



FACT SHEET

The Launch of the World Alliance For Patient Safety

" Please do me no Harm "

27 October 2004

Washington, DC

1. This unique and essential Alliance is set up by the World Health Organization (WHO) and its partners to focus global attention and resources on patient safety issues, and to advance the goal of *"First do no harm"*¹ and reduce its adverse health and social consequences.
2. The World Alliance is endorsed and supported by several partners representing governments, agencies and patients' groups. Key partners include the Department of Health of the United Kingdom, the Department of Health and Human Services of the United States of America and the Australian Department of Health and Ageing.
3. The launch of the World Alliance for Patient Safety aims to sustain political momentum and strengthen commitment of interested countries, and agencies, on the critical role of safety in care.
4. The launch of the Alliance provides an opportunity to enhance dialogue between country ministers and senior representatives from health authorities and agencies, foundations, regional organizations, NGOs and research institutions from G8 and developing countries on national plans to increase investment and resources in patient safety.
5. Most importantly, the new Alliance will bridge the gap between patients and the health providers by facilitating dialogue between patient's groups and health authorities, engaging in technical work and raising a broad political consensus that this public health tragedy poses serious ethical and financial challenges to the entire world.
6. The creation of the World Alliance for Patient Safety is a significant step in the quest to improve patient safety. 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.
7. The Alliance will provide a mechanism to decrease duplication of investment and activities. The Alliance aims to create an environment in which major new initiatives can flourish. It also aims to become a vehicle for the sharing of knowledge and resources to support countries in implementing their own patient safety activities. For example, solutions identified and evaluated by one or two members could be adapted for global or multicountry implementation.
8. The work of the World Alliance will focus on six major action areas:
 - A key element will be the **Global Patient Safety Challenge**, focusing over 2005-2006 on the challenge of health-care associated infection;
 - **Patients for Patient Safety** involving patient organizations and individuals in Alliance work;

¹ *"First do no harm"*, attributed to Hippocrates circa 470-360 BC

- **Taxonomy for Patient Safety** ensuring consistency in the concepts, principles, norms and terminology used in patient safety work;
 - **Research for Patient Safety** developing a rapid assessment tool for use in developing countries and undertaking global prevalence studies of adverse effects;
 - **Solutions for Patient Safety** promoting existing interventions and coordinating activity internationally to ensure new solutions are delivered;
 - **Reporting and Learning** generating best practice guidelines for existing and new reporting systems, and facilitating early learning from information available.
9. The technical areas include those concerned with product safety and safe clinical practice including: blood safety; chemical safety; clinical procedures; drug safety; immunization safety; injection safety; making pregnancy safer; medical devices and equipment; transplant safety, human genetics. Technical areas concerned with health systems operations include: estimating hazards, taxonomy, and reporting and learning systems.

Background on Patient Safety Issues

Various studies have investigated the extent of adverse effects in health care delivery.

On Increased mortality and morbidity

1. The Quality in Australian Health Care Study (QAHCS), published in 1995, found an adverse-event rate of 16.6% among hospital patients².
2. The New Zealand and Canadian studies have also suggested relatively high rates of adverse events: around 10% Canadian and New Zealand studies reported an adverse event rate of 10%³.
3. The Hospitals for Europe's Working Party on Quality Care in Hospitals reported, in 2000, that every tenth patient in hospitals in Europe suffers from preventable harm and adverse effects related to his or her care in Europe,⁴.
4. The UK Department of Health, in its 2000 report, *An organisation with a memory*, estimated that adverse events occur in around 10% of hospital admissions or about 850 000 adverse events a year. In the UK, around 10% of hospital patients suffer adverse events each year⁵.
5. The Harvard study, found that 4% of patients suffer some kind of harm in hospital; 70% of the adverse events result in short-lived disability, but 14% of the incidents lead to death⁶.
6. The Institute of Medicine (IOM) report in the USA in 1999, estimated that "medical errors" cause between 44 000 and 98 000 deaths annually in hospitals in the USA –

² Wilson RM, Runchiman WB, Gibberd RW *et al* The Quality in Australian Health Care Study. *Med J Aus* 1995, 163: 458-71

³ Davis P, Lay -Yee, Briant R *et al*. Adverse events in New Zealand public hospitals I: occurrence and impact. *NZ Med J* 2002;115 (1167):U271 ; Davis P, Lay -Yee, Briant R *et al*. Adverse events in New Zealand public hospitals II: occurrence and impact. *NZ Med J* 2003;116 (1183):U624; Baker GR, Norton PG, Flintolf V, *et al*. The Canadian Adverse events Study: the incidence of adverse events among hospital patients in Canada. *JAMC* 25 may 2004 179 (11) 1678 - 1686

⁴ Standing Committee of the Hospitals of the EU. *The quality of healthcare/hospital activities: Report by the Working Party on quality care in hospitals of the subcommittee on coordination*, September 2000

⁵ Department of Health. *An organisation with a memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer*. HMSO 2000. Crown Copyright

⁶ Brennan TA, Leape LL, Laird NM *et al*. Incidence of adverse events and negligence in hospitalised patients: results of the Harvard Medical Practice Study *N Eng J Med* 1991; 324 (6):370-7, Leape LL, Brennan TA, Laird N *et al*. The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II. *N Eng J Med* 1991; 324 (6):377-84

- more than car accidents, breast cancer or AIDS; medical error is reported to cause as many as 98 000 hospital deaths each year – more than car accidents or AIDS ⁷!
7. In developing countries the probability of adverse events in healthcare is higher than in the industrialised nations. Poor infrastructure and equipment, unreliable supply and quality of drugs, shortcomings in waste management and infection control, poor performance of personnel because of low motivation or insufficient technical skills, and severe under financing of essential operating costs of health services contribute to an ever-increasing rate of adverse events. For example, developing countries account for around 77% of all reported cases of counterfeit and substandard drugs (WHO)⁸.
 8. A recent WHO survey of the quality of antimalarials in seven African countries revealed that between 20% and 90% of the products failed quality testing. (WHO)⁹.
 9. In 2001, it was estimated there were 2 800 illegal medicine sellers in Cambodia and 1000 unregistered medicines on the market. In the Lao People's Democratic Republic 2100 illegal drug sellers are reported to exist. (WHO)⁹.
 10. At least half of all medical equipment in developing countries is unusable or only partly usable, at any given time (WHO)¹⁰.
 11. In the European countries that have achieved independence in recent years, about 40% of hospital beds are located in structures originally built for other purposes. This makes facilities for radiation protection and infection control extremely difficult to incorporate, with the result that such facilities are often either substandard or absent.¹¹

On economic impact

12. 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 claims¹².
13. Preventable adverse events in the USA including lost income, disability and medical expenses is estimated at between US\$17 billion and US\$ 29 billion a year⁷!
14. Added to these costs is the erosion of trust, confidence and satisfaction among the public and health-care providers.

On WHO and Patient Safety

15. 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 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 urged WHO

⁷ Kohn, LT, Corrigan, JM, Donaldson, MS Eds. (1999) *To err is human: Building a safer health system*. Institute of Medicine, National Academy Press.

⁸ World Health Organization *Progress in essential drugs and medicines policy, 1998-1999*, WHO/EDM/2000.92

⁹ World Health Organization steps up action against substandard and counterfeit medicines: Asian and African Countries move to improve the quality of their medicines, WHO Press release, 11 November 2003

¹⁰ Issakov A Health care equipment: a WHO perspective. In: van Grutting CWG ed. *Medical devices: International perspectives on health and safety*. Elsevier, 1994

¹¹ Schultz DS, Rafferty MP, Soviet health care and Perestroika, *American journal of Public Health*, 1990, Feb; 80(2):193-197

¹² Department of Health. *An organisation with a memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer*. HMSO 2000. Crown Copyright

- to take the lead in developing global norms and standards, encouraging research, and supporting efforts by Member States in developing patient safety policy and practice.
16. 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.
 17. Several countries have already initiated efforts to tackle patient safety challenges while others have requested WHO support for strategic analyses and public health expertise with more than half of WHO's 192 Member States making contact with the Organization about patient safety.
 18. Since 2002, WHO has supported programmes to estimate hazards and is developing a patient safety taxonomy. Guidelines on reporting and learning systems and hand hygiene are also being developed.
 19. In May 2004, the Fifty-seventh World Health Assembly noted the progress in implementing resolution WHA55.18, and Member States participated in a technical briefing. The Health Assembly considered a proposal to form a World Alliance for improving patient safety as a global initiative.

Responses to improve Patient Safety worldwide

20. **Mobilising political commitment:** Ways to support national efforts to place patient safety issues centrally within countries' health agenda are being developed by WHO and its key partners through a strategic combination of advocacy and public health expertise. The focus of this work is to raise high-level political awareness and commitment for developing country-led policies and plans to improve patient safety.
21. **Global reporting:** The growing interest in patient safety reporting and learning systems means that large databases and repositories will be needed to collate information from many sources. The Alliance intends undertake short-term global reporting on patient safety issues, linked to problem identification and solution development.
22. **Developing solutions and widely disseminating best practices:** Learning from adverse events within health care systems has been identified as a major obstacle to improving safety; learning across health care systems is an even greater challenge. The Alliance will support the development of country-led solutions recognizing the diversity of national health and economic situations and taking into account patient safety priorities, opportunities and obstacles unique to each country. Solutions would be disseminated widely through expert meetings, websites and consideration could also be given to the merit of developing joint WHO/Alliance alerts and bulletins on patient safety.
23. **Research and development:** Research on patient safety is growing rapidly in advanced health care systems, and very little attention has been given to the major safety problems of developing countries. The Alliance is planning to :

- assist countries establish patient safety research programmes to solve specific problems in their health care systems;
 - promote research on major patient safety issues in developing countries that affect millions of people;
 - establish action teams of leading researchers who would collaborate on research on patient safety issues in developing countries; more precise
 - holding a premier global research conference for patient safety, reducing the need for attendance at multiple, and often repetitive conferences.
24. **Engaging communities and people:** The Alliance will mobilise and empower patients and their representatives through the patient safety consumer movement. Efforts will be multisectoral and across all levels of society. They will include a diverse range of activities from establishing an inventory and links with patient safety initiatives, to designing programmes for active consumer participation and developing networks of health-care consumer advisors.
25. **Tracking outcomes - supporting countries assess progress:** Building a movement around patient safety issues also involves the establishment of systems to track the impact of efforts to improve patient safety . As policy-makers become more committed with patient safety issues, the Alliance will facilitate the development of an instrument that will allow countries to assess the state of readiness of their health systems in terms of safety of care. This will enable each country to benchmark its position and monitor its own progress over time against international standards.