Editorials

Patient safety — a global priority

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Patient safety is a global imperative. It has extensive implications for all WHO Member States, for all health-care workers — and for all of us when we become patients.

We already know that about 10% of people who receive health care in industrialized countries will suffer because of preventable harm and adverse events (*1–5*). By 2006 we expect to have a greater understanding of the nature and scale of the problem in developing countries and countries in economic transition. Early indications from a pilot study being carried out suggest that the figure will be significantly higher. Recent WHO data suggest that developing countries account for around 77% of all reported cases of counterfeit or substandard drugs (*6*). It is also reported that at least half of all medical equipment in many of these countries is unusable or only partly usable, resulting in an increased risk of harm to patients and health workers (*7*).

Adverse events occur in all settings where health care is provided. Most of the current evidence comes from hospitals because risks associated with hospital treatment are higher but many such events occur in other health-care settings such as physicians' offices, nursing homes, pharmacies, community clinics and patients' homes.

Every point in the process of care-giving contains an inherent lack of safety. Adverse events may therefore be the result of problems in practice, products, procedures or systems.

Current conceptual thinking on the safety of patients places the prime responsibility for adverse events on deficiencies in system design, organization and operation rather than on individual practitioners or products. For those who work on systems, adverse events are shaped and provoked by "upstream" systemic factors, which include the particular organization's strategy, culture, working practices, approach to quality management, risk prevention and capacity for learning from failures. Countermeasures based on changes in the system are, therefore, more productive than those that target the behaviour of individuals and their propensity to commit errors.

In 2002 WHO acknowledged that, to tackle patient safety internationally, a comprehensive, multifaceted approach involving cultural change, system development and technical expertise was necessary. The Fifty-fifth World Health Assembly called upon all Member States to take action in relation to patient safety (*8*), following which WHO established a number of work programmes tackling systemic issues such as taxonomy, estimating hazards and the development of reporting and learning systems. The Organization also brought together its technical experts dealing with the safety of blood, injections, vaccines, drugs and medicines, pregnancy procedures and medical devices so that their individual expertise could be harnessed to find global solutions.

On 27 October 2004 WHO launched the World Alliance for Patient Safety, whose purpose is to coordinate international action and avoid duplication of effort in coping with this escalating problem. The Alliance's action areas set out in its forward plan (*9*) will enable us to learn more about why adverse events occur and to find solutions that will prevent them in the future. Importantly, it will also strive to increase awareness and to mobilize and sustain political commitment.

The Alliance will provide international leadership to ensure that answers to the following crucial questions are sought globally, so that best practices can be established to provide decision-makers with options when shaping national strategies.

- What can policies and regulations governing the health-care system do to improve health-care safety?
- How can we create leadership, undertake research and develop tools to enhance the knowledge base about safety?
- How can we identify and learn from adverse events through mandatory and voluntary reporting systems?
- What are the best mechanisms for raising standards and expectations for improvements in safety through the actions of oversight bodies, group purchasers and professional associations?
- How do we deal with questions concerning the cost of safety measures and possible variations in acceptable levels of risk, especially in resource-poor settings?

Every health system in the world has the opportunity to make care for the patients it treats safer. The first step is to secure the commitment of political leaders, health policy-makers and the main professional bodies in each country to the goal of safer care. With the addition of technical support, skilled leadership of health organizations and the input of patients and consumers there will be an unstoppable global movement for patient safety that will save many lives and prevent much serious harm. Today's reality is that the risks of health care are far too high compared with other potentially high-risk industries that have much better safety improvement records. Tomorrow's dream is that commitment to patient safety will save lives and prevent harm across the whole world. ■

References
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