AHRQ FOCUS ON RESEARCH
Agency for Healthcare Research and Quality
www.ahrq.gov

Patient Safety

SCOPE OF THE PROBLEM

Over the past two decades, the issue of patient safety and medical errors has been made more visible by research funded by the Agency for Healthcare Research and Quality. Based on AHRQ research, the Institute of Medicine reported in November 1999[1] that:

- As many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors.
- Medical errors is the eighth leading cause of death in this country—higher than motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).
- About 7,000 people per year are estimated to die from medication errors alone—about 16 percent more deaths than the number attributable to work-related injuries.

Studies funded by AHRQ also indicated the fiscal impact of patient safety. Medical errors have been estimated to cost a large hospital more than $5 million per year. Preventable health care-related errors cost the economy from $8 to $15 billion each year.

AHRQ Research Findings

Research funded by AHRQ has helped define the scope of the medical errors problem.

- Surgery-related errors resulted in patient death, disability, or a prolonged hospital stay in 3 percent of patients admitted to hospitals in Colorado and Utah in 1992.
- One in five elderly Americans not living in nursing homes are at risk of receiving inappropriate medications. The study, based on data collected in 1996, determined that about one-fifth of such older Americans used at least one of 33 prescription medicines considered potentially inappropriate for elderly patients.
- AHRQ also supported research that resulted in a paper describing an alternative to current malpractice litigation—similar in principle to workers' compensation or no-fault auto insurance—that would allow patients or their families to receive compensation without requiring proof of practitioner fault.

Current Research Projects

In FY 2001, AHRQ awarded almost $50 million for 94 new grants, contracts, and other activities to fund research aimed at reducing medical errors and improving patient safety. AHRQ is funding a Patient Safety Research Coordinating Center to assist researchers funded under the Agency's patient safety programs to interact and help to ensure that their findings are translated into measurable improvements in health care. The awards fall into six major categories:

- Supporting demonstration projects to report medical errors data (24 projects, $24.7 million);
- Using computers and information technology to prevent medical errors (22 projects, $5.3 million);

- Understanding the impact of working conditions for health care workers on patient safety (8 projects, $3 million);
- Developing innovative approaches to improving patient safety (23 projects, $8 million);
- Disseminating research results (7 projects, $2.4 million); and
- Additional patient safety research initiatives (10 projects, $6.4 million).

These projects represent the first phase of a multi-year effort involving universities, hospitals, and other organizations in 28 States and the District of Columbia.[2]

AHRQ has also funded other projects in the area of patient safety and health care quality, including a number of additional studies that are examining the relationship between working conditions and the quality of care patients receive.

Patient Safety Research Priorities

To further address the question of improving patient safety and reducing medical errors, AHRQ developed a research agenda with input from researchers, health care providers, and members of the public. The agenda states that we need more information on such topics as:

- The epidemiology of errors—e.g., the types and rates of errors in different health care settings;
- The infrastructure to improve patient safety—e.g., needed analytic capacity and organizational culture;
- Information systems—e.g., development of common definitions of a reporting system and how to evaluate its success; and
- Knowing which interventions should be adopted and how to encourage adoption of patient safety practices.

For More Information

For more information on AHRQ's patient safety and medical errors research program, contact:

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Notes

1. Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 1999.
2. Quality Interagency Coordination Task Force. *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*. Rockville, MD: Quality Interagency Coordination Task Force, February 2000.

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