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Journal Discussion

Beyond Patient Safety to Optimal Health

A journal author argues that the current health system puts too much emphasis on patient safety when our resources should instead be aimed at the programs and activities that will result in the greatest overall improvement in patient health.

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Woolf SH. Patient Safety is not enough: Targeting quality improvements to optimize the health of the population. *Ann Intern Med.* 2004;140:33-36.

Steven H. Woolf's article, *Patient Safety is not enough: Targeting quality improvements to optimize the health of the population,* is an insightful look at the way in which the United States approaches improvements to the health care system. The fundamental premise of the piece is undeniable; Woolf proposes that we should optimally (and proportionately) aim our resources at the programs and activities that will result in the greatest improvement in patient health—and the greatest reduction in morbidity and mortality. Any other allocation scheme would result in excess morbidity and mortality. Based on this premise, Woolf further asserts that we may be placing too much emphasis on patient safety. This, of course, is almost heresy in today's political and legal atmosphere. The author is concerned that we are "concentrating on 1 niche of medicine"—patient safety—and thereby actually compromising "overall health" of the population [1]. He supports this claim with evidence from US Agency for Health Research and Quality (AHRQ) budget allocations and current US legislation, both of which display a strong emphasis on patient safety initiatives. An apt analogy is a physician who successfully (and safely) treats a chronic disease but fails to endorse the preventive care measures that can impede the development of the disease. Woolf's message is clear: look at the big picture.

Definitions of the various niches or categories of health care quality improvement activity are vital to understanding the author's argument. He defines patient safety as the subset of medical errors that pertains to actively committed errors made by health care practitioners that result in harm to the patient. The larger category of all medical errors includes not only misuse (committed errors) of medical treatment but also overuse and underuse, such as a failure to provide preventive care. Moving up the classification system, Woolf says that medical errors belong to the larger category of gaps or lapses in health care quality that have systemic features, such as lack of access, inequity, and flawed system designs. Finally, Woolf describes an overarching category of caring, which includes lapses in respect and compassion that affect patients' perspectives on health care; this final category is often difficult to measure.

There are 2 aspects of Woolf's piece that require a closer analysis: (1) Are the AHRQ funding allocations and legislative measures truly overemphasizing patient safety initiatives? (2) What elements must be considered when determining the optimal proportionality of health care improvement resource allocation?

First, we must examine the true extent to which patient safety initiatives, as strictly defined by Woolf, are dominating health care quality improvement in the United States; this is Woolf's major premise. He states that 60 percent of AHRQ grants are allocated to patient safety and that as of 2003, Congress was considering 20 bills on patient safety, and these statements are fundamentally true. Careful examination of AHRQ grant descriptions and the text of current legislation, however, reveals that the designation of "patient safety" does not necessarily mean that the grant or legislation adheres to the strict niche that Woolf describes when he refers to patient safety. Indeed, it may simply be a

difference in classification. For example, many of the AHRQ's patient safety initiatives are, in fact, designed to affect the overall health care system. Under the title of "patient safety," the AHRQ initiatives clearly take a comprehensive view of the health care system and certainly transcend classification as niche-directed initiatives. Similarly, legislation such as the Patient Safety and Quality Improvement Act of 2003 not only includes specific measures to reduce medical errors, but also provides funding for systemwide technology improvements and error-reporting procedures to identify problems in the system. It is still reasonable to conclude that patient safety receives more attention than other areas of health care quality improvement, but because of the blurred line between strict patient safety and other aspects of health care quality, the discrepancy is perhaps not so great as Woolf suggests.

Correct Action—or Convenient Action?

If, in fact, emphasis is placed on patient safety initiatives, it is important to discuss why. Patient safety initiatives have become popular for many reasons: the visibility of medical errors, the political acceptance of patient safety concerns, and the simple logic of patient safety have all contributed to the popularity of this form of quality improvement. First, medical errors have resulted in dramatic headlines in recent years. Such headlines influence public opinions and place pressure on public leaders. Second, there is little political disagreement on the worth of patient safety issues, and several reasonably researched solutions exist to address such issues. For example, electronic prescription systems have been shown to reduce medical errors unambiguously. This is in sharp contrast to other areas of health quality, including racial disparity and the uninsured, which are difficult issues both politically and logistically. Medicine's attempts to improve racial equity in care delivery and to help the uninsured have been fraught with difficulty—just as the American education system has had trouble overcoming racial inequity and poverty. It may not be unreasonable to conclude, then, that the emphasis currently placed on patient safety initiatives is a matter of convenience and political appeal. However, we can certainly agree that the most convenient action is not necessarily the correct action. Therefore, how can we strike a balance between what should be done in health care quality improvement and what is politically convenient and logistically less demanding?

Defining the correct resource allocation for the many niches of health care quality improvement is a complex task. Working from Woolf's premise, we should allocate our resources so as to reduce morbidity and mortality for the greatest number of patients.

Using this structure as a framework for analysis, we can ask several questions. Should we "strike while the iron is hot" with regard to patient safety issues, or restrain ourselves with the intent to direct a reasonable proportion of our resources to other important areas of quality improvement such as equity and the uninsured? Should we not fund solutions such as e-prescribing systems that can save lives today in exchange for funding another initiative that will save twice as many lives ten years from now?

We can at least identify some key considerations. First, we must define a time frame. Second, we must attempt to estimate the benefit to the population of any given improvement initiative. Woolf provides some good examples of this. Third, we must estimate the cost of such an initiative—monetarily, politically, and logistically. Finally, we must compare the bottom lines from several possible initiatives and choose the initiative that fits our resource constraint and provides the greatest benefit to patients.

Question for Discussion:

1. In Woolf's opinion, the current focus on patient safety obscures our vision about other solutions to health care quality problems, such as preventive medicine. What would be a better method of approaching quality improvement in health care?

Reference

1. Woolf SH. Patient safety is not enough: targeting quality improvements to optimize the health of the population. *Ann Intern Med.* 2004;140:33.

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