

HEALTH CARE FOR THE 21st CENTURY

Recent Statistics Related to Quality of Health Care in America

Medical Errors

- Between 48,000 and 98,000 people die each year in hospitals from preventable medical errors. One million more are injured. ¹
 Medical errors kill more people per year than breast cancer, AIDS or motor vehicle accidents. ²
- Medical errors have been cited as the nation's fourth leading cause of death according to the National Academy for State Health Policy. ³
- The National Academy of State Health Policy reports that 106 medical-error related bills have been introduced in state legislatures since 1999 and legislation to address medical errors has been introduced in 26 states. ⁴
- Forty-two percent of Americans report that they have been personally involved in a situation where a preventable medical error was made in their own care or that of a family member.⁵
- Thirty-five percent of physicians report that they have been personally involved in a situation where a preventable medical error was made in their own care or that of a family member. ⁵
- Seventy-three percent of the public said that the government should require health care providers to report all serious medical errors; while 21 percent said reporting should be done on a voluntary basis.⁶
- Eighty-four percent of the public thinks that increasing efforts to reduce medical errors should be a very important priority for the nation's health agenda.⁷

Providing Appropriate Care

- Doctors provide appropriate preventive care only 50 percent of the time, effective chronic care 60 percent of the time, and evidence-based acute care only 70 percent of the time.⁸
- Eighteen thousand Americans die each year from heart attacks because they didn't receive preventive medications, although they were eligible for them.

- More than 50 percent of patients with diabetes, hypertension, tobacco addiction, hyperlipidemia, congestive heart failure, asthma, depression and chronic atrial fibrillation are currently managed inadequately.¹⁰
- The lag between the discovery of more effective forms of treatment and their incorporation into routine patient care averages 17 years. ¹¹

Financial Implications of Poor Quality of Health Care

- Nearly \$400 billion -- almost one-third of the total spent on health care each year -- is wasted on poor quality health care. ¹²
- Preventable medical errors drive up health care costs by as much as \$29 billion annually. ¹³
- Medication-related errors for hospitalized patients cost roughly \$2 billion annually.¹⁴
- Nearly 66.5 million avoidable sick days and more than \$1.8 billion in excess medical costs can be traced to the health care system's routine failure to provide needed care. ¹⁵

2 - Institute of Medicine. 2000. - Centers for Disease Control and Prevention (National Center for Health Statistics). Births and Deaths: Preliminary Data for 1998. 1999. National Vital Statistics Reports. Washington, D.C.: Department of Health and Human Services.

3 - Institute of Medicine. 2000.

4 - National Academy for State Health Policy, State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals. L. Flowers. February 2002.

5 - Survey by Henry J. Kaiser Family Foundation, Harvard School of Public Health. Methodology: Fieldwork conducted by Princeton Survey Research Associates, December 3-December 13, 1999 and based on telephone interviews with a national adult sample of 1,515.

6 - Survey by Henry J. Kaiser Family Foundation, Agency for Healthcare Research and Quality. Methodology: Fieldwork conducted by Princeton Survey Research Associates, July 31-October 9, 2000 and based on telephone interviews with a national adult sample of 2,014.

7 - Harvard School of Public Health/The Robert Wood Johnson Foundation, Public Health Survey (conducted May 9-13, 2001).

8 - Schuster, McGlynn and Brook, "How Good is the Quality of Health Care in the United States" The Milbank Quarterly 76, No. 4 (December 1998).

^{1 -} Institute of Medicine. 2000. To Err Is Human: Building a Safer Health System. L. T. Kohn, J. M. Corrigan, and M. S. Donaldson, eds. Washington, D.C: National Academy Press. - Thomas, E.J., D.M. Studdert, H.R. Burstin, E.J. Orav, T. Zeena, E.J. Williams, K.M. Howard, P.C. Weiler, and T.A. Brennan. 2000. Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado. [Comment]. Medical Care 38 (3): 261-71. - Thomas, E.J., D.M. Studdert, J.P. Newhouse, B.I.W. Zbar, K.M. Howard, E.J. Williams, and T.A. Brennan. 1999. Costs of medical injuries in Utah and Colorado. Inquiry 36 (3): 255-64.

9 - Institute of Medicine, 2003a. Fostering Rapid Advances in Health Care: Learning from System Demonstrations. J. M. Corrigan, A. Greiner, and S. M. Erickson, eds. Washington, D.C.: National Academy Press. - Chassin, M.R. 1997. Assessing strategies for quality improvement. Health Aff (Millwood) 16 (3): 151-61.

10 - Institute of Medicine, 2003b. Priority Areas for National Action: Transforming Health Care Quality. K. Adams and J. M. Corrigan, eds. Washington, D.C.: National Academy Press. - Clark, C.M., J.E. Fradkin, R.G. Hiss, R.A. Lorenz, F. Vinicor, and E. Warren-Boulton. 2000. Promoting early diagnosis and treatment of type 2 diabetes: The National Diabetes Education Program. JAMA 284 (3): 363-5. - Joint National Committee on Prevention, 1997; Legorreta et al., 2000; McBride et al., 1998; Ni et al., 1998; Perez-Stable and Fuentes-Afflick, 1998; Samsa et al., 2000; Young et al., 2001

11 - Balas, E.A. 2001. Information Systems Can Prevent Errors and Improve Quality. [Comment]. Journal of the American Medical Informatics Association 8 (4): 398-9.

12 - Midwest Business Group on Health in collaboration with Juran Institute, Inc. and the Severn Group, inc., "Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership," Chicago, June 2002.

13 - Institute of Medicine. 2000.

14 - Institute of Medicine. 2000. - Bates, D.W., N. Spell, D.J. Cullen, E. Burdick, N. Laird, L.A. Petersen, S.D. Small, B.J. Sweitzer, and L.L. Leape. 1997. The costs of adverse drug events in hospitalized patients. Adverse Drug Events Prevention Study Group. JAMA 277 (4): 307-11.

15 - The National Committee for Quality Assurance, 2004. State of Health Care Quality Report. Greg Pawlson, M.D., M.P.H.; Russell Mardon, Ph.D.; Sarah Shih, M.P.H.; Oanh Vuong; Rich Mierzejewski, M.S.; Shaheen Halim, M.S.; Sarah Hudson Scholle, Dr.P.H.; Stacy Trent and Paul Rockswold, M.D., M.P.H.