THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

HON MINISTER'S REMARKS ON WORLD PATIENT SAFETY DAY

17TH SEPTEMBER 2019

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Minister

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Patient safety has been defined as **'the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum'** (World Health Organization, 2017).

The consequences of failures in patient safety are diverse and far-reaching: pain, suffering and even death for patients; the loss of loved relatives, or extra caring responsibilities, for families; the temporary or permanent loss of active members of the community; additional strains placed on already limited healthcare resources.

There is an increasing acceptance in countries across the world that medical errors can occur across the whole spectrum of health services and treatments and can be attributed to both human and system factors.

Even developed countries are not immune to the effects of patient safety incidents although two-thirds of all adverse events across the globe occur in low- and middle-income countries.

In developed countries approximately 10% of patients are harmed while receiving care in Hospitals whilst in developing nations like Uganda, this can rise to 20 times higher this number.

Patient safety is not just a medical issue but is **a moral, ethical and economic issue.**

There is an enduring belief that a sick patient who attends hospital is in safe hands. But, as has been observed, this is not true. Patients can experience harm whilst in hospital, as a result of **processes in place**, the **side-effects of medication or hospital-borne infections.** This is a fact. New technologies and ways of handling hospitals have not managed to address this problem; conversely, adverse incidents are increasing as a result of time pressures and the resources available.

Uganda is still in the phase of attributing medical error to individuals who may have 'caused' the harm – in reality, this individual is most likely only the person responsible for a patient's care and not the cause of harm. But a culture of blame persists. This negatively affects the

reporting rate of harmful incidents within hospitals. This also means that patients leave the hospital setting without understanding that they have suffered a medical error.

There needs for a paradigm change allowing health professionals to feel comfortable in reporting so that mistakes lead to learning opportunities, rather than individuals being punished by the police or by the courts. Currently, errors which are reported, especially if these reach the media, typically leads to disciplinary action taken against health professionals without further inquiry into the underlying reasons for the error.

Medical errors also have **severe economic implications** for patients and for the health system: patients have longer stays in hospitals and cannot return to work whilst more resources have to be expended on their prolonged care and treatment. This must be addressed for everyone's benefit.

Because patient safety is a complex, multi-dimensional challenge the solutions to providing safer, high quality care cannot be found through the isolated efforts of interested stakeholders. Rather, there must be ongoing, concerted actions by all those with responsibilities, experience and expertise in healthcare. These stakeholders are diverse and are drawn from all levels of national and international organizations, including: governments, policy-makers, regulators, healthcare providers, healthcare professionals, researchers, educators, lawyers, civil society, community health workers and patients. Such groups, working together, can develop regulatory frameworks, leadership, and organizational management alongside the on-the-ground capacity to successfully implement and maintain safety strategies, procedures and practices.

We are therefore very happy to join the other countries in the world to commemorate the FIRST World Patient safety day on 17th September 2019.

World Patient Safety Day builds on a successful series of Global Ministerial Summits on Patient Safety pioneered in 2016 at London as well as relentless advocacy by leaders from all sectors — politicians, patient champions, patient safety experts and global public health leaders.

The establishment of an annual World Patient Safety Day will give an opportunity to providers, seekers and managers of health care services to join a platform and express solidarity and compassion to make health care safer. The origin of the day is firmly grounded in the fundamental principle of medicine – First, to do no harm.

The objective of the very first World Patient Safety Day is to raise global awareness about patient safety with the theme 'Patient Safety: a global health priority'. Openness and 'blame-free' environments are the minimum conditions for enacting a safety culture. Hence, to promote open communication for learning from errors and to emphasize the importance of patient safety, the slogan for World Patient Safety Day 2019 is "Speak up for patient safety!"

If health care itself poses a threat to people's health, the benefit of increased health coverage is completely lost.

Unsafe care erodes trust in public health systems and deters patients from seeking care.

It can drive patients to the private sector, which they perceive as safer. This increases the financial burden on patients and undermines progress towards universal health coverage.

It also increases costs for health systems.

About 15% of hospital expenditure in industrialized countries is spent on treating safety failures. And the broader social and economic costs of patient harm amount to trillions of dollars every year.

Safe care delivers better outcomes for patients and their families, but it also delivers better outcomes for health systems by avoiding the costs of adverse events, prolonged hospital stays and compensation.

So in the end, safe care isn't just good medicine, its good economics.