions. Be able to obtain relevant information relating to patient safety concerns in the private sector and public health sector, and from other organizations
- Analyse the structure of the health system and harm reporting systems to help improve the way in which medical harm is reported.
- Not replace the HDC or undertake the work of the HDC, but would be complementary to the HDC. The PSC would not investigate individual complaints of patient harm but ultimately their work would reduce

the number of consumer complaints of harm to the HDC enabling the HDC to put more resources into investigating other types of breaches of patient rights.

- Work integrally with other health agencies to record, query and investigate reports of harm. The PSC would have total access to all data gathered by the HDC, HQSC, ACC, Medsafe (or other regulator), MoH, Te Whatu Ora, CARM, NQF and Medical Council, and undertake reviews of the data and establish patterns of harm from therapeutic products, procedures, practices and practitioners.
- Consumers can report their experiences to the PSC, and the PSC would record reports of medical harm and treatment injury for the purposes of identifying patterns of harm caused to consumers in the course of treatment within the health system, in both public and private. The reports received would enable the PSC to investigate systemic issues within the entirety of the health system.
- Be a signatory to the Code of expectations for health entities' engagement with consumers and whānau | Te tikanga mō te mahi tahi a ngā hinonga hauora ki ngā kiritaki me ngā whānau, and act in accordance with the code report annually on how the code has been applied.
- Submit an annual report of findings and work to the Minister of Health and the Minister for Disability.

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