Turning Errors into Gold

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By now, most readers of P&T are familiar with the series of recent reports from the Institute of Medicine (IOM) that are encouraging health care organizations and purchasers to implement policies that would enable health care to become more “safe, effective, patient-centered, timely, efficient, and equitable.” These Washington-based policy makers from the IOM have exhorted us to develop the key financing and payment mechanisms to support these goals, but they have not offered specific practical approaches for doing so. My good friend David Lansky, PhD, president of the Foundation for Accountability (FACCT) in Portland, Oregon, has outlined a perspective to effectively deal with this challenge in the policy journal Health Affairs.2 FACCT is the only not-for-profit, nationally prominent, consumer-focused research organization that attempts to improve health care in the U.S.3 The organization has a long history of “telling it like it is” from the consumer’s perspective and backs up its statements with outstandingly good research. I have had the privilege of working with FACCT since 1997, and I now chair its board of directors. I wish I could take credit for one of David’s outstanding ideas, as outlined in the Health Affairs article. Allow me to summarize the main issues he discusses.

Although the IOM reports have garnered widespread and well-deserved press, from an institutional perspective these reports represent a form of unfunded mandate—exhortation without dollars attached. Recent evidence as to how Congress views quality improvement and efficiency is also slim. For example, the annual budget for the Agency for Healthcare Research and Quality (AHRQ) represents only 1.3% of the entire budget of the National Institutes of Health (NIH). The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), contracts with peer-review organizations, for a total of about $235 million a year for quality oversight and improvement.2 This represents less than one-tenth of 1% of the entire budget for the Medicare program on an annual basis. Do you know of another $218 billion company that spends less than one-tenth of 1% evaluating the quality of its products?

Here is where David’s axiomatic and refreshing idea comes into play. Let us assume that Congress adopts legislation and creates the statutory underpinnings for a Medicare drug benefit. Many people, including myself, would agree that this would go a long way toward helping our senior citizens gain access to appropriate pharmaceuticals. It does seem silly that we pay billions of dollars annually for inpatient care when we might be able to decrease that pot with appropriate outpatient pharmacological intervention. Yet if a drug benefit were enacted, there are a number of sobering realities we would face.

Even though Americans spent an estimated $132 billion on prescriptions in the year 2000, we have little evidence regarding the value or the overall impact of that expense. Our readers know, for example, that despite the billions of dollars spent on cholesterol-lowering medications, many studies show that patients never achieve their targeted cholesterol levels. Errors in outpatient prescription fulfillment are rampant, having reached a rate of 24% in some geographical areas. This means, of course, that approximately 25% of prescriptions contain some kind of error—in dosage, format, or lack of accompanying patient education materials.

David’s idea, in a nutshell, is as follows: “Any new prescription drug program should incorporate mechanisms to inform Congress and the public about the benefits or harms associated with the program and create incentives to prescription drug plans, providers, and consumers to make effective use of the new benefit.”2 Under this new Medicare drug benefit that he envisions, public disclosure of information about the performance of prescription drug plans would serve multiple objectives:

Performance data could assist Medicare beneficiaries in selecting the plan most likely to meet their needs; help the government determine which plans should be made available to the public; permit Congress to determine if beneficiaries are receiving health benefits that justify the new federal expenditures; and create incentives for drug benefit plans to invest in and focus management effort on delivering safe, effective, and high quality service.2

When you reflect on this, it is a fantastic idea! Public disclosure of plan performance, coupled with public disclosure of health outcomes and disclosure of dispensing accuracy, would give society a way to understand more fully what it is paying for.
There might be additional positive effects from such a refreshingly straightforward idea. For example, people might recognize that they are not always getting the quality of care that they have paid for and that they had assumed to be good care. Here is where David’s work over the last seven years comes to the fore. FACCT’s mission, in part, is to help the public recognize that it may not be getting the value for its healthcare dollar. In addition, such a statutory support for error reporting would help us turn those errors into gold, literally, by improving the process, by weeding out poor performers, and by ensuring that Medicare beneficiaries get the right drug at the right dose, at the right time, by the right route, and for the right patient—the “five rights” that were discussed in the October 2002 issue of *P&T*.

Sometimes great ideas appear deceptively simple-minded. Of course, there are organizational and political barriers that we have not considered, such as requiring the Secretary of Health and Human Services to establish reporting specifications within 12 months of enactment, based on consultation with appropriate private and public sector experts and organizations. This is surely a tall order for our regulatory bodies, but it is doable, in my view.

Instead of continuing the debate about medical errors and the public hand-wringing and brow-furrowing that they entail, let us work together to implement effective legislation to turn errors into gold and to redistribute that “gold” in the form of a Medicare drug benefit for millions of deserving Americans.

I believe that David Lansky is onto something; I would like to hear your views as well. As usual, you can write to me, at david.nash@mail.lju.edu, or to FACCT.3

**REFERENCES**