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Hands off the watchdog

EDITORIAL

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The Norwegian government wants to merge the Norwegian Healthcare Investigation Board and the Norwegian Board of Health Supervision. This is a bad idea.

Photo: Einar Nilsen

The Norwegian Healthcare Investigation Board (NHIB) was established in 2019. If the Norwegian government gets its way, this independent watchdog for the health service will soon be gone (1). The impetus to create NHIB originally stemmed from families who had lost loved ones during hospital treatment and wanted the healthcare sector to have its own 'accident investigation authority' (2). The term was inspired by the Norwegian Safety Investigation Authority, which has served as an independent investigation body for the transport sector since 1989.

NHIB was given a regulatory framework that was virtually identical to that of the Norwegian Safety Investigation Authority, which reflected the high-risk nature of both the transport and healthcare sector. It is still estimated that at least one patient injury occurs in 12 % of admissions to somatic hospitals (3). Historically, this figure has been even higher. However, while fatal accidents in aviation have been systematically investigated since 1923 with a view to improving safety (4), it was not until 1992 that healthcare institutions were required to report all 'significant patient injuries', and the first so-called 'reporting centre' was not established at the Norwegian Directorate of Health until 1993 (4). Since then, a variety of reporting and notification systems have been shunted between different public health agencies.

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The system remains fragmented and unclear. There are different reporting and notification systems for healthcare personnel, for the organisations themselves, and for patients, each with their own complaint procedures. Information about patient injuries and adverse events is not only scattered across these various systems but, in some cases, is also held by different public health registries, the police and other administrative bodies. In terms of preventing and identifying adverse events, the Ministry of Health and Care Services, the Norwegian Directorate of Health, the Norwegian Institute of Public Health, the Norwegian Patient Injury Compensation agency, the Norwegian Board of Health Supervision and the County Governors all play a role (5). It is not surprising that there is considerable confusion, as responsibility for the system often feels fragmented and the processes are difficult to grasp. In 2021, the newspaper *VG* revealed that 80 % of all registered serious incidents in Norwegian hospitals over the previous three years had not been reported (6).

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The lack of effective, uniform systems for reporting and evaluation is serious for several reasons. One is that unidentified problems represent missed opportunities for the health service for improvement and enhanced patient safety. It is estimated that half of all injuries in health and care services could have been prevented (3).

This is precisely where NHIB has played a key role. Since its establishment in 2019, NHIB has produced reports on a wide range of individual incidents and systemic issues. It has been critical of the health authorities, been criticised itself, and sparked public debates. NHIB's legitimacy with the public, as well as patients and their families, is grounded in its independent role. Its independence is what enables it to take a critical approach to the system. It can offer critical assessments and recommendations to the full range of regulatory bodies, from supervisory authorities to directorates, government ministries and even lawmakers. Because NHIB's focus is on investigation and improvement rather than assigning blame, those involved in the incidents are more likely to share information without fearing consequences. This allows as many aspects as possible to be uncovered, and the reports can therefore inspire optimal learning.

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Most of this is at risk of being lost if the merger with the Norwegian Board of Health Supervision goes ahead as the government proposes. The Norwegian Board of Health Supervision is responsible for ensuring legal compliance and enforcing sanctions. While these duties are important, they are difficult to combine with the learning and improvement aspect, and impossible to reconcile with the strong, independent role that NHIB currently holds.

There seems to be no principled rationale behind the government's desire to dissolve NHIB. On the contrary, the Norwegian Safety Investigation Authority has recently had its mandate expanded to conduct independent investigations (4). In autumn 2024, the government also established a new and permanent body that will review all intimate partner killings in Norway (7). Its mandate is almost a carbon copy of that of NHIB, it will be independent and will not be responsible for determining blame. This is taking place at the same time the government proposes dissolving NHIB. The proposal should be abandoned. The health service needs an independent body to ensure continuous learning and improvement within the system.

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