



WORLD ALLIANCE FOR PATIENT SAFETY

Information Note

Background

There is no doubt that the ever-increasing incidence of adverse events in health care delivery represents a shocking and shameful reality in many countries. The facts are alarming. The Harvard study in the United States of America (USA) found that, 4% of patients suffer some kind of harm in hospital: 14% of the incidents lead to death; 70% of the adverse events result in short-lived disability; the 1999 Institute of Medicine report estimated that medical error is reported to cause as many as 98,000 hospital deaths each year – more than car accidents, breast cancer or AIDS! Studies in the United Kingdom of Great Britain and Northern Ireland found that around 10% of hospital patients suffer adverse events each year. In Europe, every tenth hospital patient suffers from preventable harm. New Zealand and Canadian studies have suggested rates of adverse events of around 10%. And in Australia, an adverse-event rate of 16.6% was found in hospital patients.

The situation is far more serious in developing countries, although there is less data, with millions of child and adult patients enduring prolonged ill-health, disability and death caused by unsafe vaccinations, injections and blood, counterfeit and substandard drugs, unreliable equipment and practices, inadequate infection control, and overall poor health services and environments. WHO reports that at least 50% of all medical equipment is unsafe, and that 77% of all reported cases of counterfeit and substandard drugs occur in developing countries.

The economic impact of adverse events is equally alarming. In the United Kingdom, additional hospitalization, litigation claims and hospital-acquired infections – 15% of which may be avoidable – cost about US\$ 6 billion a year, in addition to an estimated potential liability of US\$ 4.3 billion for existing and expected claims. Preventable adverse effects in the USA including lost income, disability and medical expenses can be as high as US\$ 29 billion a year!

Yet, there are well-proven strategies – and many examples of successful initiatives – that can dramatically reduce the incidence and cost consequences of adverse events in health-care provision. The missing link to “scaling up” responses is a lack of awareness of the problem of adverse events, poor capacity for reporting and responding, and a lack of commitment and resources. Progress is likely to come by raising a broad political consensus that this public health tragedy poses serious ethical and financial challenges to the entire world. In practice, patient safety can be achieved with a sustained attack on major sources of harm to patients and a gradual reduction in the level of hazards and instances of actual harm.

A world health priority

Effective reduction of adverse events in health care calls for concerted efforts not only to ensure that policies address health care safety, but also to undertake research and enhance the knowledge base about safety, establish reporting systems, and involve consumer and medical communities, while taking into account the cost-efficiency of safety measures, particularly in poorer settings.

WHO has already taken a lead in tackling specific aspects of patient safety challenges. The Fifty-fifth World Health Assembly, held in 2002, in resolution WHA55.18 on patient safety, urged Member States to pay the closest possible attention to the problem of patient safety and to establish and



strengthen science-based systems, necessary for improving patients' safety and the quality of health care, including the monitoring of drugs, medical equipment and technology.

The resolution has ensured that the drive for safer health care is now becoming a worldwide endeavour, that can bring significant benefits to patients in countries rich and poor, developed and developing. Drawing on its decentralized structure and role as convenor and adviser to its Member States, WHO has stepped up efforts – through its regional and country offices – to support national efforts with:

- international drug monitoring and safety
- immunization safety supported by the Global Advisory Committee on Vaccine Safety
- safe injection practices supported by the Safe Injection Global Network
- actions promoting environmental safety
- safety of blood products
- safe laboratory practices
- safe use of medical devices and clinical procedures.

Several countries have already initiated efforts to tackle patient safety challenges while others have requested WHO support for strategic analyses and public health expertise. Since the resolution was passed in 2002, WHO has established programmes to tackle systemic issues such as estimating hazards and developing taxonomy and reporting and learning systems. The Organization has also brought together technical experts to address global patient safety challenges.

The creation of a **World Alliance for Patient Safety** will be a significant step in the struggle to improve the safety of health care in all Member States. At present, no single player has the expertise, funding or research and delivery capabilities to tackle the full range of patient safety issues on a worldwide scale. The World Alliance will provide a mechanism to build capacity, decrease duplication of investment and activities, and benefit by economies of scale. Such an alliance will also provide an environment in which new initiatives can arise to help catalyse a large-scale and more sustainable response.

World Alliance for Patient Safety

The fundamental purpose of the World Alliance for Patient Safety is to:

- raise high-level awareness and support the leading role of governments in the development of policy and practice for patient safety
- attract global attention to major patient safety issues
- facilitate global and national reporting through coordination of existing and new reporting systems
- strengthen solution development and the sharing of knowledge and resources to improve efficiency
- encourage research and the development of national-level strategies on major patient safety issues, accommodating the opportunities and obstacles unique to each country
- involve consumer support.

The Alliance aims to cover six major action areas:

1. A key element will be the **Global Patient Safety Challenge**. The first challenge over an initial two-year cycle, starting in 2005, will address the challenge of health-care associated infection and will be entitled “Clean Care is Safer Care”.
2. **Patients for Patient Safety** will involve patient organizations and individuals who will play a role in identifying risks and devise solutions. The programme will be an ongoing activity, and will position the patient centrally within the Alliance movement.
3. **Taxonomy for Patient Safety** will introduce clarity and consistency in the concepts, principles, norms and terminology used in patient safety work that can lead to improved monitoring and reporting of adverse events. Taxonomy work has already been started and will continue for the next two years.

4. **Research for Patient Safety.** The first component of this programme will be to develop a rapid assessment tool for use in developing countries to ascertain the nature and extent of adverse events. In 2005, studies will commence in 13 countries. The second component will focus on global prevalence studies of adverse events.
5. **Solutions for Patient Safety** will widely promote existing successful interventions on patient safety, coordinate international efforts to develop solutions and support countries to establish patient safety policy and practice.
6. **Reporting and Learning** will develop best-practice guidelines to improve existing reporting systems and facilitate the establishment of new ones.

As the launch of the World Alliance for Patient Safety in October 2004 approaches, an increasing number of countries are committing to building an evidence base and strengthening national mechanisms to improve safety at the point of health service delivery and primary health care. The Alliance fundamentally supports countries as they place patient safety issues centrally within their health agenda. It catalyses global and national-level action for sharing knowledge, resources and expertise and takes a long-term look at how to build capacity to effectively, efficiently and equitably enhance performance in terms of safety of care.

The work of the Alliance builds upon existing efforts and initiatives sharing the same vision and links with national programmes, processes and mechanisms established for improving patient safety. This includes engaging a broad range of partners – national authorities, health care associations, patient safety agencies, academic and civil society groups, and technical consultants – to promote pro-patient safety strategies, and instigating new research and analyses leading to developing global standards and the design of national guidelines. It is expected that the work of the Alliance will eventually lead to much greater long-term safety in health care. The impact of well-developed and well-applied strategies on patient safety will include better-focused national planning and spending on health care, a dramatic decline in expenditures related to adverse events in the order of billions of dollars of saved costs annually, and an equally dramatic decline in disabled patients and lost lives.

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