

To Err Is Human; To Fail to Improve Is Unconscionable

By "To Err Is Human" co-author Lucian L. Leape, M.D., an adjunct professor at the Harvard School of Public Health, and Commonwealth Fund President Karen Davis, Ph.D.

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Five years ago, the Institute of Medicine (IOM) released a landmark report, *To Err Is Human*, which shattered widely held perceptions about the safety of health care in the United States. The report found that medical errors—wrong medications or doses, surgical mistakes, infections, and other preventable adverse events—contribute to more than 1 million injuries and up to 98,000 hospital deaths a year.

Virtually overnight, patient safety became a major public health issue, and a new agenda emerged for protecting patients from hospital mistakes. "It would be irresponsible to expect anything less than a 50 percent reduction in errors over five years," the report authors declared.

Irresponsible or not, that hasn't happened. The most we can say is that we've made progress. Slow progress. In response to the IOM report, hospitals across the country have launched programs to prevent errors and improve safety. The Joint Commission on Accreditation of Hospitals, the national organization that accredits hospitals, has identified and incorporated new "safe practices" into its inspections and requires hospitals to disclose errors to patients. And patient safety has emerged as a discreet and worthy area of research: Congress has appropriated \$50 million a year for patient safety research, greatly increasing work in this field and helping to build and support a research infrastructure of young investigators.

But this is all far short of what's needed.

Hospital Dangers

Error prevention efforts are isolated and uncoordinated. And federal funding for patient safety research is only a tiny fraction of what it should be. We lose more lives each year to medical errors than are saved by the technological advances of the National Institutes of Health. We need to create a National Institute of Health Safety.

When it comes to improving patient safety, we have plenty of recognition of the problem but no real commitment to solving it.

As a result, hospitals are still dangerous places to be if you are sick. Even if you live across the street from a world-class hospital, you are at risk for receiving poor care. For example, up to 2 million hospital patients a year—one of 20 of all those admitted—contract serious infections while in the hospital. These infections are a leading cause of death in this country. Pennsylvania recently became the first state to collect data on hospital-acquired infections. Using conservative measures, state officials found that nearly 12,000 Pennsylvanians contracted infections during 2004, resulting in at least 1,500 preventable deaths and costing an extra \$2 billion in care.

We can't afford this kind of health care anymore. And we shouldn't pay for it.

Paying for Safe Care

Minnesota is already starting to make this happen. HealthPartners, a large HMO in that state, has announced that it will stop paying for 27 major medical mistakes from a list developed by the nonprofit, Washington, DC–based National Quality Forum. These are mistakes that should never happen, such as surgery performed on the wrong body part or serious harm from contaminated drugs or medication errors.

Although HealthPartners is drawing a largely symbolic line—these mistakes fortunately occur relatively infrequently—refusing payment sets an important precedent. It lets hospitals know up front that there are financial consequences to egregious medical errors and that they would do well to institute systemic changes, such as automated prescription order programs, to help ensure patient safety.

Paying for performance can only inject reason into our current reimbursement system, which blindly compensates for services provided, including defects. By saying no to unacceptable errors, payers will strengthen incentives for hospitals, doctors, and other health care professionals to provide high-quality, safe care. When hospitals are paid more for getting it wrong than for getting it right, it's clear we have a perverse system of incentives.

Paying for Quality

Another example of our perverse system of paying for health care is Medicare's current fee-for-service payment system, which can actually penalize providers who try to improve quality. Take as an example a hospital that sets up a program to help coordinate post-discharge care for patients with congestive heart failure (CHF). CHF patients have a chronic condition that, although not curable, can be treated and managed to maximize quality of life and minimize acute episodes that result in expensive hospitalizations. However, Medicare payment is not set up to encourage this type of coordination. While Medicare pays for outpatient visits, it does not pay for coordination activities or reimburse providers for the costs of those activities. Moreover, since Medicare only pays for visits and hospitalizations, if the hospital is successful in preventing re-hospitalizations, Medicare will pay it less than for inferior care that results in repeated hospital care.

Indeed, most payers pay for volume rather than quality because volume is much easier to measure. In order to encourage payers to pay for quality, we need to develop better measures of quality. Medicare and other payers are working on this. Recently, the Centers for Medicare and Medicaid Services posted information on 10 measures of hospital quality on its [Web site](#), and many managed care plans, nursing homes, and home health agencies have also posted quality measures online. But much more information needs to be made available and widely disseminated. Infection rates for individual hospitals should be made available to the public at large, just as access to the National Practitioner Data Bank maintained by the Health Resources and Service Administration should be publicly available.

Paying for performance makes sense for private insurers, as well as Medicare and Medicaid. It's not the only thing we should do to improve quality and safety, but it will be a major step toward achieving the IOM's goal of cutting medical errors in half.